SATISFACTION OF NURSING MOTHERS WITH ANTENATAL CARE SERVICES RECEIVED IN SELECTED SECONDARY HEALTH CARE FACILITIES IN OYO STATE, NIGERIA

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DEDICATION

This project is dedicated to the glory of God.

ABSTRACT

Antenatal care is an important determinant of child and maternal health. However, Antenatal Care (ANC) services in Nigerian health care facilities are underutilized as a result of several factors related to client' satisfaction, which are not yet fully identified. This study, therefore, assessed the satisfaction of nursing mothers with ANC received in selected secondary health care facilities in Oyo State, Nigeria.

This is a descriptive cross-sectional study. A total of 410 three-month post-delivery nursing mothers, were randomly selected from six out of 34 secondary health care facilities in the State. A pretested semi-structured questionnaire was used to collect information on ANC services and nursing mothers' level of satisfaction. Level of satisfaction was measured on a 32-point scale. A score of 0-9 was regarded as low satisfaction, 10-19 as moderate satisfaction, and 20 and above as high satisfaction. Data were analysed using descriptive statistics and Chi-square test.

Mean age of respondents was 28.3 ± 3.4 years and 75.9% were married. Thirty-eight percent of the respondents registered for ANC in the first trimester, 43.6% in the second trimester and 18.4% in the third trimester. Mean attendance of ANC (5.3 ± 1.5 times) was higher than the expected minimum of 5 visits. The services received included weight (99.8%) and blood pressure measurements (99.5%), urine (99.5%) and blood (99.5%) tests, iron supplementation (90.9%), tetanus injection (89.5%), prophylactic malaria therapy (80.8%), instructions on the use of insecticide-treated net (71.3%) and deworming (30.1%). Mean level of satisfaction was 16.1 ± 5.0. Overall, 54.7% of respondents were moderately satisfied, while 37.3% were highly satisfied. The majority (60.0%) of the respondents were highly satisfied with general cleanliness of the health facilities and 58.8% were very satisfied with location of the health facility. Many respondents were also satisfied with care providers' show of empathy (55.6%), prompt response to clients' needs (55.4%), respect for clients (53.2%), effective listening (52.0%) and involvement in decision-making process (52.0%). More respondents (34.8%) aged 26-30 years were highly satisfied with the care received, compared with those aged 31 years and above ($p<0.05$). However, among the respondents who were not satisfied, 57.7% expressed dissatisfaction with caregivers' negative attitude and 23.1% with unnecessary demand of

delivery items. Married respondents were significantly more satisfied than the unmarried were ($p<0.05$).

The respondents were averagely satisfied with services received at the health facilities. However most of them failed to register at first trimester. Government should improve health services to encourage client satisfaction.

Keywords: Client satisfaction, Nursing mothers, Antenatal care services, Health care facilities

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CERTIFICATION

I certify that AMAO, Josephine Olufunmike, Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria carried out this project under my supervision

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GLOSSARY OF ABBREVIATION

ANC	Ante Natal Care
DoH	Department of Health
FANC	Focus Antenatal Care
FMOH	Federal Ministry of Health
HCP	Health Care Provider
ICPD	International Conference on Population and Development
IPAS	Issues on Post Abortion Safety
IPPF	International Planned Parenthood Federation
MDGs	Millennium Development Goals
MOH	Ministry of Health
NDHS	National Demographic Health Survey
Pop Report	Population Report
PRECEDE	Predisposing, Reinforcing, Enabling Causes in Educational Diagnosis and Evaluation.
PROCEED	Policy, Regulation, in Organization, Constructs in Education and Environmental Development
SM	Safe Motherhood
SPSS	Statistical Package for Social Science
STDs	Sexually Transmitted Diseases
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Operational definitions of terms

Accessibility: Freedom to utilize any of the selected secondary health Institutions in Oyo State without any hindrance

Affordability: Ability to access the relevant maternity services with no hindrance from time, money or energy spent on the care

Antenatal care: Health care services rendered to pregnant mothers

Clients: Newly delivered mothers within the first six months of delivery or mothers that are nursing infants within the first six months of life

Health Care Providers: Skilled midwives, nurse or doctors attending to pregnant mothers during antenatal, intranatal and postnatal periods in the selected health institutions in Oyo State

Health Outcome: Live male or female babies delivered naturally by the women understudy

Health/facility: One or all the six selected secondary health institutions

Midwife: Pregnant mothers' health care provider

Quality: Any form of midwifery service that gave newly delivered mother a level of satisfaction in the selected health institution

Satisfaction: Sense of happiness derived by newly delivered mothers because of maternity care received in any of the six health facilities

Verbal Analgesia: Words of encouragement

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

In many countries, Antenatal Care (ANC) is the only time women contact the health-care system. Therefore, ANC is a unique opportunity or platform for providing a variety of health services. ANC as a key component and a pillar of Safe Motherhood, which rest on a foundation of basic health services, equity, emotional and psychological support (Federal Ministry of Health-FMOH-2008). Proper care during pregnancy and delivery is important for the health of both the mother and the baby and is an indicator of maternal and child health in society. Antenatal care from a trained provider is important to monitor the pregnancy and reduce morbidity risk for the mother during pregnancy and delivery. (National Demographic and Health Survey –NDHS- 2008).

The major objective of antenatal care is to ensure optimal health outcomes for the mother and the baby. Some of the benefits of antenatal care, as identified by the NDHS (2008), are early detection of complications and prompt treatment; prevention of disease through immunization and micronutrient supplement, birth preparedness and complication readiness, and health promotion and disease prevention through messages and counselling of pregnant mothers.

The ANC policy in Nigeria follows the newest WHO approach, which is to promote safe pregnancies, recommending at least four ANC visits for women without complications. This is called Focused Antenatal Care (FANC). Four goals of ANC, as itemized by FMOH (2008), include: health promotion, prevention of complications of pregnancy and childbirth, early detection and prompt management of problems with birth, and emergency planning. Recommendations made by FMOH (2008) to make ANC services more user-friendly are improving client provider interaction with emphasis on respecting clients' rights; ensuring that all the antenatal users have the right to be treated with dignity and respect; giving antenatal users right to full information and access to all services; and ensuring right to privacy, confidentiality, comfort, safety, free expression of opinion and continuity of care for antenatal users.

Nigeria, like most developing countries, has one of the highest maternal mortality rates in the world. Haemorrhage and obstructed labour are the principal causes, closely followed by anaemia and other serious infections. Many affected women do not book for antenatal care early to receive care that will have remarkable prevention of those preventable diseases that can complicate pregnancy and terminate maternal and foetal life abruptly (Adekunle 2002). All pregnant women are at risk of developing complications such as anaemia, malaria in pregnanacy, hypertension and so on (FMOH 2008).Many pregnant women in Nigeria do not appreciate the importance and benefits of ANC by underutilizing the services. They attend ANC just to obtain a registration card in case of unexpected emergency. However, most pregnant mothers do not attend or patronize health facilities because they were not satisfied with poor provider attitudes, unfriendly policies, such as compulsory blood donation for ANC services, inability to pay for services, inaccessibility and non-availability of services (FMOH 2008).

According to WHO (2005), a skilled health worker is 'an accredited health professional – such as a midwife, a doctor or a nurse who has been educated and trained to acquire proficiency skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-partum period and skills for identification, management and referral of complication in women and newborns. Midwives are among health care providers in pregnancy, during and after labour. Their roles include supporting and assisting the birthing parents in their journey through pregnancy, labour, birth and postpartum (though assumed a normal life process). A midwife, utilizes her clinical skills, intellect and intuition, to inform parents if anything falls outside the range of normal. She also handles emergencies by referral to where help can be assessed, that is next level of health care system. This is to reduce birth injury, trauma, caesarean section, mortality and morbidity of both the newborn and the mother.

Crow, Gage and Hampson (2007) view, midwives' attitude as a great influencing factor on service use and programmes affecting its patronage. Health care providers are encouraged by the Federal Ministry of Health to make antenatal clinic attendance pleasurable, rewarding, assuring, empathetic, accessible and affordable experience for all clients (FMOH 2008). Osungbade, Oginni and Olumide (2008), who investigated the contents of antenatal care services in Secondary Health Care facilities in Nigeria, found that blood pressure measurement, abdominal palpation and detection of foetal heart rate

were provided to all participants. Ninety-nine percent of the respondents were reached with at least one educational message. Similarly, heamoglobin estimation was done for 42.3% of the respondents, urine checked for protein was done for 43.1% of the respondents. Routine iron, and folate supplement, and malaria prophylaxis were respectively given to 36.4% and 5.4% of them.

AbouZahr/WHO and Wardlaw/UNICEF (2003) estimated that the total global maternal death was 529,000 covering 251,000 in Africa, 253,000 in Asia, 22,000 in Latin America, and 2,500 in the Caribbean. Maternal mortality rate was estimated to be 830 per 100,000 in Africa, 330 in Asia, 240 in Latin America, and 190 in Caribbean. Nigeria was ranked the second highest with maternal death among 13 countries by WHO, UNICEF and UNFPA. The WHO National Health Promotion Policy (2006) rated Nigerian's overall health system performance to be 187th among 191 member states. Maternal mortality rate in Nigeria in 2006 was estimated to be 545 per 100,000 live births. The national lifetime risk of maternal death was one in 13, which was one of the highest in the world (National Health Promotion Policy, 2006).

Okoghenun (2012) opines that pregnant mothers die in Nigeria everyday like cockroaches. He traced the cause to the three common delays in maternal deaths: delay in decision making by household whether a woman should deliver in health care facility; delay caused by roads and transport bottlenecks, like traffic jam on the way to the hospital; and delay caused by health care facility in attending to pregnant women in crisis. He also mentions dearth of infrastructure and other socio-economic factors militating against maternal well-being in pregnancy, labour and puerperium. Only 58% of mothers received antenatal care from trained health personnel, while 36.3% had no antenatal care. Thirty-nine percent of the women received delivery care from a skilled provider; 35% of the births were delivered in a health facility (59% in urban and 25% in rural settings); 39% of the births were assisted by a skilled provider; and only 32.5% received care from a nurse/ midwife.

Trends in maternal health care, as reported by NDHS (2008), revealed that the proportion of pregnant mothers that received antenatal care from a skilled provider from 2003 to 2008 remained 58% (that of urban areas was 84%, while that of rural settlements was 46%). In urban settings, skilled providers assisted 65% of the women; while in rural settlements it was 28%. In 2008, the total births in a health facility were 35%; while urban births in a

health facility had 59%, rural births in a health facility were 25%. North Central births were 41%, North-East were 13%, North-West were 8%. South-East were 74%; while South-East were 48%; and South-West were 70%. NDHS (2008) identifies missed opportunities for essential interventions in Nigeria as ANC (any) 58%, ANC (4+) 47%, TT2+ 40%, IPT 0.01%, PMTCT (mother) 0.1%, and many others. From the above demographic data, it is obvious, that maternal mortality is a serious health burden in Nigeria and women underutilize the maternal care services available during pregnancy, delivery and afterwards, despite the high fertility rate of 5.7 and high mortality rate of 545 per 100,000 live births.

Recently, the Nigerian health system considered increasing access to professional care during pregnancy, labour and delivery as a central strategy to reducing maternal mortality ratio. It then recruited midwives who were posted to rural communities and hard-to-reach areas. The success of this programme has not been evaluated but pregnant mothers' patronage of institutionalized care is unimpressive. In spite of the national recognition of the need to improve maternal health with laudable programmes, universal access to quality service remains a distant goal. Failure in quality of care is a major contributor to maternal death and serious morbidity. Health-seeking behaviour is a complex issue determined by the interplay of many factors related to patient's satisfaction and perception of their quality of care, health-services factors, socio-cultural, economic or geographic (FMOH 2008). There is a need to look at ways to improve utilization of services provided during antenatal care in order to improve client's satisfaction on quality of maternity care and access to the services.

Olaniyi (2010) opines that client satisfaction is an important component of the quality of medical care in the client-centred preventive health care. Client's satisfaction has been defined as how clients value and regard their care; it is a process as much as an attitude (Crow, et al., 2002). Some Investigators define satisfaction as a state where the patient's own expectations for treatment and care are met (Thompson and Sunol, 1995). Studies show that client satisfaction is an important determinant of the choice of health facility clients would want to attend in order to maximize health services (Bernhart 1995). Caregivers' technical skill and interpersonal skill, such as waiting time for appointment as well as helpfulness and communication of staff, emergency responses and facility's appearance all immensely contribute to patient satisfaction (Crow, et al., 2002). However,

little work has been done on clients' perceived level of satisfaction with ANC services in Nigeria, especially with secondary health facilities in Oyo State, Nigeria. This study was conducted to address the observed gap and use the data generated in the process to provide solutions to any observed lapses. This study identified satisfaction levels of mothers on the quality of antenatal care they received in six selected secondary health facilities in Oyo State, Nigeria.

1.2 Statement of the problem

The Nigeria Demographic and Health Survey-NDHS-(2008), revealed that only 58% of women aged 15-49 years received antenatal care (ANC) from a skilled provider (doctor, nurse/midwife, or auxiliary nurse/midwife) during their last pregnancy. The proportion of those who obtained ANC services from a skilled health worker was higher among women residing in urban areas (84%) than among women in rural areas (46%). The proportion of those not exposed to ANC is prone to many risks during pregnancy, labour and delivery. Such also have knowledge deficit on matters relating to their welfare during these vulnerable periods. Receiving ANC from a trained provider is an important strategy in monitoring pregnancy and reducing morbidity risk for the mother and the child during pregnancy and delivery. It also enables early detection of complications and prompt treatment. Besides, it helps in prevention of disease through immunization and micronutrient supplementation.

Increasing the births delivered in health facilities is an important factor in reducing deaths arising from the complications of pregnancy. Only 35% of pregnant mothers delivered in health facilities nationwide (20% in public sector, 15% in private sectors), 62% at home and 3% in others places (NDHS 2008). Birth attended by midwives in Oyo State was 60% compared with 74% in Osun and 64% in Ekiti States. Are mothers in Oyo State not satisfied with the care received from care providers? Vuori (1987) claims that patient satisfaction is potentially a vital predictor of partial cure as it determines whether a patient will seek medical help, comply with therapeutic regimen and would have a sustained relationship with the physician (NDHS, 2008). Patient satisfaction may be one of the factors for underutilization of prenatal care in Oyo State. This study was conducted to determine newly delivered mothers' satisfaction levels with antenatal care received in the selected secondary health care facilities in Oyo State.

1.3 Justification of the study

Prompt patronage of institutionalized care will increase access to health care services, improve maternal well-being and reduce maternal morbidity and mortality rates in Nigeria. Trends in maternal health care, as reported by NDHS (2008), revealed that the proportion of pregnant mothers that received antenatal care from a skilled provider from 2003 to 2008 remained 58% (that of urban areas was 84%, while that of rural settlements was 46%). Underutilization of maternal health services is a major challenge in patronizing institutionalized care. Antenatal, intranatal and post natal care services can give endless opportunity to mothers of reproductive age to access care when the need arises during pregnancy, labour and puerperium. This study examined the satisfaction level of antenatal care users. It suggested ways for improving the quality of maternal patronage and utilization of antenatal care.

The information gathered from this project may be used for several purposes. Programme planners and maternal health care providers can use it to develop an evidence-based, participatory plan and intervention to improve the behaviours of maternal health care providers towards antenatal care. Midwife educators/tutors can tap facts from the study to use as practical behavioural guidelines to strengthen the pre-service behavioural training of midwives. Oyo State Ministry of Health can also adopt the instrument in assessing the patronage of antenatal care in all state maternity centres. Likewise, the national Ministry of Health can cite and adopt the study to identify gaps in utilizing amenatal care by expectant mothers in different parts of the nation.

