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Original Article

What does quality maternity care mean in a context of medical pluralism? Perspectives of women in Nigeria

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Abstract

User priorities regarding quality care in contexts of medical pluralism are poorly documented. Drawing on group and individual interviews with women, we interrogate ideas of quality maternity care in the context of Nigeria's medical pluralism. We found complex utilization patterns for conventional, complementary and alternative maternity care services as well as ideas of quality maternity care that stress effective coordination and integration of different typologies of maternity health services; socially sensitive and truthful providers; and socioeconomic, physical and parochial forms of safety. Informal providers were the commonly reported source of maternal health services in the study. Maternal health services in the country were also generally viewed as poor quality, characterized by pervasive abuse, quackery and lack of commitment to the needs and sensitivities of women. Convenience, availability and affordability of maternal health services, as well as sociocultural factors were major influences on women's use of services. Results demonstrate the embeddedness of women's quality of care notions in the vast socioeconomic inequities that typify Nigeria's particular form of poorly regulated medical pluralism, raising need for strategies to strengthen the delivery, coordination and supervision of maternal health services in the country.

Keywords: Women, quality of care, qualitative research, Nigeria

Key Messages

- Lay ideas of maternity care quality in pluralistic medical systems remain poorly understood.
- Women's quality notions stress socially sensitive and truthful providers; and socioeconomic, physical and parochial forms of safety.
- Women's quality of care notions reflect the vast socioeconomic inequities that typify Nigeria's particular form of poorly regulated medical pluralism.

Introduction

Improving maternal health outcomes requires, *inter alia*, aligning maternity care practices with tested strategies for ensuring quality services and mainstreaming care-seekers' perspectives of quality into service delivery (Kagawa-Singer and Kassim-Lakha 2003; Filippi *et al*. 2006). Currently however, few studies have pondered the priorities of women—the direct beneficiaries of maternity care—regarding the meaning of quality maternity care (Rudman and Waldenström 2007; Wiegers 2009). Valentine *et al*. (2008) write that while there is some consensus among quality of care researchers "on concepts like structure, process and outcome, and non-clinical vs clinical processes of care," these "concepts are commonly

explored through surveys measuring patient experiences" and not patient or user quality of care priorities and notions. Yet as Pitchforth *et al.* (2010) argue a focus on user and community perspectives can enlarge understanding of the underlying factors in care quality and support care improvement efforts.

Existing studies have mostly considered patient or care-seeker perceptions of the quality of health services that they have previously used or are using (Oladapo *et al.* 2008; Pitchforth *et al.* 2010; Luck *et al.* 2014), and not their direct ideas of what constitutes quality for particular types of health services (Sitzia and Wood 1997; Valentine *et al.* 2008). Much fewer studies of patients' quality of care notions have unambiguously addressed maternity care (Wiegers 2009), and these focus mainly on the global north. A glaring paucity of research pervades the direct ideas of patients on maternity care quality in global southern contexts with pluralistic medical systems—where care-seekers simultaneously or consecutively use different types of maternity health services and providers at different points during pregnancy and the periods surrounding it. These contexts, however, host the bulk of global avertable pregnancy-related deaths and morbidities arising from poor quality maternity care. They also face some of the thorniest challenges related to developing, delivering, sustaining, regulating and utilizing quality maternity services.

In this study, we assess user priorities regarding quality maternity care in a pluralistic health setting among a sample of Nigerian women. Our focus aligns deeply with current global and scholarly interest in experiences of person-centred maternity care among women; quality issues in different health systems; perspectives of patients and users on service quality; and strategies for increasing all health actors' awareness of challenges to quality maternity care (Pittrof *et al.* 2002; Wiegers 2009).

Empirical and theoretical context

As in many developing countries, western medicine does not enjoy a monopoly in Nigeria (Cant and Sharma 2004). The country's maternal health care system is pluralistic, characterized by conventional, complementary and alternative providers. Maternity health care services are obtainable from formal providers, itinerant medicine hawkers, traditional birth attendants (TBAs), and patent medicine sellers, among others (Izugbara *et al.* 2005, 2016). Spiritual/faith healing, often involving the laying-on of hands, ingestion of materials that have been prayed over, holy water, oil, incantations and prayer is also a conspicuous maternity health care option, with women in Nigeria sometimes seeking maternity services, including delivery, in spiritual centres or faith homes and churches (Alubo 1995; Izugbara *et al.* 2016).