1.4 Broad objective

The broad objective of the study was to determine satisfaction level of nursing mothers with antenatal care in selected secondary health institutions in Oyo State, Nigeria.

1.5 Specific objectives

The specific objectives were to:

1. Document time during pregnancy when pregnant women register for antenatal care
2. Measure key components of prenatal care received by the nursing mothers.
3. Describe the level to which nursing mothers were satisfied with the antenatal care received in the selected secondary health institutions.

4. Document mothers' expressed need for improvement in maternity care in the secondary health institutions.

1.6 Research questions

The study provided answers to the following questions:

1. What time do mothers commonly register for antenatal care?
2. What are the components of antenatal care received by the newly delivered mothers during pregnancy?
3. What satisfaction levels do newly delivered mothers have with antenatal care in the areas of study?
4. What are nursing mothers' expressed need for improvement in health care services at the selected secondary health institutions?

1.7 Research hypotheses

The study tested the following hypotheses:

HO_1 There is no significant relationship between respondents' marital status and seeing health workers during pregnancy.

HO_2 There is no significant difference between services received in health facilities and level of satisfaction with empathy-showing and reassurance by midwives.

HO_3 There is no significant difference between respondents' levels of education and fully meeting with personal expectations in health facilities.

CHAPTER TWO

LITERATURE REVIEW

2.1 History of antenatal care

Antenatal care refers to the care that is given to a pregnant woman from the time that conception is confirmed until the beginning of labour (Anne, 2003). Dame (2004) traces the history of formal provision of antenatal care to the First World War, with the setting up of the first clinic. The clinics were rare. The huge loss of life through the war gave an impetus to using antenatal care as a method of reducing infant and maternal mortality. The first hospital antenatal clinic was opened in 1915 by doctor Ferguson in Edinburgh and supervised by Ballantyne, who also opened the first antenatal bed for inpatients. Until then, most women had no routine antenatal care during pregnancy and rarely were seen either by a midwife or by a doctor until they went into labour. By that time, there were often complications, which might have responded to earlier diagnosis and treatment if they had been available and so improved the outcome for both mother and baby.

Antenatal care service was limited in the early days, to abdominal examination, possibly urinalysis and advice or instruction on diet (Dame, 2004). The concept of antenatal care as a preventive measure grew slowly and developed until well after the Maternal and Child Welfare Act of 1918, which encouraged local authorities to set up antenatal clinics. The content and intervals of antenatal visits were first specified in 1929 by the then Ministry of Health. Later, measurement of the mother's blood pressure, external assessment of the pelvis and guidelines for the minimum number of antenatal examinations undertaken during pregnancy were included (WHO, 1985). Only a doctor would carry out the first examination; those at 32 and 36 weeks had midwives carrying out the remainder (WHO, 1985).

By 1935, it was estimated that 80% of the women in the UK were receiving some antenatal care and the recommended intervals were similar to those of today, namely 16, 24, 28, 32, 34, and 36 weeks and then weekly until the outset of labour (Oakley, 1982). By 1946, the estimated figure for women receiving antenatal care had risen to 91% (Oakley, 1982). Now, most women in the UK seek regular antenatal care and accept that it

is important for their own health and the health of their babies. Unfortunately, those who are least likely to attend an antenatal care clinic tend to be those who are most at risk of developing complications, for example women from the lower socioeconomic classes, young teenagers and women at high parity (Oakley,1982).

2.2 Concept of safe motherhood

A meeting held by Regional Reproductive Health Task Force in Dakar, Senegal in 2003 called all partners to develop and implement a road map for accelerated maternal and newborn mortality reduction in Africa, because the Millennium Development Goals (MDGs) call for 75% reduction of maternal mortality ratio and 2/3 reduction of child mortality rate by 2015 in Africa. To achieve this, there is an urgent need to ensure universal access to quality health care services during pregnancy, labour and after delivery. The provision of skilled birth attendant during pregnancy, childbirth, and post-natal period at all levels of health care delivery system to strengthen the capacity of individuals, families, and communities to improve maternal and neonatal health captures the concept of safe motherhood. Safe motherhood is a concerted effort by a pregnant woman herself, her immediate and extended family members, her community and all health personnel at the primary, secondary, and tertiary levels to ensure the safety of a pregnant woman and her baby during pregnancy, labour and after delivery. Safe motherhood is a multi-sector approach to the reduction of maternal mortality. Related sectors include education, health, transport, human rights, mass communication and so on. A similar single-sector approach to reducing maternal and newborn mortality rates introduced by WHO and other development partners is Making Pregnancy Safe Initiative. It is a health-sector response to alleviating maternal and newborn morbidity and mortality. The aim is to provide safe antenatal care, delivery and post-natal services as well as quality neonatal care (FMOH, 2003).

There is a significant mismatch in reproductive health services and the workforce (FMOH 2008). For example, more than half (58.2%) of the health centres that offer antenatal care and delivery services do so without a midwife, or a SCHEW, while midwives work in some health centres that do not offer pregnancy care services. The mismatch is attributable to a lack of trained health work force and to inappropriate distribution of the available workforce (FMOH 2008). For quality antenatal care and attainment of Millennium Development Goals, there is the need to put in place training and retraining of maternal

health care providers on safe motherhood and other life-saving skills to make pregnancy safer for Nigerian mothers.

2.3 Components of antenatal care

Anne (2003) identifies the following as essential components of ANC globally:

Booking visit- The initial visit to the antenatal clinic aimed at introducing women to maternity service. During this period, information will be shared between the women and the midwife or health care provider in order to discuss, plan and implement care for the duration of the pregnancy and postnatally. Mothers will be encouraged to book early because the earlier the time of first contact with the maternity health care provider, the more appropriate and valuable the advice given relating to nutrition and care of developing foetal delicate organs. Early pregnancy may leave the woman feeling exhausted and overwhelmed.

Referral to a physician or obstetrician for expert care. The care include : introduction to maternity care, physical examination, the midwife's examination, medical examination, abdominal examination, preparation for labour and initial assessment. Osungbade, Oginni and Olumide (2008) note that antenatal services include blood pressure measurement, abdominal palpation and detection of foetal heart rate, which has reasonable capacity for intervention against pre-eclampsia and some foetal problems and could contribute to delivery in a health facility and by a health worker.

2.4 Patterns of antenatal care

From the outset of antenatal care in the UK, the pattern of antenatal visits has rarely been questioned even though when set up there was no evidence to suggest there were any benefits. The attendance ritual appeared to be generally acceptable, with neither women nor professionals questioning the rationale. There was a recommendation, as far back as 1982, that maternity providers review the number of visit for 'low- risk women' but this was never widely implemented (Hall et al., 1985). This challenge to routine practice was less likely to happen in one place of birth changed and women were under further scrutiny in the hospital environment. The publication of changing childbirth (Dott, 1993) urged service providers to review the system of antenatal visits, suggesting that it must focus on the most effective way. The WHO's newest approach is to promote safe pregnancies, recommending at least four ANC visits for women without complication instead of focusing on the traditional number of visit (FMOH, 2008). The new schedule of visits is as

follows: the first visit should occur by the end of 16 weeks of pregnancy; the second visit should be between 24 and 28 weeks of pregnancy; the third visit is at 32 weeks; and the fourth visit takes place at 36 weeks. However, women with complications, special needs, or conditions beyond the scope of basic care may require additional visits (DHS 2008).

2.5 Status of antenatal care in Nigeria

A total of 59.2% of women attend at least one ANC visit in Nigeria (NDHS, 2008). The pattern of ANC in Nigeria involved transition from traditional approach to FANC approach. Ndidi and Oseremen (2010) assert that a study on the timing of booking in Nigeria showed that 73.6% (256) booked in the second trimester and 26.4% in the third trimester. However, in answer to the question on the best time for women to book for antenatal care, about three quarter (73.3%) felt the first three months of pregnancy was the best time to book for antenatal care, while 22.4% chose the second trimester and 4.3% the third trimester. Of the 256 multiparous women, 205(80%) had booked at least one previous pregnancy late. Arulogun (2007) asserts that antenatal care aims at providing care for normal, low risk and abnormal high-risk pregnancies. There is a great variation in the provision and content of prenatal care in developed and developing countries. Specific barriers to free access to prenatal care persist, as it appears that the number of women not seeking or receiving antenatal care is increasing in Nigeria. Many strategies were put in place to increase prenatal, natal and postnatal care uptake. Among them was deployment of 4000 midwives to 1000 health facilities to provide skill care to mothers in rural setting during pregnancy, labour, and puerperium. Providing financial incentives was another strategy planned in Nigeria to encourage increased access to maternal care and reduce mortality rates in rural health facilities that render maternity care services (FMOH, 2012).

Arulogun (2007) avers that financial incentives alone do not overcome barrier to receiving prenatal care. Additional efforts to facilitate enrolment and enhanced social support services for the pregnant mothers are necessary. Antenatal care is inevitably about balance. All women seek a healthy outcome to their pregnancy but not necessarily have the same antenatal care as their neighbours. Antenatal services should be acceptable to all women who use them. Whenever these are provided, there should be visible and accessible information. All the staff in the team should be trained appropriately to meet the varying needs of women, particularly those who may be vulnerable and disadvantaged.

Antenatal care has several functions. It gives the health professional an ideal opportunity to share information and offer support. Earle's (2000) qualitative study exploring the relationship between women's experiences of pregnancy and the maintenance of self-identity found that the relationship between the community midwives and the woman was important to the experience, and that continuity of both cares might be influential. Despite increase national efforts to rectify this challenge of underutilization, access to institutionallscd care remains a distant goal (FMOH, 2011).

2.6 Roles of health care providers during pregnancy

Health care providers, otherwise known as health workers or skilled attendants, are defined by Liamputtong et al. (2005) as individuals or institutions that provide preventive, curative, promotional or rehabilitative health care services in a systematic way to individuals, families or communities. A joint statement made by WHO/ICM/FIGO (2004) defines a skilled birth attendant as "an accredited health professional, such as a midwife, doctor, or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and immediate postnatal period, and in the identification, management, and referral of complications in women and newborns". Health care providers may be an health care professionals, gynaecological nurses or midwives, or obstetricians. Health facilities, include hospitals, clinics, primary care sites, and other delivery points.

Mavis (2000) observes that midwives do not relate only to mothers; they also relate to babies, partners, fathers, grandparents, whole families and many varying significant others. They equally relate to isolated women and help them to build the support network. She cites Nicky leap's opinion of midwives as being "alongside with women", embracing uncertainty together as women "take up" the power that will enable them to lead fulfilling lives as individuals and mothers and motivating the women's friendship group to be there for her. They are professional servants Mavis (2000) describes midwives as extraordinarily powerful when a woman is in labour influence; they also direct women in labour. They are a safe anchor (feeling safe enough to let go) that is trustworthy. They are calm and quiet, able to avoid being unobstructive, for example not naughty, and angry; producing intrusive directions; being undermined; wrong assumptions; trust betrayed; and anxiety-provoking interventions. Any problem in the relationship often become obvious because of heightened emotional atmosphere that surrounds a birth.

A midwife has many roles to play during pregnancy, labour, and post-delivery. Her/his roles during pregnancy period inch de:

i To give the necessary supervision, care, and advice to women during pregnancy.

ii Health counselling and education. She/he should include antenatal education and preparation for parenthood and extend to certain areas of gynaecology, family planning, and childcare. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other services (Adam, 1998).

Roles during delivery: Midwives are to conduct deliveries and to care for the newborn. This care includes preventive measures for the detection of abnormal conditions in the mother and the infant. They give procurement of medical assistance and the execution of emergency measures in the absence of medical help. To perform the above roles, according to Wiman et al. (2004), involves being open to and perceptive of others, being genuinely concerned about patients, being morally responsible, being truly present for the satisfaction of patients and being dedicated and having the courage to be appropriately involved as a professional nurse. Oli (2008) identifies care as a requisite for coping and an inherent feature of nursing practice whereby clients are assisted to recover in the face of illness, understand the illness, cope, and re-establish connection. She views the outcome of caring as the outcome of health, which, in turn, affects future interventions.

The above definition can be adopted to describe quality antenatal care as being open to and perceptive of others, being genuinely concerned about patients, being morally responsible, being truly present for expectant mothers, and being dedicated and having courage to be appropriately involved as a professional. These roles and attributes can be used to measure the quality of antenatal care or services.

2.7 Concept of quality and satisfaction

Thiedke (2010) said "In 20 years of practice, I rarely received a report on patient satisfaction that I found useful. Like many of my colleagues, I felt ambivalent about patient satisfaction and wondered why so many organizations seemed to value it so highly". The irony, of course, is that providing care to patients that is respectful and helps them maximize their health is among the most important things to do. In addition, discussions in the literature make it clear that quality of care is not what is being measured in patient surveys. In fact, many surveys intentionally avoid asking patients how they feel

about the quality of their care, presumably because patients are not in a position to judge their physician's technical skill. It appears that what's being measured is typically a combination of the patient's expectation before the visit, the patient's experience at the visit and the extent to which the patient experienced a resolution of the symptoms that led him or her to making the visit.

The published output appearing in the medical and nursing literature, which incorporated the term "patient satisfaction", rose to a peak of over 1000 papers annually in 1994, reflecting changes in service management especially in the U.K. and U.S.A. over the past decade. National Health Policy Guidelines and Standard of Practice (2005) claims that the aim of quality assurance is to improve provider's performance and increase client's satisfaction. Professionals define quality in many ways. Deming (1998) defines quality as "doing the right things right.' Quality, from a public health perspective, means offering the greatest health benefits, with the least health risk, to the greatest number of people, given the available resources. World Health Organization (1996) affirms that "Quality of Health Care consists of the proper performance (according to standards of interventions) that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on morality, morbidity, disability and malnutrition". Clients' perspective of quality depends largely on client's interaction with providers. Such attributes include waiting time and privacy, ease of access to care, and whether they get the service they want. Most client's want respect, understanding, complete and accurate information, technical competence, access and fair results.

Donabedian and Maxwell (1980) view the level of patient satisfaction as being an important determinant in quality of care. Satisfaction is a measurement that obtains reports or ratings from patients about services received from an organization, a hospital, a physician, or a health provider (Donabedian and Maxwell, 1980). Bruise (1990) identifies six independent elements of quality health service that are termed the 3'A's and 3'E's. The service must be Appropriate, Accessible, Acceptable, Equitable, Effective, and Efficient. Mohammed and Rajiv (2008) aver that reviewing the client's perspective should be an integral part of health programme management. The feedback of clients must be complemented by direct observation of process and resource evaluation. They observe that client satisfaction related to antenatal care services in the Musandam region of Oman was very good. Communicating with clients in their native language could be the key to

satisfying their antenatal service needs. They also claim that the presence of community support group members or Arabic-speaking health staff improved cooperation of participants in the study. Ivanov, Flynn,West and June (1999) note that client satisfaction is the litmus test that enables health programmes to assess the impact of their services; hence, it is an integral part of quality assurance process of health delivery. IPAS (Issues in Post Abortion Cares) identify some elements of quality care. These are discussed below:

2.7.1 Timing of counselling and provision of methods: Mavis (2000) asserts that, in her study, all the women experienced temporal and locality distortion, and experienced a sense of timelessness. Also, Beck (1994) found that labouring women's sense of time fluctuates throughout the process. This has implications for midwifery practice (Mavis, 2000). Time taken for antenatal care must be within the limit that the expectant mothers will be able to cope with to improve access. Improving access can have positive effects on health care outcomes (Surji, Wadhwa and Fraçp, 2002).