The need to improve the delivery of quality maternity care is particularly urgent in Nigeria (Ezeonwu 2011, 2014). Nearly one in every four women in sub-Saharan Africa (SSA) is Nigerian. Enhancing the quality of maternal health care in Nigeria is key to reducing its gloomy maternal morbidity and mortality statistics and achieving the SDGs related to women's health in SSA in general (Izugbara *et al.* 2016). Currently, Nigeria is the second largest contributor to maternal mortality globally. Its current maternal mortality ratio of 596 per 100 000 live births is higher than the SSA average of 511 deaths (WHO *et al.* 2015). The country's estimated annual 40 000 pregnancy-related deaths account for about 14% of the global total. Every day, 109 Nigerian women die in childbirth. Abuse and mistreatment of care-seekers are also common in maternity care-settings in Nigeria (Okafor *et al.* 2015).

Current efforts to address Nigeria's poor maternal health situation are constrained by poor funding, shortage of skilled providers, poor referral and regulatory systems, inadequate funding, as well as poor acceptability, accessibility and affordability of existing health services (Ezeonwu 2014; Izugbara *et al.* 2016). These efforts have also focused largely on the formal sector, often oblivious of the pluralism that characterizes the country's health delivery system.

While advancing the quality of maternity care settings is key to enhancing maternal health outcomes in Nigeria, such efforts need to reflect the sensitivities of expected beneficiaries as well as best practices in health service delivery (World Health Organization 2012; Ezeonwu 2014). Presently however, systematic evidence is lacking on the perspectives of Nigerian women—the expected direct beneficiaries of maternity care—on quality in maternity care. Building on the critique that existing studies of lay care quality notions ignore the structural context of care delivery (Coyle and Battles 1999), we investigate women's perception of quality maternity care against the backdrop of Nigeria's pluralistic medical architecture.

Popay *et al.* (1998) offer an important framework for understanding lay health ideas. Noting that social life is storied and that narrative, ontologically speaking, derives from social life, they suggest that people's constructions and notions of their health issues spring from their location within social systems, what has happened/is happening to them, as well as their projections, expectations, and memories drawn from a diversity of events, lessons and experiences. Lay notions are therefore not often intangible conceptualizations. Rather, they are socially produced, and nested in experiences, relationships, and lived realities. In India, Broom *et al.* (2009) found a contextualization of patient disease and therapeutic trajectories in vast social vulnerabilities and inequalities associated with the country's therapeutic pluralism. They concluded that notions of pluralism, so often espoused by global health organizations, conceal important forms of social inequality and cultural divides. In this article, we survey lay ideas of quality maternity care in the context of Nigeria's medical pluralism, endeavour to make sense of their drivers and raise insights for health care improvement.

Methods

The study was conducted in six purposively selected states in Nigeria. These states were selected on the basis of their performance on critical maternal health indicators. In each state, one urban, one rural and one semi-urban community were purposively selected (Table 1). Key community-based informants introduced the study to local community authorities and heads and sought their permissions to implement it in their areas. They also helped to identify and recruit women respondents in the communities who met the study's particular reproductive and demographic criteria, including childbearing history, parity and pregnancy status.

Focus group and individual interviews were held with the women on their views and experiences regarding quality maternity care. The interviews were conducted by trained undergraduate and graduate female fieldworkers who spoke both English and the local languages of the study communities. Depending on the literacy status of the participating women, interviews were conducted in local languages, Pidgin English or English.

A total of 173 women were studied. One hundred and thirty (130) of them participated in 16 FGDs while forty-three (43) were IDI participants. Interviews lasted roughly 60 minutes, and (except those conducted in English), were first translated from local language to English and then transcribed by professional translators.

Table 1. Characteristics of sampled states

States	Maternal mortality	Use of skilled antenatal services	Use of skilled delivery services	Use of formal postnatal services
Bauchi	High	Low	Low	Low
Ebonyi	Moderate	Moderate	Moderate	Moderate
Nasarawa	Moderate	Moderate	Low	Low
Ondo	Low	High	High	High
Edo	Low	High	Moderate	High
Zamfara	High	Low	Low	Low

Sources: Adapted from Izugbara *et al.* (2016). Also see National Population Commission of Nigeria & ICF Macro., Nigeria 2013 Demographic and Health Survey, Abuja, Nigeria. 2014.