2.7.2 Information and counselling: Health care organizations should be encouraged to address those aspects of service that consumers most readily appreciate: relationships between health practitioners, meaningful and understandable information and participation in their own health care and treatment decision-making processes (Surjit et al., 2002). One aspect of health care quality that is being increasingly recognized for its importance is the influence of patient perception which relies on information. The ability of the health care organisation to satisfy the consumer's demand for convenience and information can significantly influence the quality of health care it ultimately delivers. Providing patients with relevant information is a link that increases patient compliance (Surjit et al., 2002).

2.7.3 Technical competence: International Planned Parenthood Federation (IPPF) Framework (Huezo and Carrigar., 1997) identifies providers' need for training on technical and communication skills in quality. It is an influenced framework developed by the IPPF, as cited by Population Reports Volume XXVI No. 1 (1998), which empowers clients and motivates providers by presenting elements of quality care. The framework adds access as another basic element of quality. Population Report (2000) affirms that quality of care is closely linked to accessibility. Ensuring access to services means making good quality and affordable care available where and when convenient to the nearby health worker or facility. It adds that: "When a facility lacks properly trained staff, opens irregularly, suffers from supply shortages, charges high prices, the community does not have adequate access to services". Quality services help programmes to pursue their goal

of making services universally available. Quality of care is a cardinal issue in health service delivery with many elements.

2.8 Dimensions of quality

There are eight dimensions of quality of health service delivery as identified by Brown Dickie, Brown and Biehn (1995):

2.8.1 Effective: Means the desired outcomes (results) of care achieved through accurate and appropriate diagnosis and treatment to this degree. It relates the accuracy of the diagnosis (be it medical, nursing or midwifery) and the capacity of the treatment to boosting the health of the clients such as safe delivery, life babies and mothers.

2.8.2 Efficiency refers to clients' perceptions of how well the personnel perform administrative processes and use resources to achieve a set goal. It is the ratio of the outputs of services to the associated cost of producing those services, taking into consideration both material and time resources.

2.8.3 Technical competence: According to Clients' Feedback in Peru, technical competence is "the ability and performance of health providers as measured against clinical guidelines". Some indicators that can be useful in measuring technical competence are trained professionals (specialists), meticulous and thorough care, rapid service or timely attendance and painless care such as painless injection.

Mensol et al. (1994) opine that people everywhere continually assess the quality of the services that they receive. Given a chance, they use providers and facilities that offer the best available care, as they perceive it. Vuori (1987), cited by Population Report, (1998), notes that clients can and do judge the technical competence of the services they receive, although they may not be technically accurate. For example, clients surveyed in Chile based their judgement on the cleanliness of the clinics in Kenya; those in Zambia based theirs on how thoroughly they were examined; those in Indonesia on what type of medicine they received. Population Reports (1998) avers that client could judge technical competence by whether their needs are met or whether their problems are resolved.

2.8.4 Interpersonal relations: These include: level of respect, courtesy, responsiveness, empathy, effective listening and communication between clinic personnel and clients.

2.8.5 Access to service: The degree to which health care services are unrestricted by geographic, economic, social, organizational, or linguistic barriers.

2.8.6 Safety: The level of trust, confidentiality, and privacy in the services and the degree to which the risks of injury, infection, or other harmful side effects are minimized.

2.8.7 Continuity: The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment.

i. 2.8.8 Physical aspects: The physical appearance of the facility and the level of cleanliness, comfort and amenities offered. The physical aspects of the facility, such as the appearance and cleanliness of the clinic and provider, and arrangements to assure maximum privacy during the examination are other important dimensions of quality of care. Olaniyi (2010) notes that women in Kenya reported that they had more confidence in a provider who had clean and ironed clothing, a clean appearance, clean instruments, and clean linen on the examination table. PATH (2002) claims that screened women were more likely to believe that equipment was safe ($p < 0.002$), found waiting times acceptable ($p < 0.001$), reported receiving good care ($p < 0.02$) and were more likely to say that they were satisfied with the services they had received at the health facility ($p < 0.001$). In addition, screened women exhibited significantly higher mean scores on the client satisfaction scale ($p < 0.001$) than unscreened women(Winkler, Bingham, Coffey and Penn, 2007).

From the above, one can deduce that quality of care is an important issue in health service delivery, that has many elements or components. The component of interest in this research is satisfaction of nursing mothers with services received, interpersonal relations of health providers in some secondary health facilities, the outcome of such experience and the influence it will have on access or patronage of institutionalized maternity care in Oyo State at large.

2.9 Measurable Indicators of quality

In managing health programme or organization, programme managers must first translate quality objectives into measurable indicators of the performance of individual staff members and of an entire system (Diprete, Franco, Rafch and Hatzell, 1993). A comprehensive quality control system uses different types of indicators, each measuring a particular aspect of quality, and providing complementary information (De Geyndy, 1995). There are many ways to conceptualize and define indicators. The Evaluation Project specifically for family planning programmes adapts the following system:

- Input indicators gauge whether a programme has the needed resources, for example, the number of trained providers and the stock of contraceptives.
- Process indicators measure how well programme activities are implemented. Examples include waiting times, the percentage of providers who follow infection-prevention procedures, and the percentage of clients who are informed on when to return for resupply or a check-up.
- Output indicators measure results at the programme level. Examples include the number of clients served, the percentage of clients who receive an appropriate method, continuation rates, and the percentage of cases of STDs successfully treated.
- Outcome indicators measure the programme's short-term effects and long-term impacts on the general population— for example, contraceptive prevalence, the incidence of sexually transmitted diseases, and the fertility rate (Bertrand et al., 1994).

2.10 Elements of quality measured in this study

The elements of quality measured in the study include the following

2.10.1 Effectiveness: The aim of antenatal care is to ensure safe and uncomplicated delivery, leading to a living and healthy newborn without causing injury or trauma to maternal health. Antenatal care must be health-promoting to both the foetus and the mother. The indicators to measure the outcome effectiveness of midwifery care are: (a) mode of delivery, (b) live baby, (c) injury to the mother and (d) trauma to the new born. Whether baby is alive or not was a yardstick of the effectiveness of service because safe delivery is the hallmark of the interaction.

2.10.2 Technical competence: Vuori (1987), Vera (1993), Mensol et al. (1994), Ndhlovu (1995), Ndulo (1995) and Population Reports (1998) assert that technical competence is very difficult to measure. The indicators of technical competence include presence of a trained midwife or professional that attends to the mother in pregnancy, during deliveries and, gives meticulous and thorough care. Such care includes early diagnosis of danger that can complicate delivery and prompt referral to the next level, explanation of procedures prior to intervention in order to obtain informed consent. It also includes the involvement of the client in decision-making processes in terms of treatment options, rapid service or timely attendance to client complaints and readiness to assist. Painless care is another indicator of technical competence of midwives. Midwives relive labour pains through use

of analgesics, verbal analgesia, back rubbing, therapeutic touch, and so on. Going deep into technical competence of midwives is essential to be sure of safety of client and emergency prepamtion in order to improve matemal and infant well-being and directly or indirectly reduce morbidity and mortality rate. To attain the ultimate goal of antenatal care, skilled care is necessary for early diagnosis of risks that can complicate delivery right from pregnancy and prompt intervention when necessary.

2.10.3 Interpersonal Relations: June (2010) asserts that, for one to gain patients' trust, one must show interest in their values, goals and be a good listener per excellence. It is also necessary to refrain from dominating conversation during visits. If one forces patients to accept a treatment plan before they are ready, they will be less likely to trust one's advice and comply with the plan. Effective listening and inquiry will help one to uncover a patient's real needs and goals. Therefore, it is important to encourage dialogue not monologue. Developing strong patient relations that increase levels of satisfaction is challenging but a realistic goal. Good interpersonal relationship will provide fresh insights into the approach to adopt with the patient and can lead to greater understanding of the patient's need and increase compliance. Indicators of good Interpersonal relationship are courtesy, respect, empathy, responsiveness, effective listening and communication between clients and health care providers.

2.10.4 Access to antenatal service: This is one of the major elements of quality. Increased patronage to antenatal care always advocated for in health care enterprises in order to achieve the aim and objectives of the health programme. The success of any business is to encourage patronage or win customers. Accessibility is a good indicator of success or failure of any business, including health programme. Accessibility of qualified health care services and satisfaction of those receiving them are very important issues, which have always received much attention and are progressively gaining more importance. Pregnant mothers in Thailand attend at least four (4) antenatal care check-ups every month until 28weeks, then fortnightly from 28 to 32weeks and every week until delivery. Antenatal care is also free in Thailand in the public health sector, private and teaching hospitals. However, the number of visits depends on the woman and her health care providers.

2.11 Satisfaction levels of the mothers with antenatal care

This can be an outcome or process indicator. It can be achieved through satisfying the needs of mothers and their expectations which, in turn, causes a pleasant feeling and promotes well- being. It also brings about feeling of calmness and security. Scholl (2000) states that "if the needs and expectations are satisfied, the satisfaction achieved will be more profound and complete and vice versa. In other words, failure to satisfy their needs causes anxiety and imbalance. He adds that "without complete identification of the perceptions satisfying them will certainly be defective". So the mother's needs and expectations must be identified. Acceptance and compliance should be evaluated in order to promote the quality of maternity care, prevent dissipation of health care provider and expenses incurred in providing maternal services.

2.12 Positive predicting factors of client satisfaction

The determinants of satisfaction examined in relation to the expectations, and demographic and psychosocial variables. These distinguished from the multidimensional components of satisfaction as aspects of the delivery of care, identified by many authors. Fosbinder (1994) has identified the following factors as key areas determining patient satisfaction and quality of care:

1 Attitude of staff: Fosbinder (1994) observes that "interpersonal competence" and "intercultural competence" for skilled providers may be as important as technical competence, at least from the perspective of patient satisfaction with maternity care; and that "core competencies" for skilled providers must go beyond skills training alone. Many maternal survival programmes already recognize the essential role of provider behaviours in quality of, and satisfaction with, skilled childbirth care. Most clinical skills training manuals and programmes include basic principles and guidelines for providing emotional and informational support to women and their families during normal pregnancy and birth, and also during complications and emergencies. "Core competence" for skilled care providers has been expanded to include courteous, respectful, individualized care during birth, and awareness of and respect for cultural differences.

2 Affordability of cost of care: Drucker (2000) claims that the purpose of any business is to create a customer, because it is the customers who determine what a business is. Any business enterprise has two and only two basic functions as marketing and innovations. Howgill (2000) encourages health managers and planners to position

themselves in their markets' minds and embrace fundamental marketing principles, beginning with a sound understanding of the feelings, attitudes, and expectations of those they serve. Jasper and Raymond (2006) describe customer satisfaction as largely developed in the production sector and consumer services markets, and is regarded as the raison d'etre for company's existence and operations. The provision of service or production of a product offered for sale should be aimed at satisfying the identified needs of the targeted customers.

3 Availability of doctors or midwives: Ofi (2009) opines that care can be construed as a professional connection and involvement, which is personal, value laden, cultural bound and with moral implications. In other words, care is professional touch and human touch.

Are the maternity services having human professional touch? What about the attitudes of health caregivers? Are they therapeutic or injurious to expectant mothers? Are clients satisfied with human touch of maternity care providers? Is there any genuine concern of the health care providers about patients? Are health care workers morally responsible individuals? Do they present to attend to expectant mothers in faces of needs? Are they dedicated? Do they summon courage as professionals in the discharge of their duties? Time spent at the hospital, availability of drugs, availability of equipment, proximity to the hospital, explanation of health problems to patients and language barrier are other factors that can predict patronage of antenatal care services.

In satisfying consumers, there is need for communication, a two-way process whereby a person or a group of persons passes a message through a channel to another person or group of persons and gets a feedback that acknowledges the recipient's understanding of the message. It has four major types: (1) Intra-personal communication, with oneself; it include self-justification for one's action; (2) Inter-personal, person-to-person communication, and this type is verbal and non-verbal exchange that involves sharing information and feelings between individuals or in a small group; (3) Mass communication, transmitting massages to a large audience through the mass media; (4) Organizational communication within a group or an organization and among organizations.

Communication can be verbal or non-verbal. Non-verbal communication may include facial expression, body gestures (hand, leg, foot, or eye), body posture/position, finger

drumming, toe/foot taping, and folded arms when non-verbal behaviour does not match verbal messages. Odeku (2005) asserts that, when clients feel uncomfortable, they start rumours, default (drop out) and use the method incorrectly. She then gives some pieces of advice on what a midwife could do to ensure clients' satisfaction as: welcome clients to the clinic, introduce yourself, speak in the client's language, be patient, do not interrupt, make eye contact, don't discuss other clients, keep the clinic clean and show that you are listening. In verbal communication, something is said. Words, tone and behaviour should convey interest and concern. Verbal communication may be influenced by emotions, such as anger, boredom, happiness, frustration, and disgust, lack of interest, impatience, and disapproval. A good health provider must recognize clients as consumers of health services that need to be satisfied.

2.13 Factors that determine satisfaction

According to Thiedke (2010), factors that determine satisfaction include:

1. Patient-related factors:

Some studies state that patient demographics are a minor factor in patient satisfaction, (Hall and Dornan 1990), while others claim that demographics represent 90 percent to 95 percent of the variance in rates of satisfaction (Sixma, Spreeuwenberg and Pasch,1998). Nevertheless, the literature sheds some light on how particular demographic factors affect patient satisfaction.

Age: The most consistent finding has been related to age: Older patients tend to be more satisfied with their health care Thiedke (2010)

Ethnicity: Studies that have looked at ethnicity have generally held that being a member of a minority group is associated with lower rates of satisfaction. In a ranking of degrees of satisfaction, non-Hispanic whites had the highest satisfaction, followed by African Americans, Asian/Pacific Islanders and Hispanics. The lowest degree of satisfaction was found in Indians/Alaskan natives (Haviland, Morales, Dial and Pincus, 2005).

Gender: Studies on the effect of gender are contradictory, with some studies showing that women tend to be less satisfied and other studies showing the opposite.

Socioeconomic status: Most studies have found that individuals of lower socioeconomic status and less education tend to be less satisfied with their health care (Kersnik, Svab and Vegnuti, 2001). Other studies have shown that poorer satisfaction with care is associated with experiencing worry, depression, fear or hopelessness(Frostholm, Fink, and Oernboel, 2005) having a psychiatric diagnosis, such as schizophrenia, post-traumatic stress disorder or drug abuse (Desai, Stefanovics and Rosenheck, 2005).

Health status: Looking at patients with chronic diseases has shown some consistent patterns. Patients with poorly controlled diabetes were less satisfied with their care (Desai et al, 2005) as were migraine sufferers who reported more migraine-related disability (Walling, Woolley, Molgaard, and Kallail, 2005). Dissatisfied migraine sufferers were less likely to use triptans currently, were more than two times more likely to have stopped them, and were less likely to have their medications paid for by their insurance. Patients with two or more chronic illnesses reported more hassles with the health care system than

those with a single chronic illness (Parchman, Noel and Lee, 2005). In this study, when communication and coordination of care increased, the patients' perception of hassle decreased and satisfaction improved.

2 Physician-related factors

Physicians can promote higher rates of satisfaction by improving the way they interact with their patients.

Expectations: Perhaps the most important lesson for physicians is to take the time and effort to elicit patient expectations. When physicians recognize and address patient expectations, satisfaction is higher not only for the patient, but also for the physician. Patients often show up at a visit desiring information more than they desire a specific action (Walling, 2000). In addition, approximately 10 percent of the patients in one study had one or more unvoiced desires in a visit with their physicians. The desires for a referral or for physical therapy were the most common. Young and undereducated patients were more likely to experience unmet needs at their visits, and they demonstrated less symptom improvement and evaluated their visits less positively.

Communication: Doctor-patient communication can also affect the rate of satisfaction. When patients who presented to their family physician for work-related, low-back pain felt that communication with the physician was positive (that is, the physician took the problem seriously, explained the condition clearly, tried to understand the patient's job and gave advice to prevent reinjury), their rates of satisfaction were higher than could be explained by symptom relief (Rao 2005).