Table 2. Summary of respondents' quality maternity care notions

Key quality ideas	Data sources	Thematic expressions
Integrated and coordinated service and providers	FGDs and IDIs	Well integrated and coordinated maternity service providers and settings; linked services and providers; effective inter and intra-provider and service-type referral and response systems; capacity to meet the diverse needs of different women during pregnancy and delivery; services that facilitate the exploitation of different providers-specialty and skills to respond to maternal health needs; a coordinated multi-provider engagement and involvement in serving women during pregnancy and delivery, etc.
Safety	FGDs and IDIs	Services that are holistically protective of women during pregnancy and delivery; provider and facility capacity to manage diverse maternal health conditions; excellent, compassionate, and accessible care to women irrespective of socioeconomic status; risk and harm-averse services; confidentiality; deeply knowledgeable services and providers; availability of right tools; low-cost but effective services; hygienic care, respectful providers, etc.
Truthful, factual, and culture-sensitive services and providers	FGDs and IDIs	Honest with women about their conditions; factual communication to women about their health; provider and facility consideration for and sensitivity to patients' beliefs in the context of care; respect for women's views about their conditions, etc.

Transcribed interviews were then coded with Nvivo using a codebook agreed by the research team. A qualitative inductive approach involving iterative assessment of narrative material for tendencies, relationships and particularities, was adopted to make sense of the data. The study findings are summarized in Table 2 and elaborated in the results section.

The study was reviewed and approved by the Obafemi Awolowo University Research Ethics Committee. For all data collection activities, fieldworkers obtained appropriate informed consent from respondents. The limitations of the study include its reliance on self-reports, the likelihood of recall bias among respondents and its exclusive focus on women. Table 3 shows the sociodemography of the women we studied.

Results

Maternity care seeking practices and experiences

The complexity of maternity care-seeking practices in Nigeria is a longstanding theme in the literature (Wall 1998; Izugbara *et al.* 2005; Ononokpono and Odimegwu 2014). The women we studied used different maternity health services and settings for prenatal, postnatal and delivery care. These settings included prayer houses, TBA homes, chemist and patent medicine shops, public health facilities, private-for-profit facilities and private-not-for-profit facilities. Some respondents had used only one type of maternity services. However, majority had combined conventional, complementary and alternative health services for different reasons and at different points during pregnancy and the period surrounding it. For instance, one woman concurrently relied on a TBA and public health facility-based health providers. She regularly visited the TBA for antenatal services, but delivered her baby in a facility. Another woman used TBA services for antenatal care; formal health centres for delivery; and patent medicine sellers for post-natal care. There were yet other women who used formal care centres for antenatal care; TBAs for delivery; and formal postnatal services. Other remarkable utilization patterns were also reported by the women. Knowledge of other women who have combined different types of maternity services was also widespread among the respondents.

Interviews indicated the role of economic, cultural, accessibility, availability and interpersonal factors in women's maternity services utilization decisions and patterns. Public health services and patent medicine sellers were considered more available and affordable; TBAs were easily available, often the only providers available in some communities, and considered trustworthy and culturally sensitive; and faith-based providers viewed as able to address and avert the supernatural maternal health conditions and complications. One respondent had relied regularly on the village TBA for her deliveries. Her past four deliveries were difficult and she knows she would benefit from a well-equipped formal health facility. But her rural community did not have such a facility. In some instances, the high cost of private maternity services was a motivation to use public ones for delivery, returning to private facilities for postnatal care.

Maternity service types and providers were perceived in different ways. Interviews focused private formal facilities as good settings for maternity services. They were prompt, careful and often staffed with experienced providers. However, they were also reportedly extortionate and out of the reach of ordinary health-seekers. They exploited women, making them undergo needless caesarean deliveries, take unnecessary medicines, attend clinics excessively and stay longer in the facilities after deliveries. Regular acknowledgements of