Control: Physicians can also improve patient satisfaction by relinquishing some control over the encounter. Studies have found that, when physicians exhibited less dominance by encouraging patients to express their ideas, concerns and expectations, patients were more satisfied with their visits and more likely to adhere to physicians' advice (Bell, Kravitz, Thom, Krupat and Azari, 2001).

Decision-making: Patient satisfaction can also be influenced by physicians' medical decision- making. Patients expressed a preference for physicians who recognized the importance of their social and mental functioning as much as their physical functioning (Sherbourne, Sturm and Wells, 1999).

Time spent: Time spent during a visit plays a role in patient satisfaction, with satisfaction rates improving as visit length increases. In a study, the gross time spent chatting during the visit was also related to higher rates of satisfaction. Physicians with high-volume practices were more efficient with their time but had lower rates of patient satisfaction, offered fewer preventive services and were viewed as less sensitive in the doctor-patient relationship (Zyzanski, Stange, Langa and Flocke, 1998).

Interestingly, one study showed that, while physicians felt rushed 10 percent of the time, patients felt that way only 3 percent of the time. Patient satisfaction was identical whether the physician did or did not feel rushes (Lin, Albertson and Schilling, 2001). This suggests that physicians may be more sensitive to feelings of being rushed and their feelings may not reflect the actual time spent during the visit.

Technical skills: Several studies have looked at patients' assessment of their physicians' technical skills and the effect on satisfaction, but the findings are contradictory. In a survey of 236 "vulnerable" older patients, better communication skills were linked to higher patient satisfaction but technical expertise was not (Chang, Hays and Shekelle, 2006). However, another study found that, when forced to make a trade-off, participants expressed a strong preference for physicians who have high technical skills (Fung, Elliott and Hays 2005). Patients also indicated that a physician's ability to make the correct diagnosis and craft an effective treatment plan were more important than his or her "bedside manner" (Fung et al 2005).

Appearance: Patients also seem to respond to a physician's appearance. In one study from New Zealand, patients indicated that they preferred "semiformal" attire and a smile. Next in order of preference were "semi-formal" dress without a smile, a white coat, a formal suit, jeans and casual dress (Lill and Wilkinson, 2005). They were less comfortable with facial piercings, short tops, or earrings on men. In addition, most patients wanted to be called by their first name, be introduced to the doctor by his full name and title, and see a name badge.

3 System-related factors

Patient satisfaction is not simply a product of the patient's demographics and the physician's skills. It is also affected by the system in which care is provided.

Patient satisfaction surveys of inpatient physician performance showed an inverse relationship between satisfaction and risk management episodes (Stelfox, Gandhi, Orav and Gustafson, 2005). The following pieces of advice are given to improve positive client providers interpersonal relationship: Treat patients with dignity and include them in decision making; work with n team you can be proud of and invest in their ongoing development; Elicit patients' concerns by asking questions such as "What do you think is going on?" or "What are you afraid of?" Dress in semiformal attire – and do not forget to smile. Caregivers med to find pleasure in what they do. Physicians who report high professional satisfaction have patients who are more satisfied with their care (Haas, Cook, Puopolo, Burstin, Cleary and Brennan 2000).

2.14 Outcome of patients' satisfaction

Client satisfaction is one of the most important results of good-quality care because clients' satisfaction influences their behaviour. It is a worthwhile programme goal. Satisfaction may influence whether clients seek care; whether they go for care; whether they are willing to pay for service; whether people in need of family planning; whether clients follow the provider's instructions on correct use, whether clients continue using their method; whether they return to the provider and whether they recommend services to others. Adrienne (1998). Clients' satisfaction level influence health-seeking behaviour, patronage, utilization of health services and continuity of service utilization. Schuler et al (1998) recorded the opinion of c poor woman in Bangladesh, as "even though they behaved badly, I have to be content. We are lucky if we can get the free medicine that they give out at the clinic". The statement is loaded with meaning and implies that client satisfaction depends not only on service quality but also on client's expectations. Clients are satisfied when services meet or exceed their expectations. If clients' expectations are low or if they have limited access to any services, they may be satisfied with relatively poor services.

Brown et al, (1995) give a survey report that health care clients often expect poor quality care, accept it without complaint, and even express satisfaction. Client satisfaction does not necessarily mean that quality is good. It may mean that expectations are low.

Mohlowv (1999) avers that clients may say they are satisfied because they want to please the interviewer. They are afraid that care might be withheld in the future. They have cultural norms against complaining. They want to respond positively to the word

"satisfied. Brown et al. (1995) also opines that managers should not assume that the care provided is adequate just because clients do not complain. Low level of reported dissatisfaction as low as 5% should be taken seriously. Bennet et al (1994), Gilson, Alilco and Heggenhougen, (1994), Olatunbosun and Edward (1997), and Paredes et al. (1996) observe that when clients perceptions of quality are inaccurate, their expectations can influence providers' behaviour and actually lower the quality of care. Some clients sometimes want inappropriate tests, procedures, or treatments in the mistaken belief that they constitute good quality. Gilson and Heggenhaugen (1994) gave two accounts of what care did in response to such demands: Peruvian physicians have prescribed unnecessary medicines for childhood diarrhoea; while Indonesian providers have given unnecessary injections to ill patient.

Jasper and Rnymond (2006) itemize the advantages of client satisfaction as follows:

1. Add value to the organization from a number of perspectives: creation of sustainable client loyalty to the firm.
2. Repeat purchase
3. Acceptance of other products or services offered by the service firm
4. Increase market share and profitability levels
5. Creation of positive word of mouth and a measure of market performance
6. Reflection of a positive outcome from the outlay of scarce resources and/or fulfilment of unmet needs.

Michael (2012) asserts that 'efforts to obtain useful information on patient satisfaction in Indonesia have been frustrated by a tendency of respondents to withhold critical comments. His survey of 75 patients in eleven health centres on three islands attempted to obtain credible information on satisfaction by asking for information on events, not opinions, and on the relative importance of the factors surveyed. Unlike previous research where 95% of respondents typically answered that they were 'fully satisfied', 28% of the respondents replied that their consultation had not been conducted in private (ranked first in importance among the non-medical factors), 65% said the facility could be cleaner (ranked second in importance), and 19-48% reported not receiving various kinds of information (ranked third). The respondents were able to support their positive answers with corroborative information in a high percentage of instances.

For many decades, the goal has been to satisfy customers. While satisfaction is important, it is not sufficient to guarantee that your customers will continue to buy from you. The world changes quickly and the minute you get complacent, a new competitor surfaces with a solution it claims is better, faster or cheaper. A satisfied customer is NOT always a loyal customer. Profiles International (2009) gives seven indicators that will help programme planner to go beyond simply satisfying customers, to protecting and growing strategic accounts (see Appendix iii).

2.15 Conceptual framework

2.13 Application of the PRECEDE framework for Understanding Clients' Perceived Level of Satisfaction with Maternal Health Care Services Given By Health Care Providers.

PRECEDE is an acronym for Predisposing, Reinforcing, Enabling Causes in Educational Diagnosis and Evaluation Figure 1. PROCEED is an acronym for Policy, Regulation, in Organization, Constructs in Education and Environmental Development. The PRECEDE-PROCEED model was developed as a planning framework from which health education and health promotion programmes could be designed (Green, Kreuter, Deeds and Partridge, 1980; Green & Kreuter, 1991) The PRECEDE (figure 1) model is based on the platform that an educational diagnosis should precede an intervention just as a medical diagnosis precedes a treatment plan (Green et al., 1980). This model is multidimensional, founded in the social/behavioural sciences, epidemiology, administration and education. As such, it recognizes that health and health behaviours have multiple causations, which must be evaluated in order to ensure appropriate intervention. This model believes in problem-solving based on targeting the root cause of the problem. The comprehensive nature of PROCEED allows for application in a variety of settings, such as school health education, patient/client education, community health education, and direct patient care settings.

The planning process outline in the model rests on two principles:

- The principle of participation, which states that success in achieving change, is enhanced by the active participation of members of the target audience in defining their own high-priority problems and goals and in developing and implementing solutions.
- The important role of the environmental factors as determinants of health and health behaviour such as media, industry, politics, and social inequities

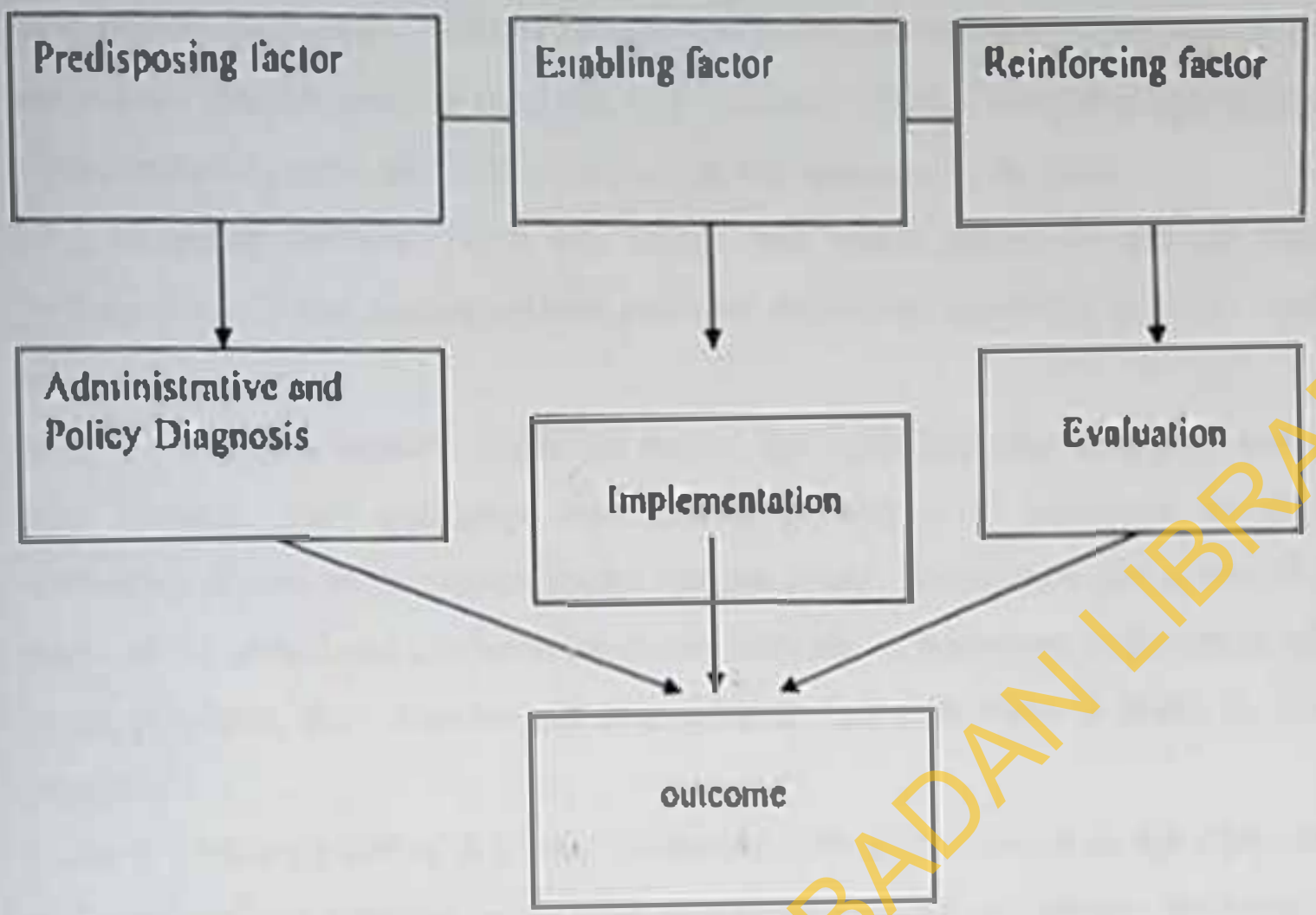
PROCEED has 7 phases (figure 2):

Phase 1 - Social Diagnosis: This phase identifies and evaluates the social problems which influence the quality of life of a target population. Prevent behaviors that lead to underutilization of maternal health care services that predisposes to maternal ill health and death during pregnancy, labour and puerperium. Social diagnosis in this study is on client satisfaction issue that has great influence on utilization of antenatal care services in Oyo State.

Phase 2 - Epidemiological Diagnosis: This phase helps determine health issues associated with the quality of life. It helps identify minor or major disorders of pregnancy, labour and puerperium such as malaria and anaemia. This, in turn, helps in reduction of women morbidity and mortality related to pregnancy, labour and puerperium.

Phase 3 - Behavioural Diagnosis: This phase focuses on the systematic identification of health practices and other factors, which seem to link to health problems defined in Phase 2. This includes non-behavioural causes (personal and environmental factors such as use of insecticides treated net or prophylactic use of antimalaria) that can contribute to health problems, but not controlled by behaviour or mothers seeking maternal health care services. Likewise measures and services rendered in preventing complications and Infection during pregnancy for example blood check for early detection of the anomaly that may complicate pregnancy and Tetanus Toxoid injection to expectant mothers in pregnancy to prevent tetanus infection.

FIGURE 1 DIAGRAM SHOWING PRECEDE MODEL USED FOR THE STUDY



Phase 4 - Educational Diagnosis: This phase assesses the causes of health behaviours. See figure 1.

2.4.1 Predisposing factors: These factors motivate or provide reasons for behaviours. They include knowledge, attitudes and cultural beliefs. Knowledge of predisposing factors and attitude towards prenatal care, will help to decide whether it requires special treatment when detected or not it also aids perception of the outcomes of the care.

2.4.2 Enabling factors: These are factors that enable people to act on their own predisposition. These factors include available resources, supportive policies, assistance and services.

2.4.3 Reinforcing factors: These are factors that come into play after a behaviour, has been initiated, They encourage repetition or persistence of behaviour by providing continuing reward or incentives, social support, praise, reassurance and symptom Relief might all be considered a reinforcing factor. Attitude of midwives, experiences with the health providers, their attitudes and disposition as well as location of health facilities are important

Phase 5 - Administrative & Policy Diagnosis: This phase focuses on the administrative and organizational concerns which must be addressed prior to programme implementation. It includes the assessment of resources, budget development and allocation, implementation timetable, organization or personnel within programmmes, and coordination of the programme with all other departments, and institutional organizations and the community.

Administrative Diagnosis: This has to do with the analysis of policies, resources, prevailing circumstances and organizational situations that could hinder or facilitate the development of the health programme, for example, number of antenatal visits schedule during pregnancy.

Policy Diagnosis: The aim is to assess the compatibility of programme goals and objectives with those of the organization and its administration, does it fit into the mission statements, rules and regulations?

Phase 6 – Implementation of the programme

Phase 7 – Evaluation: Evaluation measures change in terms of overall objectives and changes in health and social benefits or the quality of life. Safe delivery with little or no trauma to both the mothers and the newborn is the expected results of midwifery care. It may take years before an actual change in the quality of life is achieved. The outcome is to

improve maternal and child well-being, which, in turn has drastic and consistent reduction effects on mortality and morbidity rates in both mothers and their newborn.