Table 3. Respondents' sociodemography

Characteristics	FGD	IDI	Total
Location			
Rural	43	14	57
Semi urban	44	16	60
Urban	43	13	56
Religion			
Christian	53	22	75
Muslim	77	21	98
Marital status			
Married	129	43	172
Single	1	0	1
Education			
None	13	2	15
Madrassa	11	5	16
Primary & below	26	5	6
Secondary & above	80	31	71
Occupation			
Formal	13	7	20
Housewife/Farmer	43	12	52
Informal	4	1	5
Own business	51	20	71
Unemployed/missing	19	3	7
Parity			
None, but pregnant	6	4	10
1–3	69	26	95
4+	44	13	36
Missing	11	0	32

positive care experiences among users of private maternity centres existed alongside concerns about the exorbitance of such services. One respondent had a caesarean delivery in a private health facility and incurred debts which were only offset through the support of church members. Nearly half of the IDI respondents knew at least one woman who had been detained for an inability to clear up the cost of private medical care. All study respondents had also heard such detention tales. One middle-aged mother's view was:

> *There is an aspect of money, the way they take their patients. There was a woman who had a delivery and I met here there at a private facility and I left her there. Her child died after the caesarean section and the bill was too high. The husband couldn't pay the bill and left her there. So, the woman was there and there was nothing she could do to raise the money to discharge herself. They won't allow you to leave the hospital premises …*

Some respondents depicted public health facilities as useful settings for maternity care. They were considered affordable, accessible, staffed by qualified personnel and usually stocked with quality medications and equipment. However, not all study participants were persuaded about this. The negative views expressed about public maternity services related to the apathy and poor commitment of their providers, characteristic lack of life-saving equipment and supplies and abusive provider practices in the context of care. The extended narratives of the two respondents below bring the above issues to relief:

> *My own experience is that when I went for delivery, the nurses and doctors in the government hospital were not really serious. I went there at night, and around 1 am, I felt like the baby coming out. But the nurses were asleep and the baby's head was out already. I started shouting and the nurse woke up … I was mad and asked them if they wanted me to die … . I was wondering how a nurse could be sleeping when there were women in labour (34-year old woman).*

> *I took my sick child to the government health centre and nobody was willing to help me … they did not even have medicines. Do you know they said that if we don't have up to N6000 ($20), they will not attend to the child? We took the child and ran to a TBA. She just took the baby and gave him drugs … and before you know it the baby become well again (40-year-old woman).*

TBAs and faith healers had major reported usefulness. Reportedly, high-quality TBAs could identify and deal with both the physical and non-physical basis of poor maternal outcomes. They were considered affordable, handy, trustworthy and culturally knowledgeable. Narratives contrasted TBAs with hospital-based providers who ridiculed and mistreated women, extorted patients, stole or exchanged babies born in their care, and performed other malevolent acts against women and their babies. Lay critiques of TBAs and other informal providers, including chemist-shop operators, stressed their lack of formal training, limited capacity to deal with severe obstetric emergencies; and poor knowledge of modern medicines. Being poorly regulated, informal providers were largely seen as quacks and charlatans.

Quality maternity care notions

Previous research shows that quality of care is often a concern for many lay health-seekers (Haddad *et al.* 1998; Teleki *et al.* 2006; Wiegers 2009). Whilst they may not always articulate quality care using expert and scientific languages, their health care decisions are also nevertheless often foregrounded by a concern with quality (Haddad *et al.* 1998; Luck *et al.* 2014). Quality of maternity care was a key theme in data we collected and responding women defined 'quality' using such terms as 'superior', 'better', '*ogbonge (superior or high quality in Nigerian Pidgin-English)*', 'good' or 'excellent' maternity care. Pregnancy and the period surrounding it were generally considered risky. Quality maternity services reportedly helped women successfully traverse the precariousness of the period, deal with the dangers associated with pregnancy, give birth to healthy children, and stay alive and well to wean them. Quality maternity services were reported as the exception rather than the rule in Nigeria. Responding women linked poor quality maternity services with maternal death and morbidity as well as women's avoidance of particular services and providers. The importance of quality maternity services was driven home as follows:

> *Women need good places and providers because you can't predict what will happen during pregnancy … I always choose the place I know my mind will be at peace with … . In one hospital, one of my friends was told on the day of delivery that her baby was too big to be delivered normally. They told her she needed a caesarean section. She had been attending this hospital for antenatal care and they never told her about it … I know the suffering she went through to pay for the caesarean … So truthful and honest providers are very important.*

Quality care was equated with integrated and coordinated maternity service providers and settings to meet women's multifaceted needs during pregnancy and delivery. Because no one maternal health provider or service-type was considered capable to meet all these needs, the poor linkage and coordination of these service and provider-types in Nigeria emerged as a major concern for responding women. A respondent recalled that she was refused admission into a private facility during an obstetric emergency because she had not registered there for antenatal care. In another case, a woman who used a public maternity centre for delivery was not allowed a visit by her TBA while she was in labour. She came close to dying during the delivery. In her extended narrative, she believed that the TBA would have

addressed her problem had she been allowed into the hospital during the delivery process. Instances of arrest of TBAs or patent medicine providers who bring women during emergencies to hospitals were also reported by the women.

Quality maternity settings and services were viewed as those with the capacity to recognize and meet the diverse needs of different women and also coordinate providers' efforts and facility resources to respond to them. As respondents in one FGD put it:

> *Sometimes, a hospital is good and has all the qualified people and equipment … but people still die there or it can be too expensive for some women. Then, it will not provide good services to all women who go there because their problems are not the same.*

In confirmation of research evidence that lay health seekers in the developing world tend to believe that certain health conditions are the specialty of informal providers (Izugbara and Ukwayi 2003; Hughner and Kleine 2004; Izugbara *et al.* 2005; Sudhinaraset *et al.* 2013), we found a particular belief that TBAs and faith healers manage certain maternal health conditions better than conventional providers. Against this context, a coordinated multi-provider engagement and involvement in serving women during pregnancy and delivery was widely seen by respondents as key to the delivery of quality maternity health services. Some authors (Romero-Daza 2002; Izugbara *et al.* 2009; Abdullahi 2011) have noted that the continued use of alternative maternal care services in Africa in the face of the growing availability of formal services is not driven primarily by ignorance. Contextual factors related to beliefs, notions of disease and provider expertise, poverty and local health experiences of households and individuals play critical roles in care-seeking decisions.

Safety was also a commonly identified feature of quality maternity care. Whilst formal notions of quality maternity care emphasize the protection of women during pregnancy and delivery, responding women's notion of safety was much broader, emphasizing provider and facility capacity to manage maternal health conditions, offer excellent and compassionate care, remain accessible to women of different socio-economic statuses, protect women from harm broadly defined, and ensure confidentiality during pregnancy and delivery. One IDI respondent noted: "Quality means that the setting and provider know what they are doing, can be trusted, and do not expose the women to any additional risks during pregnancy and delivery." Many similar views were also expressed in the FGDs:

> *Respondent 1: "Safety is also very key … and women consider the knowledge of the provider very important in making things safe for women. Even if they are TBAs, they need to have the right tools, hospitals need to have the proper drugs, equipment, and healthcare workers …"*
>
> *Respondent 2: "We consider safety very important…which means availability of qualified personnel and equipment. We also consider availability of drugs that is why we attend Jama'are or Dogon Jeji hospital. We suffer much on the road however. We use animal-drawn cart to Jama'are General Hospital. It is a good place, but it is not near or safe to reach. The TBAs are just here, safe, and near."*
>
> *Respondent 3: "They must be safe, which means availability of the right tools, the cost of the services is low, and also availability of knowledgeable health care workers, even if even they are just nurses or TBAs."*

Safety as a maternity care quality characteristic also indicated the capacity of providers and facilities to offer clean and hygienic care, confidential management of women, shielding women and children from poor outcomes, respecting care-seekers and being protective of them. Most care-settings and providers reportedly mistreat pregnant women, spread rumours about their conditions, facilitate the theft or exchange of babies or connive with malevolent people to harm women and the newborns.

Safe maternity settings or providers were described as affordable and respectful. Affordability as a corollary of safety was framed in terms of the economic accessibility of services to the poor. Rich-only maternity services were considered unsafe. Quality services were expected to be available to everybody who needs them. Further, quality facilities and providers also supposedly treated pregnant women with utmost care and respect, making them feel secure and safe in the context of care. Mistreatment of maternal care seekers was considered common, making services unsafe for women. Reportedly, women avoided some providers and facilities because they feared humiliation, insult and abuse. One woman noted, "There are some health centres where you will go to, they will just be shouting at you, they will say, 'When you were having sex, was I part of it? Don't come here and disturb our ears'. Those are not safe places."