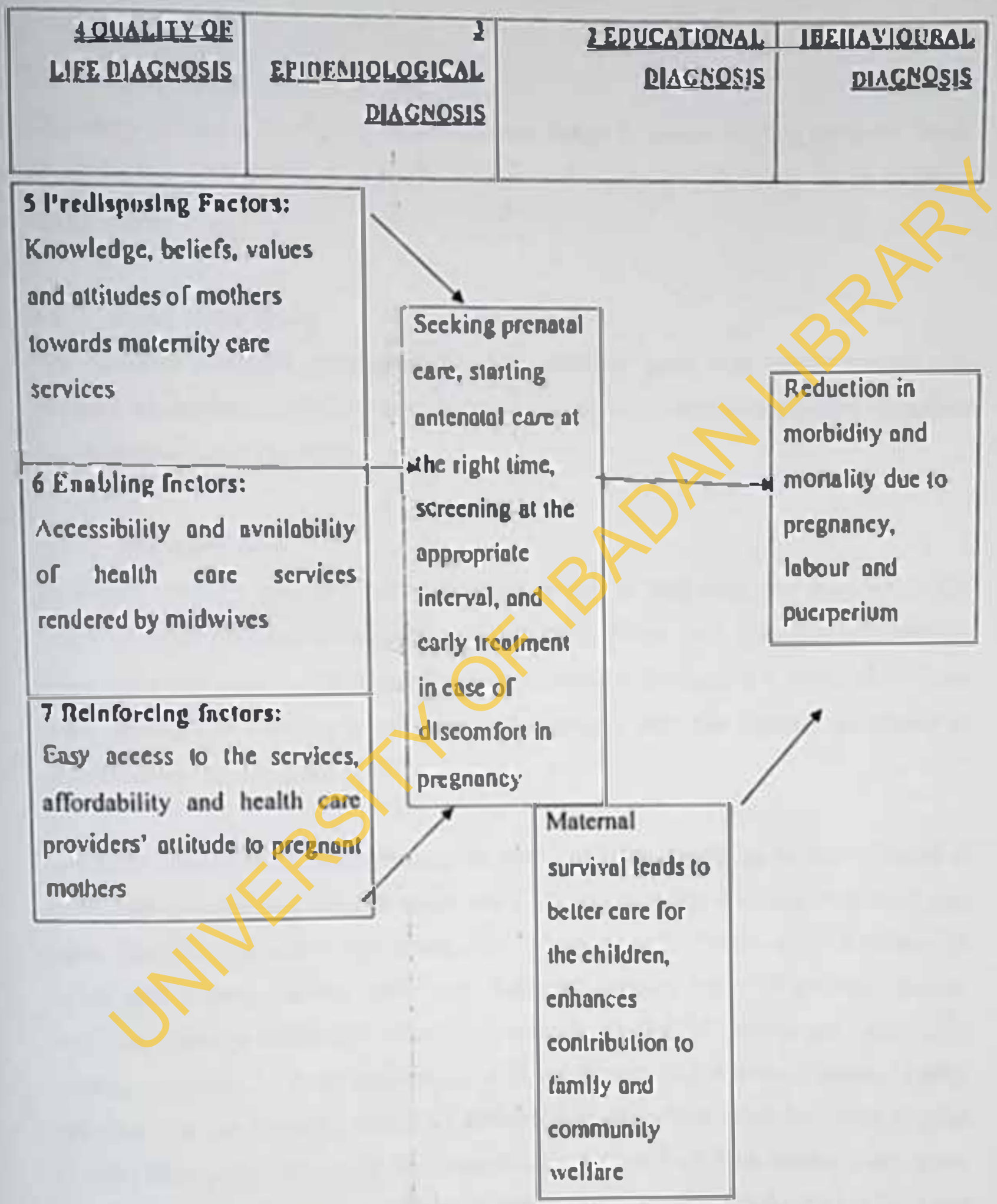


FIGURE 2: Diagram Showing Proceed Precede Conceptual Framework Explaining Satisfaction Level of the Respondents with Antenatal Care

CHAPTER THREE

METHODOLOGY

3.1 Study design

This study utilized a descriptive cross-sectional design to assess Nursing mothers' levels of satisfaction with antenatal care services received in selected secondary health facilities in Oyo State.

3.2 Scope of the Study

The research measured nursing mothers' satisfaction level with caring relationship between the maternity care providers and their clients in six randomly selected secondary health institutions in Oyo State.

3.3 The study area

Oyo state covers a total of 27,249 square kilometers of land mass and bounded in the South by Ogun state and in the north by Kwara State. To the west, it is bounded partly by Ogun State and partly by the Republic of Benin; while in the East, it is bounded by Osun State. Ibadan has been the reputed largest indigenous city, and capital, and centre of administration of Oyo State.

The State consists of 33 local governments with population (according to 2006 Census) of 5,591,589 comprising 2,809,840 males and 2,781,749 females. The state is divided into three senatorial districts of Oyo North, Oyo Central and Oyo South. Oyo North has 13 Local governments, namely: Saki West, Saki East, Atisbo, Irepo, Olorunsogo, Kajola, Iwajowa, Itesiwaju, Ogbomoso North, Ogbomoso South, Orire, Oorelope and Iseyin. Oyo Central comprises 11 local governments Afijio, Akinyele, Ogo Oluwa, Egbeda, Lagelu, Surulere, Ona-ara, Oluyole, Atiba, Oyo East and Oyo West. Oyo South Senatorial District consists of 9 local governments, viz: Ibadan North, Ibadan North East, Ibadan North West, Ibadan South east, Ibadan South West, Ibarapa Central, Ibarapa North, Ibarapa East and Ido. The state is homogeneous, comprising mainly the Yoruba ethnic group who descended from Oduduwa and speak the Yoruba language. They are rich in culture and believe in strong kinship ties with extended family system. Agriculture is the major source

of income for the greatest number of the people of Oyo State, especially those that reside in rural settlements.

Oyo State has 47 general hospitals. 351 primary health centres, 166 primary health clinics, 113 rural health centres (health posts), 1 maternity and dental centre at Aremo. The state has 887 registered private hospitals and clinics.

There are 5 notable state hospitals namely: State Hospital Ring Road Ibadan, General Hospital Ogbomoso, State Hospital Oyo, General Hospital Saki and Adeoyo Maternity Teaching Hospital, Yemetu, Ibadan, Adeoyo Maternity opened in 1927 and was upgraded on Sunday, 3 October, 2003. The list of secondary health institutions rendering antenatal care services is in appendix IV and appendix III. This project collected data from six secondary health institutions located in urban and rural settlements of Oyo State. The urban sites are Ibadan, Ogbomoso, and Oyo, while the rural sites are Moniya, Fiditi and Igboora.

In Ibadan, a large maternity hospital known as Adeoyo Maternity Hospital selected because it is one of the busiest hospital in Oyo State and for her appellation "Baby Factory." Adeoyo Maternity Teaching Hospital is the oldest hospital in Oyo State, established in 1927 by the Native Authority. The regional government took over, then the State Government of Nigeria in 1957. It is situated in Ibadan North Local Government. The hospital takes care of all aspects of medical services like medical-surgical, obstetrics and gynaecology, ophthalmology, peadiatricts and so on. In 1986, the hospital services were limited to maternity services owing to the large number of deliveries being conducted in the hospital hence its appellation "the baby factory of Oyo State. The hospital provides antenatal, intranatal, family planning, children outpatient and breastfeeding services. The clinic runs from Monday to Friday, while the wards run all shifts for 24 hours. It has 247 bed spaces with 483 staff strength. The religious practices in the hospital area are Christianity, Islam and African Traditional Religion. The available social services to the people in the local government area include road network, electricity, boreholes, pipe-borne water and educational institutions. The hospital has just being upgraded "after 80 years of neglect," from the former Oyo State Governor, Alao-Akala. General Hospital, Ogbomoso was recently upgraded to a Teaching Hospital under the auspice of Ladoke Akintola University of Technology, Ogbomoso. General Hospital Oyo

and State Hospitals in Igboora, Moniya and Fiditi were under the management of Oyo State Hospital Management Board, secretariat, Ibadan. All the facilities treat complicated obstetric cases and give referral services to the next level of care.

3.4 Study population

The population for this study consisted of Nursing mothers within 15-49 years of age.

3.5 Target population

Nursing mother that received care from midwives and other health workers during pregnancy, labour and peurperium.

3.6 Sample size determination

The sample size for this study was determined by using electronic device in calculating the number of respondents. Epi-Info software device was used to calculate from the state female population in Oyo state, which was 2,781,749. Expected frequency used was 27% of the population. The calculated expected population for female in the state was 1,892. 1,892 female population was divided by 33(No of the Local Government areas of Oyo state) = 57.3. So 57.3 female population per local government was multiplied six (6), the number of selected local government areas in the state. (57.3 X 6 = 344).

Taking non-response to be 20% Adjusted sample size: 344+68.8 = 412.8. Approximately = 410. (Devane, Begley, Clark, 2004).

3.7 Inclusion criteria

Inclusion criteria for selecting the research participants included:

1. Newly delivered mothers must visit the selected secondary hospitals for antenatal care regardless of the number of visits or their marital status.
2. Delivery status must be one or more.
3. Mothers must deliver within a period of six months.
4. Age: 14-49 years

3.8 Exclusion Criteria

1. Staff of the unit
2. Women with gynaecological problem
3. Women too ill to respond
4. Women that delivered before getting to the hospital, that is Born Before Arrival (BBA).

3.9 Sampling technique

The Multistage sampling technique was used to select the secondary health facilities.

Stage 1- A record review was done and a sampling frame of 34 secondary health facilities rendering maternity care in Oyo State was generated.

Stage 2- Oyo State has three senatorial districts. Therefore, the facilities were clustered into three.

Stage 3- From each cluster, one rural secondary health institution and one urban secondary health institution were selected

Stage 4- From each of the facilities selected, respondents were selected using snow balling method. The respondents help in tracing the newly delivered mothers in the community and those that qualified, using the stipulated inclusion criteria, were interviewed.

3.10 Instrument for data collection

The instrument used for data collection for this study was, semi structured Interview Guide (please see appendix 1).

Section A: Socio-demographic characteristics of respondents

Section B: Maternity service received by mothers in the health facility

Section C: Mothers' satisfaction level with quality of care

Section D: Perception and expectations of mothers on utilization of the health facility

Section E: Areas needing Improvement

3.11 Validity of the Instrument

The instrument drafted under supervision and subjected to several stages of pretesting. Initially, it was peer reviewed. In-house assessment of the instrument was done among nobles in the field of Reproductive Health, Faculty of Public Health, College of Medicine, University of Ibadan to ensure face and content validity. Necessary corrections were made based on the experts' observations in order to improve the standard of the instrument. Then the instrument was pretested in a secondary government health institution in Ikire, Osun State. From the data collected, it was observed that the mothers interviewed in the hospital setting were not assertive enough to give details of their experiences with the care providers. So ten (10) instruments was administered to respondents in their community settings. It was then observed that mothers were assertive enough to give details on their satisfaction with the care received in the selected secondary health institutions. This necessitated a change in the proposed in-depth exit interview to in-depth interview with

house-to-house community approach to elicit reliable information on the topic under study. The findings of the pretest were used to further scrutinize and reset the items in the instrument for necessary adjustment for the main study.

Training of research assistants was conducted. Six research assistants were employed and trained to assist in data collection. During the process of training, emphasis was laid on the following:

- Understanding the concepts of the study and the objectives of the study
- How to approach and probe respondents to collect data during interview
- Review of inclusion and exclusion criteria
- Interpersonal communication skill
- Practical demonstrations

3.12 Reliability of the instrument

The instrument also went through measures of internal consistency, with the use of Cronbach's alpha coefficient analysis to confirm its reliability. This is a model of internal consistency, based on the average inter-item correlation. The result showing correlation coefficient greater than 0.5 is said to be reliable. In this study the result was 0.615, which is greater than 0.5, thereby confirming its high degree of reliability.

3.13 Ethical Considerations

The following ethical steps were taken:

1. Permission was obtained from Oyo State Hospital Management Board and the selected secondary health institutions prior to the data collection. See Appendix vii for UCH/UI Ethical Review Committee approval and Appendix viii for University of Ibadan Postgraduate Registration of Title of Thesis/Dissertation.
2. Participation of each was voluntary.
3. Careful explanation of purpose, content and implications of the study was provided and verbal informed consent was obtained from each respondent before the collection of data.
4. Respondents were assured of the confidentiality of the data.
5. Names, addresses and other identifiers of the respondents were excluded from the instrument.

3.14 Procedure of data collection

Six research assistants (two male four female) recruited in July 2010, went in pairs from house to house, per each local government per day. Snowball method of sample selection was used in choosing the house and the respondents. On getting to the respondents, the research assistance validated the respondents' status to participate and obtain verbal consent from them ethically before the interview. After the interview, the respondents were inquired of the next house to go in order to trace another respondent thus snowballing method. All women that were ready to participate with the inclusion criteria were chosen for the study. Initially, questions were asked on place of delivery to be sure that birthplace was under one of the health facilities under study. The research assistants had been trained to document place of birth and participants' intension to participate (please see appendix I - the sample of the instrument). The study lasted two weeks working days. The first six days were for collection of the data, other days for mop up. Each of the research assistants obtained data from 10 -15 respondents on daily basis. Weekends days were not included in order to meet the respondents on ground. The following stages were procedure involved in data collection:

Stage one tracing the respondent from the health facilities.

Stage two interview of the respondent.

Stage three asking the interviewed respondent to trace newly delivered mothers in the community.

Stage four screening of the nursing mothers to ascertain her suitability for the Interview.

Stage five the interview of the new respondent and repetition of stages 3 and 4 until the total number of the respondents interviewed.

The intention of the interview explained to the respondents and the trained research assistant interviewed newly delivered mothers in their home settings and workplace after verification of the inclusion and exclusion criteria. The respondents were traced from the other respondents. After each day's work, data cleansing done. Action plan for the collection of data was ensued and then followed.

3.15 Data Analysis

The investigator and two research assistants checked the data collected each day to make sure that they were accurate. The data collected were cleansed manually, coded and were fed into a computer for analysis using the coding guide. The number of the instruments used was checked daily for errors and corrections were made before entering the data into the computer; that is, data cleansing and sorting were done daily. SPSS Software Package was used for data analysis. Frequencies generated and Chi-square test was used to test the associations between categorical variables in the data. The level of statistical significance was set at 0.05. Information obtained summarized and presented in Tables and charts for better comprehension.

3.16 Limitation of the Study

Cost and time limit were major factors that restricted this study.

CHAPTER FOUR

RESULTS

4.1 Social-demographic characteristics of the respondents

Table 4.1 shows the socio-demographic characteristics of the respondents. The respondents' age ranged between 17 and 45 years. About one third of the respondents (37.3%) were within 30 - 39 years age group; and more than half (52.4%) of the respondents were between 20 and 29 years, with a mean age of 28.34 years ±5.5. Most of them (74.4%) were married and 20.0% were co-habiting. Almost all the respondents (94.4%) were Yoruba. A total of 61.7% had secondary education, and 25.6% had primary education. Many 57.8% of the respondents were Muslims, while 42.2% were Christians. The majority 32.4% of the women had two children. The highest parity was six (6). Only 7% of the respondents were widows. More than half (50.3%) of the women were self-employed, followed by those who were artisan (10.2%).

Table 4.1 Socio-demographic characteristics of the respondents (n=410)

		Frequency	Percentage
Age Group in years	<19	17	4.1
	20 – 29	215	52.4
	30 – 39	153	37.3
	40 – 49	13	3.1
	No Response	12	2.9
Educational Status	Primary	105	25.6
	Secondary	253	61.7
	Higher	42	10.2
	No formal education	6	1.46
	Arabic	1	0.24
	No response	3	0.73
Ethnic Group	Yoruba	389	94.9
	Hausa	8	2.0
	Ibo	3	.7
	Edo	4	1.0
	Togolese	6	1.5
Marital Status	Single	6	1.5
	Married	305	74.4
	Cohabiting	82	20.0
	Widow	3	.7
	Separated	6	1.5
	No response	8	1.9
Parity	1	105	25.6
	2	133	32.4
	3	85	20.7
	4	64	15.6
	5	14	3.4
	6	3	.7
	I can't say	1	.2
	No response	5	1.4
Occupation	Civil servant	21	5.1
	Self employed	323	50.2
	Farmers	2	.5
	Artisans	42	10.2
	Students	8	2.0
	Unemployed	5	1.2
	Apprentices	3	.7

N:B Non-Nigerians included Togolese (1.5%)

4.2 Type of health workers that provide antenatal care – A total of 38.8% of the respondents claimed that during pregnancy they received antenatal care from nurses, 25.4% from community health workers, 13.7% from doctors, 8.7% from midwife and 12.4% from more than one health worker. See Table 4.2

TABLE 4.2 Types of health workers that gave antenatal care services

Health Worker	Frequency	Percentage
Doctor	56	13.7
Nurses	151	36.8
Midwives	36	8.7
Auxiliary midwives	5	1.2
Community/village health worker	104	25.4
Multiple health workers	51	12.4
Unable to identify cadre of Health workers	7	1.7

4.3 Antenatal care services received

Antenatal care services received by the subjects were prenatal diagnostic care, preventive care received during, pregnancy and prenatal curative care.

4.3.1 Pre natal diagnostic care

Almost all the pregnant mothers (99.5%) were weighed, 99.3% had their blood pressure estimated, almost all (99.5%) had their urine tested and 100% had blood test done. See table 4.3

4.3.2 Preventive care received during pregnancy

Many (90.0%) of the pregnant women had tetanus injection: Most of the respondents (71.3%) reported that they were told to sleep under insecticide-treated net. Most mothers, (78.8%) received prophylactic antimalaria Table 4.3

4.3.3 Pre natal curative care

A large proportion (89.7%) of the subject had iron drugs. Also 28.8% were dewormed. See Table 4.3

Table 4.3 Services provided by the health care providers for the respondents

Type of services during ANC		No	%
Diagnostic	Weight	408	99.5
	B/pressure	407	99.3
	Urine test	408	99.5
	Blood test	410	100
Curative	Iron drug	368	89.7
	Deworming	118	28.8
Preventive care	T.T. injection	369	90.0
	Anti-malaria	323	78.8
	Told to use Insecticide Treated Net		71.3

4.4 Respondents' level of satisfaction with care given by the health care providers

A majority (93.1%) of the respondents' declared that their personal expectations were fully met. Many (60%) of them were very satisfied with the general cleanliness of the health facilities, good physical outlook of the labour ward and location of the health facilities (58.8%), with midwives showing empathy and reassurance (55.6%); with prompt responsiveness of the midwives to their needs (55.4%), midwives' level of respect (53.2%), and with effective listening of midwives and their involvement in decision making process (52%) and of appropriate management of pain during labour (51.5%).

The few respondents (6.6%) claimed that their expectations were not fully met. The reasons given were uncaring attitude of their caregivers (57.7%), demanding too much (23.1%), and wasting a lot of time (15.4%). See Table 4.4.

Table 4.4 Mothers' satisfaction level with quality of health care received from the providers

Statement on satisfaction	Very satisfied		Satisfied		Low satisfaction		No comment	
	No	%	No	%	No	%	No	%
Level of respect	218	53.2	170	41.5	20	4.9	2	.5
Prompt responsiveness to your need	227	55.4	164	40	19	4.6	—	0
Show empathy and reassurance	228	55.6	150	36.6	30	7.3	2	.5
Effective listening of midwives	213	52	163	39.8	31	7.6	3	7
Allowing family members to see visitor	166	40.5	207	50.5	32	7.8	5	1.2
Involves you in decision making process	213	52	155	37.8	38	9.3	4	1
Supportive care given by midwives	207	50.6	176	42.9	24	5.9	2	.5
Antenatal clinic visit schedule	210	51.2	187	45.6	9	2.2	2	.5
Enjoyed therapeutic touch	194	47.3	189	46.1	19	4.6	6	1.4
Cleanliness of the health facilities	248	60.5	151	36.8	36	8	3	.7
Keeping privacy	205	50.0	176	42.9	7	1.7	22	5.4
Good physical outlook (labour ward)	241	58.8	102	39.5	5	1.2	2	.5
Location of health facility	224	54.6	169	41.2	16	3.9	1	.2
Referral services	181	44.1	203	49.5	7	1.7	19	4.6
Appropriate management of pain	211	51.5	191	46.5	6	1.5	2	.4
Ensuring baby is given BCG immunization	254	62	150	36.6	5	1.2	1	.2

4.5 Respondents' level of satisfaction score

Table 4.5 below shows the frequency distribution of level of satisfaction score in groups. The median satisfaction score among respondents was 17.0, while the mean was 16.1±5.0 and ranged between 0-22. A little above half of the respondents had moderate satisfaction (54.7%), more than one third had high satisfaction (37.3%). Only 33 of the respondents (8.0%) had low satisfaction. See Table 4.5

Table 4.5: Level of satisfaction score

Satisfaction score	Frequency	Percentage
Low satisfaction (0-9)	33	8.0
Moderate satisfaction (10-19)	227	54.4
High satisfaction (20 and above)	150	37.6

4.6 Comparisons Of mean satisfaction score between levels of socio-demographic variables.

The table 4.6 shows the comparison of mean satisfaction score between socio-demographic characteristics of mothers. Mothers aged 26-30 years had a higher mean satisfaction score (17.2), compared to those 16-20 years (16.5), 21-25 years (15.6), 31-35 years (15.3); and 36 years and above (13.4) (p=0.00). Those that were married had a higher mean satisfaction score (16.7), compared to those that were cohabiting (13.8), and those in other categories (15.9) (p<0.001). Those with primary/no education had a lower mean satisfaction score (16.1), compared to those with secondary/tertiary education (16.3). This, however, was not significant (p=0.651). Mothers from the Yoruba ethnic group had a higher mean satisfaction score (16.2), compared to those from other ethnic groups (14.2); this was significant (p=0.049).

Table 4.6 Comparisons Of Mean Satisfaction Score Between Levels Of Socio-Demographic Variables. N=410

Variable	Mean Score	Sd	T/F Test	P.Value
Age				
<19	16.9	4.9	4.984	0.001
20-29	15.6	5.0		
30-39	17.2	4.8		
40-49	15.3	5.1		
No response	13.4	4.8		
Marital status				
Married	16.7	5.3	12.213	<0.001
Cohobiting	13.8	3.2		
Others	15.9	4.8		
Occupation				
Skilled	14.8	5.0	1.342	0.262
Semi skilled	16.	5.1		
Unskilled	15.7	4.5		
Level of education				
Primary	16.1	4.8	-0.454	0.651
Secondary	16.3	4.8		
Higher				
No formal education				
Arabic				
No response				
Religion				
Christian	16.1	5.1	0.154	0.878
Islam	16.0	5.0		
Tribe				
Yoruba	16.2	5.1	2.068	0.049
Others	14.2	4.3		
Income (naira)				
1000-10000	13.2	5.1	47.197	<0.001
11000+	13.7	3.9		
Others	20.2	3.0		
Parity				
Once	15.6	4.8	1.070	0.361
Twice	16.7	5.0		
Thrice	3.9	5.8		
Four and above	16.1	4.7		

4.7 Areas of midwifery care that need improvement in the selected health facilities

About half 185 (45.1%) of the respondents expressed some concerns for improvement in the services provided at the health facilities, which include: attitude towards patient (47.5%), inadequate materials (26.5%), and insufficient staff (15.1%). (Table 4.7)

Table 4.7 Areas of Midwifery services that need improvement in the selected health institutions N= 185

Areas that needs improvement	No	%
Involvement of patients	4	2.2
Insufficient staff	28	15.1
No. adequate materials	49	26.5
Cleanliness of the surrounding	4	2.2
Midwives should have good attitude towards patient	88	47.6
ITN should be provided for pregnant women on admission	1	.5
Midwives should stop giving patients episiotomy	3	1.6
Midwives should be checking the weight of the baby	1	.5
Improve Family Planning	2	1.1
Incompetent midwives	5	2.7
TOTAL	185	100

Table 4.8: Number of respondents that identified needs for Improvement per sampled facility/town

	Adeoyo	Ogbomoso	Oyo	Monlya	Fiditi	Igboora	Total
Involvement	3	0	0	1	0	0	4
Insufficient of staff	5	9	7	1	3	3	28
Inadequate materials	12	3	7	10	11	6	49
Cleanliness of the surrounding	2	0	2	0	0	0	4
Need for improvement on attitudes of midwives	40	18	11	10	0	9	88
Provision of ITN for pregnant mothers	0	0	1	0	0	0	1
Episiotomy should stop	0	0	1	0	0	2	3
Midwives should be checking baby's weight	1	0	0	0	0	0	1
Family planning services should be improved	2	0	0	0	0	0	2
Improve midwife's competency	4	0	1	0	0	0	5
Total	69	30	30	22	14	20	185

4.9 Time of first antenatal care

The majority of the respondents (52.9%) booked at about the fifth month (second semester). The mean number of visits was 5.3 times. See Table 4.9

Table 4.9 Time of first antenatal care

Month (Trimester)	Frequency	Percentage
1 First	109	26.6
2 Second	217	52.9
3 Third	76	18.5
4 No response	8	2.0

4.10 Test of hypothesis

Hypothesis 1- The first hypothesis states that there is no significant relationship between respondents' marital status and seeing health worker during pregnancy.

The results showed that out of 74.4% respondents' that were married, received care from health workers during their pregnancy. All (1.5%) respondents that were separated saw health workers. Out of 1.5% of the respondents that were single, only 0.2% did not see any health worker during pregnancy. All (20.0%) of the respondents that were cohabiting saw health workers during pregnancy. The statistical test of significance revealed that $p<0.05$, indicating there is association between respondents' marital status and whether they saw health workers during their pregnancy. This suggests that the hypothesis is not true; it is, therefore, rejected. (Table 4.10).

Table 4.10: Association between marital status of respondents and weather they seen health worker during pregnancy.

Marital status	Seen health worker during pregnancy					
	Yes		No		Total	
	No	%	No	%	No	%
Single	5	1.5	1	0.2	6	1.5
Married	304	74.2	1	0.2	305	74.4
Cohabiting	79	19.3	3	0.7	82	20.0
Widow	2	0.4	1	0.2	3	0.7
Separated	5	1.2	1	0.2	6	1.5
Those who did not disclose their marital status	8	1.9	0	0.0	8	1.9

$X^2 = 62.423$ Degree of freedom = 4 p value 0.000 $p<0.05$

Hypothesis 2: The second hypothesis states that there is no significant difference between services received in health facility and level of satisfaction with empathy showing and reassurance by midwives.

The results showed that, out of 34.4% respondents that used Adeoyo Hospital, 15.9% were very satisfied, 12.7% were satisfied, and 5.9% were not satisfied. In General Hospital, Ogbomoso, out of 14.4% respondents 8.0% were very satisfied, satisfied (6.1%) and 0.2%. In General Hospital, Oyo, out of 14.4% respondents; 8.5% were very satisfied, 4.9% were satisfied, 0.5% were not satisfied; and 0.5% were not sure. In General Hospital, Moniya, out of 14.9% respondents; 9.0% were very satisfied, 5.6% satisfied and 0.2% were not satisfied. In General Hospital, Fiditi, out of 7.1% respondents; 5.6% were very satisfied while 1.5% were not satisfied. In Igboora General Hospital, out of 14.9% of respondents, 8.5% were very satisfied, 5.9% were satisfied, and 0.5% were not satisfied. The statistical test of significance revealed that $p<0.05$, indicating there is association between services received in health facility and showing of empathy and reassurance to respondents' by midwives. This suggests that the hypothesis is not true, it is, therefore, rejected. (Table 4.11)

Table 4.11: Association between services received in health facility and level of satisfaction of respondents with showing of empathy and reassurance by midwives.

Health Facility	Showing of empathy and reassurance			
	Very satisfied	Satisfied	Not Satisfied	Not sure
Adeoyo	65 (15.9%)	52 (12.7%)	24 (5.9%)	0 (0.0%)
Ogbomoso	33 (8.0%)	25 (6.1%)	1 (0.2%)	0 (0.0%)
Oyo	35(8.5%)	20 (4.9%)	2 (0.5%)	2 (0.5%)
Moniya	37 (9.0%)	23 (5.6%)	1 (0.2%)	0 (0.0%)
Fiditi	23 (5.6%)	6 (1.5%)	0 (0.0%)	0 (0.0%)
Igboora	35(8.5%)	24 (5.9%)	2 (0.5%)	0 (0.0%)

$\chi^2 = 48.501$ Degree of freedom = 15 p value 0.000 $p< 0.05$

Hypothesis 3: There is no significant difference between respondents' level of education and fully meeting with the respondents' personal expectation in health facility.

The results showed that all the respondents' without any formal schooling (1.3%) and those with Arabic education (0.3%) had their expectations fully met. Among respondents with Primary Education, 23.5% had their expectations were fully met. Most, 59.2% with Secondary School Certificate, had their expectations fully met, and 8.8% of respondents' with higher education had their expectations fully met. The statistical test of significance revealed that $p>0.05$, indicating there is no association between respondents' level of education and weather personal expectation fully met in health facility. This suggests that the hypothesis is true; it is, therefore accepted. (Table 4.12)

Table 4.12 Association between respondents' level of education and fully meeting with the respondents' personal expectation.

Level of Education	Meeting with personal expectations		
	Yes	No	Can't say
No Education	5 (1.3%)	0 (0.0%)	0 (0.0%)
Primary	88 (23.5%)	6 (1.6%)	0 (0.0%)
Arabic Education	1 (0.3%)	0 (0.0%)	0 (0.0%)
Secondary Education	222 (59.2%)	14 (3.7%)	1 (0.3%)
Higher Education	33 (8.8%)	5 (1.3%)	0 (0.0%)

$X^2 = 3.802$ Degree of freedom = 8 p value 0.875 $p > 0.05$

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

Reducing maternal deaths and complications around childbirth will depend on many factors, especially identifying and improving the services that are central to the reproductive health of Nigerian women. These factors include high quality and access to antenatal care, intra- natal care, postnatal care, family planning and the like. This study examined utilization and satisfaction of mothers with antenatal care services received in health facilities in Oyo State, Nigeria.

5.1 Socio-demographic characteristics of the respondents

A large number of the respondents were aged between 20-39 years (Table 4.1). This age corresponds to the most active age during which most women engage in childbearing. Most of the respondents were married. This may be because the majority of those sampled were above 20 years of age and they were likely to be married. Culturally and physiologically, the female reproductive age ranges between 15-44 years of age. Economic factors force parents to marry off their daughters at an early age in Nigeria. In Nigeria, most men get married around 23 years and most women at 17 years. More than three-quarters of the respondents were from the Yoruba ethnic group. This was expected because the study area is in southwest part of the country, a region predominately inhibited by the Yoruba. There was not much difference in the religious affiliation of the respondents, as they were mainly Christians and Muslims, the two major religions in Nigeria. Almost all the respondents had acquired at least secondary education. This might be due to the fact the free education scheme has been the hallmark of successive governments in Southwest Nigeria since the 1950s. Despite their educational background, most of the respondents were traders. This might be the result of massive rural-urban migration witnessed after independence in the country. The search for white-collar jobs in the cities often leads to unemployment and people usually resort to petty trading (Table 4.1).

5.2 Mothers' opinion on health workers competence and key componeats of antenatal care

The majority of the respondents received antenatal care from skilled birth attendants. This health-seeking behaviour is good and indicates quality health care services during pregnancy. The finding is in line with WHO, ICM and FIGO (2004) joint statement on skilled birth attendants. In addition, Focused ANC opines that ANC increases the likelihood that a skilled attendant will be present at birth (WHO/UNICEF 2004). The higher the proportion of pregnant women attending antenatal clinics also determines, the higher proportion of women delivering at health facilities.

The competence of the midwives were judged based on the diagnostic care, preventive care and curative care received by the respondents during antenatal, natal and postnatal care. During antenatal visit, the diagnostic care recorded by the respondents included weighing, blood pressure check, urine test and blood test. Almost all the respondents were weighed, with blood pressure measured, and urine analysis and blood test done as diagnostic care. This means that the health care providers were competent in giving diagnostic care during antenatal care to the respondents. This is in line with what Population Report (1998) affirms, that clients can judge technical competence by whether their needs are met or their problems are resolved. The indicator cited by Population Report (1998) for measuring competence include presence of trained midwives, professionals that attend to mother in deliveries, meticulous and thorough care to include early diagnosis of danger that can complicate delivery. Vuori (1987) avers that clients surveyed in Chile based their judgment on the cleanliness of the clinic; those in Kenya and Zambia on how thoroughly they were examined; and those in Indonesia on the type of medicine they received.

5.3 Time of first visit to antenatal clinic

It was observed that most of the respondents visited antenatal clinics during their recent pregnancy periods when they were in the second trimester and few booked very late (Table 4.9). This result implies that late booking for first ANC indicates underutilization of essential maternity care, especially health promoting, preventive and detective information/teachings to empower mothers against slight touch of pregnancy, that is, minor disorders of pregnancy that may increase morbidity and mortality during this vulnerable period. This calls for special attention to search for causes of late or delayed

antenatal visit. The new schedule of visits is as follows: the first visit should occur by the end of 16 weeks of pregnancy; the second visit should be between 24 and 28 weeks of pregnancy; the third visit is at 32 weeks; and the fourth visit takes place at 36 weeks. However, women with complications, special needs, or conditions beyond the scope of basic care may require additional visits (ICF Macro, 2009).

5.4 Level of satisfaction with the care given by the health care providers

Most of the respondents reported satisfaction with the services given by midwives, including level of respect, general cleanliness, and good physical outlook. most of them were married and few were co-habiting. Majority of those that were satisfied had secondary education, and few had primary education. This high-level rating indicates a remarkable level of service delivered by health workers especially the midwives, and it needs to be maintained. Thomas, Messerschmidt Mersserschmidt, and Devkota (2004) found that effective and respectful provider communication to clients influenced women's experience with care. Furthermore, the women appreciated being addressed by their names and wanted providers to speak simply, softly, and gently and avoid brusque behaviour. However, many of the respondents were not satisfied with not being involved in decision making on their care, not allowing family members to visit or come into the room during hospitalization, and not providing them with supportive care during pregnancy. This corroborates a study by Surjit (2002) in which clients were more satisfied when they were involved in their health care and treatment decision making.

5.5 Implications of the findings for health promotion and education

Considering the reproductive age population in Oyo State, with 34 secondary health facilities rendering health care for pregnant mothers, there is no doubt that women might have limited access to health care. It was also observed that the available ones were underutilized. Many respondents reported dissatisfaction with the negative attitude of maternity service providers towards them, which can be a hindrance to the patronage of the care given to the expectant mothers by the midwives. Those negative attitudes can translate to negative effects on how users of the health care are treated.

5.6 Conclusion

A large number of the respondents were aged between 20-39 years, were Yoruba and were either Christians or Muslims. The majority of the respondents received antenatal care from skilled birth attendants. Few of them were not satisfied with the care received from the selected health facilities. The findings of this study showed that clients' dissatisfaction stems from negative attitudes of health care providers, insufficient workforce and materials to give adequate expected health care to pregnant mothers during the prenatal period by the health care providers.

5.7 Recommendations

In line with the findings of this study, the following are hereby recommended

1 Publicity programmes should be intensified by the government in order to create awareness and improve utilization of competent health care given to mothers during pregnancy, labour and puerperium in the state.

2 To prevent untoward effects of the negative attitudes, there is the need for staff development programmes and continuous education of maternity health care providers in order to encourage positive behaviours of the providers towards their patients.

3 Stakeholders of maternal and child health care should address issues of positive client-provider interactions to motivate mothers and encourage patronage..

4 In a critical period of childbearing where the outcome is not mathematically predictable, it is necessary for competent and expert handling of the expectant mothers to ensure life and safe delivery with little or no trauma to both the mother and the baby. So the government should provide adequate manpower

5 The pull factors on service utilization identified in the study need to be encouraged, for example, affordability and availability of the services within easy reach.

6 The Nursing and Midwifery Council of Nigeria should embark on strategies to lay more emphasis on positive behaviours and attitudinal aspects of antenatal care as a vehicle to accelerating patronage and utilization of the services in order to better the lots of mothers during pregnancy, labour and puerperium.

7 Focused antenatal care should be encouraged in government hospitals to minimize the time of visits and reduce time and energy spent in the clinic in order to encourage utilization of antenatal care.

Areas for further study

1. Need for community assessment on the availability, accessibility and affordability of quality health care for mothers during pregnancy, labour and puerperium. This is essential for uplifting the utilization standard of care
2. The Hospital Management Board of Oyo State should endeavour to carry out research that lays more emphasis on supervision of health care providers services especially where client patronage is low.

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APPENDIX I

INTERVIEW GUIDE

TOPIC: APPRAISAL OF CLIENTS SATISFACTION LEVEL WITH MIDWIVES CARE AMONG NEWLY DELIVERED MOTHERS IN SELECTED SECONDARY HEALTH INSTITUTIONS IN OYO STATE

Dear Respondent,

My name is Amao, Josephine Olufunmike. I am a student of the Department of Health Promotion and Education Faculty of Public Health College of Medicine, University of Ibadan. I am carrying out a research to assess the level of satisfaction of patients with midwifery care and services at some selected healthcare facilities you will be asked some questions on your experience, kindly give sincere and genuine answers to the questions. No answer is wrong or right. Your response will be kept confidential and used for the research purpose only. The survey usually takes between 20 and 60 minutes to complete. Should you have any questions feel free to call any of the following contact person(s)

Contact person: Mrs Amao E-mail: ifnmk@yahoo.coom Phone: 08056435906

Supervisor: Professor Oladepo O. E-mail: Oladepod@yahoo.com Phone: 08033263302

Participation in this survey is voluntary and if we should come to any question you don't want to answer, just let me know and I will go on to the next question. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer: _____ Date: _____

Respondent Agrees to be interviewed ..... Respondent does not agree to be interviewed

Record the time: Hours ( ), Minute ( )

Start ___ ___

Stop ___ ___

Name of the Health facility-----

1 Was the baby delivered in this health facility? Yes ( ) No ( )

If no don't Intervie w

2 If Yes, when-----

SECTION A: Demographic Data

3. How old are you at your last birthday? _____

4. Have you ever attended school? Yes [ ] No [ ]

5. What is the highest level of school you attended: Primary [ ], Secondary [ ], Higher [ ], No former education [ ] Other (specify) _____

6. What is your religion? Christianity [ ], Islam [ ], Traditional Religion [ ] Other (specify) _____

7. What is your ethnic group? _____ Yoruba [ ] Hausa [ ] Ibo [ ] Other (Specify) _____

8. What is your occupation, that is, what kind of work do you mainly do? Civil servant [ ] Self employed [ ] Farmers [ ] Artisans [ ] Others (Specify) _____

9. Are you paid in cash or kind for this work or are you not paid at all? Cash only [ ], Cash and kind [ ], In kind only [ ], Not paid [ ]

10. Give an estimate of your income daily, weekly or monthly

11. State your marital status: Cohabiting [ ] Widow [ ] Never married [ ] Unmarried [ ] Separated [ ]

12. Total number of pregnancy ever had _____

13. Number of children ever born? Number alive [ ] Number dead [ ] Total [ ]

SECTION B

Maternity service received in this health facility

14. What is the mode of delivery of the new baby? Normal vaginal delivery [ ] Assisted delivery [ ] Caesarean Section [ ] Other (Specify) _____

15. What was the outcome of your labour? Baby alive [ ] Baby dead [ ] Still birth [ ]

16. Did you sustain any injury during birth? Yes [ ] No [ ]

17. If Yes, what type of injury _____ If No go question number 18

18. Did your baby had any form of trauma during birth Yes [ ] or No [ ]

19. If yes, what form?..... If No go to question 20

20. Did you see anyone for antenatal care for this pregnancy? Yes [ ] No [ ]

21. If Yes, whom did you see? Doctor [ ], Nurse [ ], Midwife [ ], Auxiliary midwife [ ], Traditional birth attendance [ ], Community/village health workers [ ], Others (specify) .....

If No go to question 38

22. If you received antenatal care for this pregnancy, how many months pregnant were you when you first received antenatal care for this pregnancy in this healthy facility? Months ( ), Don't know ( )

23. How many times did you receive antenatal care during this pregnancy in this facility?: Number of times ( ), Don't know ( )

24. As part of your antenatal care during this pregnancy, were any of the following done at least once by the midwives in this facility?

	Yes	No
Weight		
BP		
Urine		
Blood		

25. Were you given injections on your arm to protect you from getting a disease called Tetanus Yes ( ) No ( )

26. If yes, how many? (a) 1[ ] (b) 2[ ] (c) 3[ ] (d) Can't remember [ ]

27 If No, why? (a) I have completed the dose of the injection [ ] (b) I booked late [ ] (c) I am reacting to it [ ] Others (specify)_____

28. During this pregnancy, did the midwives give you any drugs to keep you from getting malaria? Yes ( ) No ( ) Don't know ( )

29. How many months pregnant were you when you took your first dose of (SP/Fansidar/Amalar/Maxoline)?: Month ( ), Don't know ( )

30. How many months pregnant were you when took your second dose of (SP/Fansidar/Amalar/Maxoline)?: Months ( ), Don't know ( )

31. Were you told by the midwives to sleep under insecticide treated net? Yes [ ] No [ ]

32. During this pregnancy, were you given any iron tablets or iron syrup by the midwives? Yes ( ), No ( ), Don't know ( )

33. During the whole pregnancy, for how many days did you take the tablets or syrup? Days ( ), Don't know ( )

34. During this pregnancy, did the midwives give you any drug for intestinal worms? Yes ( ), No ( ), Don't know ( )

35. Was the baby weighed at birth by midwives? Yes ( ), No ( ), Don't know ( )

36. When the baby was born, was he/she very big, bigger than average, average, smaller than average, or very small? very big ( ), Bigger than average ( ), average ( ), smaller than average ( ), very small ( ), don't know ( )

37. How long after the baby was delivered did you stay there?: Hours 1 ( ), Days 2 ( ), Weeks ( ), Don't know ( )

38. Before you were discharged after the baby was born, did any midwives check on your health?: Yes ( ), Nc ( )

39. How long after delivery did the first check took place? Hours 1 ( ), Days 2 ( ), Weeks ( ), Don't know ( )

40. Were you given any pain relief measure in labour by midwives? Yes [ ] No [ ].

If No go to question 42

41. If Yes, what form of pain relief measure did you receive in labour?.....

(i) Back rubbing [ ] (ii) Verbal analgesia [ ] (iii) Pain drugs e.g. (a) paracetamol [ ] (b) I don't know the name of the drug [ ] (iv) Pain injection: (a) Analgin [ ] (b) Paracetamol [ ] (c) Fortwin [ ] (d) DF 118 [ ] (e) I don't know [ ]

(f) Other Specify _____

42. After delivery of this baby, were you given injection to control blood loss Yes ( ) No ( )

43 If no why? Not available [ ], I reject it [ ] Other (Specify) [ ]

44. After you were discharged, did midwives check on your health? Yes ( ), No ( )

45. If Yes, what did they do? _____ If No go to question 55

SECTION C

Mothers' satisfaction level with quality of care

	How satisfied are you with the following Midwives behavior in respect to this last delivery you just had	Very satisfied	Satisfied	Not satisfy
46	Level of respect			
47	Prompt responsiveness to your needs			
48	Showing empathy and reassurance to you			
49	Effective listening			
50	Allowing family members to see you			
51	Involves you in decision making process of your care			
52	Midwives supportive care you received during pregnancy			
53	Antenatal clinic visit schedule by the midwives			
54	Enjoyed therapeutic touch of midwives			
55	Cleanliness of the health facility			
56	Midwives keeping your privacy			
57	Good physical outlook of this health facility			
58	Location of the health facility			
59	Referral services given by the midwives.			
60	Appropriate management of pain			
61	Ensuring my baby is given first immunization			

SECTION D

Perception and Expectations of mothers on Utilization of the Health Facility

62. Mention the type of service you utilized in the facility?.....

63. In case of new pregnancy, will you, if you have alternative maternity care switch to it? Yes [ ] Partially [ ] No [ ]

64 If yes, why?_____

65 If No, could you please give reasons for preferring this facility to others_____

_____

66 Were your personal expectation fully met? Yes( ) No ( )

67. If No, please specify what aspects were not met

(1)_____

(2)_____

68. Were you satisfied with list of items you were asked to bring? Yes ( ) No ( )

69 If No, why?----------

SECTION E

Areas needing Improvement

70. Mention areas of midwifery care you think need improvement in this facility——

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71. Identify any form of challenge to access care from this health institution in respect of this last pregnancy and delivery .....

a. Economic (ability to afford the cost) ----------

b. Geographical (ability to reach the facility easily) ----------

c. Social (acceptability of the facility by the community) ----------

d. Organizational (availability of several maternal services) ----------

e. Time spent (generally) ----------

Thank you.

APPENDIX II

List of Secondary Health Facility rendering Midwifery Services in Oyo State

S/N	Total	Staff				LGA	Type of sett.
		SNM	SN	Others	Total		
1	Adeoyo Maternity	203	4	3	210	Ibadan North	Urban
2	Ring Road	188	2	—	190	IBNE	Urban
3	Jericho Special	60	3	5	68	IBNW	Urban
4	Jericho NS Home	51	4	4	59	IBNW	Urban
5	St. Peter Mat. Hos.	18	—	—	18	IBNE	Urban
6	G.H. Kuteyi	6	2	—	8	Lagelu	Rural
7	G.H. Igboora	7	2	4	13	Ibarapa Central	Rural
8	G.H. Eruwa	5	2	4	11	Ibarapa East	Rural
9	State Hospital, Oyo	57	14	13	84	Oyo (Atiba)	Urban
10	State Hospital, Ogbomoso	34	3	17	54	OGNorth	Urban
11	G.H. Iseyin	19	5	2	26	Iseyin	Urban
12	State Hospital, Saki	33	—	9	42	Saki	Rural Urban
13	G.H. Igbaho	6	2	2	10	Iberapa Central	Rural/Urban
14	G.H. Okeho	8	1	2	11	Kajola	Urban
15	G.H. Igbeti	4	3	4	11	Olorunsogo	Rural
16	G.H. Sepeteri	3	2	4	9	Shaki East	Rural/Urban
17	G.H. Tede	6	3	—	9	Atisbo	Rural
18	G.H. Ilora	10	2	1	13	Afijio	Rural/Urban
19	G.H. Kishi	7	2	—	9	Irepo	Rural
20	G.H. Fiditi	4	5	—	9	Afijio	Rural
21	G.H. Kasun Ajia	10	—	1	11	Egbeda	Rural/Urban
22	G.H. Lagun	13	—	—	13	Lagelu	Rural
23	G.H. Moniya	21	4	1	26	Akinyele	Rural/Urban
24	G.H. Orile Odo	13	3	—	16	Oluyole	Rural
25	G.H. Iresa Adu	7	2	—	9	Surulere	Rural
26	G.H. Lanlate	6	2	—	8	Iberapa East	Rural

27	G.H. Okaka	7	—	5	12	Iiesiwaju	Rural
28	G.H. Ago-Are	4	2	—	6	Atisbo	Rural/urban
29	G.H. Ayete	2	3	2	7	Iberapa East	Rural
30	G.H. Ikoyi-Ile	4	3	3	10	Olorunsogo	Rural
31	G.H. Ado Awaye	5	2	2	9	Iseyin	Rural
32	G.H. Ago Amondu	–	—	—	5	Shaki East	Rural
33	G.H. Igamu	–	—	—	6	Iwajowa	Urban
34	MCH Apata	20	1	–	21		
	Total	841	83	87	1023		

N.B: Others include: Nurses with Accident and Emergencies Nursing, Health Education (BSC), Orthopaedic Nursing, Psychiatric Nursing, Public Health Nursing, Peri-operative Nursing, Paediatric Nursing, Theatre nursing, Medical Surgical Nursing, Bachelor of Nursing Science, Occupation Health Nursing, etc

APPENDIX III

DISTRIBUTION OF HEALTH FACILITY BY SETTLEMENTS

S/N	Settlement		
	Urban	Rural	Rural Urban
1	Adeoyo Maternity Hospital	G.H. Kuleyi	State Hospital Saki
2	Ring Road, State Hospital	G.H. Igbeti	G.H. Igboho
3	Jericho Special	G.H. Kishi	G.H. Okeho
4	Jericho NSH	G.H. Fiditi	G.H. Sepeteri
5	St. Peter Maternity Hospital	G.H. Lagun	G.H. Iloro
6	G.H. Iganna	G.H. Orile Odo	G.H. Kasimu Ajia
7	G.H. Okeho	G.H. Iresa Adu	G.H. Moniya
8	State Hospital Oyo	G.H. Laniate	G.H. Ago Are
9	State Hospital Ogbomoso	G.H. Okaka	G.H. Igboora
10	G.H. Iseyin	G.H. Ayete	G.H. Eruwa
11	MCH Apata	G.H. Ikoyi Ile	—
12	—	G.H. Ado-Awaye	—
13	—	G.H. Ago Amondu	—
14	—	G.H. Tede	—
Total	12	14	8

APPENDIX IV

Model of Midwifery Practice

Model of practice adapted from Alberta Association of Midwives are set of principles outlined below as fundamentals of midwifery practice which when taken together ensure that midwifery meets the needs of the women who choose this service in Manitoba and can be adopted by Nigerian Midwives.

1. Midwives are autonomous health care providers

Midwives are primary health care providers that clients may choose as their first point of entry to the maternity care system.

As primary healthy care providers, midwives make autonomous decisions in collaboration with the clients and are fully responsible for the provision of primary health services within theirs scope of practice. They coordinate services to ensure continuity of care. They identify conditions that require management outside their scope of practice and refer such cases to other providers.

2. Community input

Community input is fundamental to the development and evaluation of midwifery practice across all settings. Community participation must be structured into the midwifery system during the development and ongoing planning of midwifery services and education. This would be achieved by:

a. Facilitation ongoing community input into midwifery practice in all sites (e.g. community forum, community boards, formal; liaison with consumer organizations, consumer representation or governing body).

b. Each and every client being able to give input at some level (e.g. client evaluation of care)

c. Each midwife being responsible for soliciting client and community input (e.g. client evaluation of care).

d. Education about the role of community input at all levels incorporated into the education of midwives (e.g. public representatives on advisory committee(s); consumer participation in the teaching of midwives).

3. Informed choice

Responsiveness to women's needs is a guiding principle of midwifery practice. Midwives respect the right of their clients to make informed choices and actively encourage informed client decision-making.

Midwives facilitate decision-making by making relevant objective information available to their clients. Informed choice is a process which relies on a full exchange of information in non-urgent, non-authoritarian, cooperative manner. Midwives support the principle of informed choice by;

a. Encouraging clients to participate actively in their care and to make choices about the services they will receive and the manner in which they are provided.
b. Recognizing and supporting the pregnant woman as the primary decision maker and promoting shared responsibility between the woman, her family and her care givers.
c. Discussing the scope and limitations of midwifery care with their clients.

Community of care is fundamental to the midwifery model of practiced. It is both a philosophy and a process that enables the midwife to provide holistic care and to establish an on-going partnership with the client in order to build understands, support and trust. Continuity of care is facilitated through a relationship between midwife and client.

There must be 24-hour availability of the primary care midwives known to the woman. Every midwife must make the commitment necessary to develop a relationship pf trust with the woman during pregnancy in order to support the woman during the childbearing year.

In group practices, continuity of care could be achieved by a small team of midwives (not greater than four) provided the client has the opportunity to establish relationships with all the members of the team. Midwife involved in group practice must share a common philosophy in order to support continuity of care. Women must have input into the manner in which continuity of care is provided.

5. Choice of birth setting

Midwives respect the right of women to make informed choices about the setting for birth. Midwives provide care in a variety of settings, including hospitals, birth centres and homes. The ability to follow the client is an essential aspect of continuity of care and informed choice.

6. Two attendants at each birth

The safest care can be provided at birth when there are two qualified present. The Canadian standard of care is to have two attendants, skilled in neonatal and maternal emergencies at each birth.

The second birth attendant must understand and support the midwifery model care and could be

- Another midwife
- A health care practitioner with the knowledge and skill required to assist the midwife.
- Reject any form of gift, favour or gratification which might appear to have undue influence or advantage towards obtaining preferential treatment.
- While providing care, ensure that use of technology and scientific advances are compatible with the safety, dignity and rights of clients/patients.

The Professional Nurse and Professional Colleagues:

The Nurse must:

- Work co-operatively and collaboratively with professional colleagues and other members of the health team for ethical procedures and other members of the health team for ethical procedures ONLY.
- Exhibit "SPIRIT DE CORPS" in all situations except when it involves fraudulent and unethical practices.
- Delegate functions and responsibilities to subordinates according to their abilities and competencies, supervising them accordingly.
- Not ridicule professional colleagues and especially NOTE' in the presence of clients/patients or other members of the health team.

Accountability and Evaluation of Practice

Midwives are accountable to their clients, their peers and the wider community for safe, competent, ethical practice. Midwives fundamental accountability is to their clients. They are also accountable to their own regulatory body, employers, the health care institutions in which they practice and to the public.

Midwives continuously evaluate their practice to improve the quality of care they provide and to ensure their client's needs are met the results of this evaluation are incorporated into midwifery practice

9. Accessibility of midwifery care

Midwifery care must be accessible to all women. Mechanisms should be in place to ensure equitable access to midwifery care for all women regardless of place of residence or circumstances.

A midwifery practice must consider the demographics of the practice area so that services are offered to the variety of women therein. This ensures that women who would most benefit from midwifery care, but who might not seek such are, have an opportunity to use midwifery services. The midwives and the community which support practice are responsible for being knowledgeable about the women within their practice area and for developing and implementing outreach programmes.

If a midwifery practice finds out that cannot serve all women who are requesting services, the midwives are encouraged to try and reach a representative variety of clients and be able to refer women to other midwifery practices or related services (e g labour companions, empowering childbirth classes).

10. Research on effectiveness of midwifery

Midwives develop and share midwifery knowledge and initiate, promote and participate in research regarding midwifery outcomes Results of this research should be incorporated into midwifery practices.

11. Midwives as educators

Midwives have a responsibility to share their knowledge and experiences with colleagues, clients and students of midwifery.

In keeping with the history and tradition of midwifery, midwives have the responsibility to participate in the apprenticeship of midwifery.

The Nursing and Midwifery Council of Nigeria subscribes to the fact that using is an inalienable right of citizens and as such the Professional Nurse has the responsibilities of assisting them to attain the optimal level of health. The Nursing and Midwifery Council of Nigeria believes that this Code of Professional Conduct will serve as a springboard for providing effective nursing care in Nigeria

The Code of Professional conduct highlighted in this document is intended to empower the Professional Nurse Practitioners to provide effective care to individuals, families and communities.

APPENDIX V

CODE OF PROFESSIONAL CONDUCT FOR NURSES AND MIDWIVES IN NIGERIA

(Established By Decree No. 89 of 1979)

The Code of Professional Conduct places the client/patient at the center at Nursing activities -

The purposes of the Code of Professional Conducts are to:

- Inform Professional Nurses of the Standards of Professional Conduct requires of them in the exercise of their Professional accountability and practice;
- Inform the public, other professions and employers, of the standard of professional conduct that they can expect of a registered practitioner;

A nurse is a person who has received authorized education, acquired specialized knowledge, skills and attitudes, and is registered and licenced with the Nursing and Midwifery Council to provide preventive, supportive and restorative care to individuals, families and communities, independently, and in collaboration with other members of the health team. The nurse must provide care in such a manner as to enhance the integrity of the profession, safeguard the health of the individual client/patient and protect the interest of the society.

The Professional Nurses and the Health Care Consumer

- The nurse must provide care to all members of the public without prejudice to their age, religion, ethnicity, race, nationality, gender, political inclination, health or socio-economic status
- The nurse must uphold the health consumer's human rights as provides in the constitution.
- The nurse must ensue that the client/patient is of legal age of 18 years and above gives informed consent for nursing intervention.
- The nurse must incase the health consumer is under aged, the next of Kin or the parents can give the informed consent on his behalf.
- The nurse must keep information and records of the client confidential except in consultation with other members of the health team to come up with suitable

intervention strategies or in compliance with a court ruling or for protecting the consumer and the public from danger.

- The nurse must avoid negligence, malpractice and assault while providing care to the client/patient.
- The nurse must A with a consumer in a professional manner only.
- The nurse must not to take bribe or gift that can influence to give preferential treatment.
- The nurse must consider the views, culture and beliefs of the clients/patient and his family in the design and implementation of his care/treatment regimen.
- The nurse must know that all clients/patients have a right to receive information about their condition.
- The nurse must provide information that is accurate truthful and presented in such a way as to make it easily understood.
- The nurse must respect clients and patients autonomy, their rights to decide whether or not to undergo any health care intervention even where a refusal may result in or death to themselves or a foetus, unless a court of law orders to the contrary.
- The nurse must presume that every patient and client is legally competent unless otherwise assessed by a suitably qualified practitioner. A patient or client who is legally competent can understand and retain treatment information and can use it to make an informed choice.
- The nurse must ensure that when clients and patients are detained under statutory powers (e g Mental health Act), he/she should know the circumstances and safeguards needed for providing treatment and care without consent.
- The nurse must provide care in emergencies where treatment is necessary to preserve life without clients/patient consent, if clients/patients are unable to give it, provided that the nurse can demonstrate that she is acting in the client/patients best interest.

The professional Nurse and the Nursing Profession

The Nurse must:

- Attend workshops, conferences, seminars and courses that are recognized by the Nursing and Midwifery Council of Nigeria and which are relevant to the profession, at lease once a year.
- Engage in behaviour and activities that uplift the social status and integrity of Nurses.

- Always appear neat and decently dressed, without using bogus/dangling ear-rings, long and big wigs (all hair do must not extend below the neck level), high heeled shoes, long painted nail and elaborate make up while on duty and in uniform.
- Not fight or steal on duty.
- Be courteous, honest and resourceful.
- Not wear uniform without an overall outside the hospital premises.
- Not strap a baby on her back while in uniform
- Provides care, using current evidence based principles and practice and the nursing process.
- Participate in the training of students Nurses/Midwives and students of health related disciplines.
- Co-operates and collaborates Professional Association to secure good conditions of services.
- Demonstrates and abilities required for lawful, safe and effective Professional practice without direct supervision.

The Professional Nurse and Nursing Practice

The Nurse must:

- Be personally accountable for the care she provides to clients/patients. This means that she is answerable for her action and omissions regardless of advice or directives from other health professionals.
- Be punctual to duty and hand over patients and equipment physically.
- Avoid the use of self in the advertisement, promotion or sale of commercial products services and illicit trade such as trafficking in hard drugs.

APPENDIX VI

FACTORS OF EXTREME CUSTOMER LOYALTY

Josiah Royce, an American philosopher in the mid-to-late 1800s, identify what really drives customer loyalty and claimed that the trait of loyalty was most often associated with political institutions - religion, war, and family. In these situations, people had one key influence in common - a passionate link a "common cause".

He believes that one build loyalty when he and his customers are aligned on seven key factors. These factors of extreme customer loyalty are:

1 Emotional dependence

Emotional dependence is the psychological commitment from the customer. It is the customer's reliance on an organization for support, guidance, and decision-making - the tendency of the customer to see help from you as a supplier in making decisions or in carrying out difficult actions. When an individual is emotionally dependent and things do not go as expected, they can distance themselves and seek out a relationship that provides the support they need. Emotional dependence includes: integrity, reliability, depth of relationship, and empathy. Go beyond your customer's expectations to satisfy their emotional needs. Sometimes the smallest things can make the biggest difference. Conversely, a negative experience can have a detrimental effect on customer loyalty when you are in a heighted emotional state.

Profiles International (2009) gave tips on how to create emotional dependence as follows:

Learn what your customers value on a personal level and go beyond their expectations to demonstrate that you care about them.

Show a high degree of empathy and responsiveness when you sense your customers are getting emotional about an issue. Even if you cannot solve the problem on the spot, let them know they are important and that you will do what it takes to satisfy their personal needs.

Put the right person on the job. This person should be able to connect with the customer on a personal level. Make sure your employee can provide this support and that you have the right processes in place for triaging issues. Make the customer feel good about working with your organization.

2 Structural dependence *Can you help strengthen your customers' weak links?* Structural dependence is the operational foundation of the relationship and consists of people, facilities, systems, and distribution channels. Structural dependence builds a common cause between the buyer and seller, and this helps build loyalty.

An organization outsourcing non-core operations to companies creates structural dependence. Having outsourced, it is much more difficult for them to bring these functions back in house because the investment is high and expertise is scarce. Although switching service providers is possible, it is difficult and risky. Structural dependence is among the most powerful loyalty builders.

How to create structural dependence:

Understand how your customers' businesses operate. Then determine where they have gaps or inefficiencies that would enable you to operate portions of their businesses better, cheaper and with fewer headaches or risks for your customer.

3 Business dependence Business dependence is the marketing positioning of the relationship. This includes how you help your customer create go-to-market solutions, grow and retain their customers, and be competitively sound in their market.

How to create business dependence:

3.1 Identify areas where your customer is weak but you are strong - as well as areas where you are weak and your customer is strong.

3.1 After conducting this analysis, identify opportunities for building on each other's strengths and minimizing each other's weaknesses.

3.2 Then, start to envision how the relationship would work operationally and financially to build mutual value.

4 Satisfaction

Customer satisfaction influences loyalty, but it isn't the only predictor. Customer satisfaction is often an indication of how well your organization performed during a recent event. This often includes elements of service, support and delivery - delivering a new product or service; solving a service or maintenance issue; or executing a campaign, pilot

program or evaluation.

Customer satisfaction measures are too limited to be an accurate predictor, especially when it comes to complex business solutions.

Satisfaction ratings are important because we need to know that if we've been tasked to deliver something, we have successfully done so. But we need to be careful that we don't use that as the only driver or only metric of our loyalty assessment.

How to create high customer satisfaction:

Creating high customer satisfaction starts with a careful assessment to determine needs and uncover expectations with regard to price, impact and level of service. Then you must meet or exceed expectations.

"How" you deliver can be as important as "what" you deliver, so don't underestimate the impact emotions play in satisfaction scores. Formal surveys and properly designed questionnaires are a big help.

Performance *Not too hot, not too cold - just right!*

"Performance" refers to how a product or service holds up to expectations and required industry standards. Measurements of performance can include meeting ISO and Six Sigma requirements. Typically performance is measured over a longer period of time and with more objective criteria than the measurement of satisfaction, which is event-based and emotionally influenced.

Performance is important, but is not the sole predictor of loyalty.

APPENDIX VII

Ethical Approval