Truthfulness and factual communication to women about the state of their health and sensitivity to their beliefs regarding their conditions were also mentioned as characteristics of quality maternity services. The common practice, respondents noted, was for providers to support them through pregnancy and delivery without properly testing or checking them for other health conditions. As one respondent noted: "Today, you deliver your baby in a hospital or a traditional birth home. Two months you are back there for another condition. A quality provider and facility should do thorough examination when women present to them, but this is not the case with the providers and services we have." Maternity care providers and facilities in Nigeria reportedly do not often fully disclose women's health situations, do thorough check-ups of care-seekers, or listen carefully to patients. One respondent's experience was: "Sometimes they check you or your baby. They know the baby won' t make it or that you do have another disease, but they won't tell you. Or maybe they don't even check you well. That is what they did to me."

Women routinely noted that the information which they often volunteered about their conditions was routinely ignored, taken lightly, or dismissed as superstition by facility-based providers. The consequences were reportedly always deleterious for the women. One woman blamed the loss of her baby in the hospital to providers' refusal to listen to her ideas of how to stop her prolonged labour. As she said, women in her family usually experienced prolonged labour. When she told the nurses who attended to her about it and how to manage it, they laughed at her. In her words, "I almost died and they could not help me. My child died because they won't listen to an insignificant person like me."

Barriers to quality maternity care

Extant research has identified a number of factors that constrain quality maternity care in Nigeria. In a recent report on maternal health in Nigeria, Izugbara *et al.* (2016) noted that the poor quality maternity care in Nigeria is not unrelated to the problems of inadequate funding, corruption, massive shortages in skilled health professionals, weak referral and regulatory systems, defective public policies, weak coordination of health services as well as poor acceptability, limited accessibility and unaffordability of existing health services. In their explanations of the barriers to quality maternity care in Nigeria, study respondents clearly alluded to the above issues

and even more. For them, barriers to quality maternity care included weak governmental commitment to public interest, poor support for complementary and alternative health services and weak regulation of services and providers. Data indicated a pervasive belief that the public health sector has been neglected by successive leaders. Political leaders' lack of interest in the health of citizens was blamed for this. There was, for the women, dwindling governmental interest and investments in health and the entire public sector, leading to underfunding and crisis in the health sector. One clear articulation of the problem of governmental neglect was provocative: "The wives of our leaders use top private hospitals or travel abroad to give birth so politicians don't really care whether other women are been treated well by providers in the country…"

Low motivation of health providers, lack of basic essentials in public facilities and infrastructural decay were also mentioned as barriers to quality in maternity care delivery. Facility-based health workers were particularly identified as poorly motivated in Nigeria while TBAs and chemist shopkeepers were said to be regularly harassed by government officials. In the succinct words of one woman: "What is happening now is that money rules wherever you go". The typical belief of the women we studied was captured in this view shared by a participant: "If you go to public facilities and offer them ten thousand naira, they will attend to you the way you want and nothing will happen to you …. But if you get there without money and you are waiting for service…..you will stay there and die." Low motivation of providers in the Nigerian public maternity health system was blamed for the common problem of patient abuse and theft of monies, drugs, supplies and medical equipment by providers.

Public facility-based health workers were reportedly apathetic, abusive, unfriendly and uncommitted. Many alternative and complementary providers of maternity care were considered to be quacks, unqualified and poorly supervised. All these supposedly resulted in poor maternity care quality. Accounts of abusive patient treatments inundated the data. Eight IDI participants were denied bed spaces and made to deliver their babies on the floor. Up to seven women reported being hit, mocked or abused verbally while seeking services by providers. There were also women who were asked to clean facility floors, wash beddings and left uncleaned after their delivery. Yet, others were asked to vacate their beds immediately after deliveries to create space for other patients. The case of one woman is worth citing: "Like for me, that day I was in labour at the government hospital …. I was just shouting, saying "leave me", "don't ask me question". So, afterwards the nurses there started mocking me. They were calling me "leave me", "don't ask me question …"

Discussion

For a long time now, quality of care has furnished researchers and practitioners a conceptual basis for assessing health care outcomes as well as patient experiences and satisfaction with care and care-settings (Teleki *et al.* 2006). Dixon-Woods *et al.* (2012) argue that quality of care offered has implications for health outcomes. In this study, we interrogated user-notions of quality maternity care in Nigeria's pluralistic health setting. Findings indicate a complex maternity care-seeking situation, in which women have access to and use one or more of a range of conventional, complementary, and alternative health services. The significant use of a variety of maternal care services, particularly informal services is key. In a review of the informal health care sector in developing countries, Sudhinaraset *et al.* (2013) found that that informal providers comprise a significant portion of the healthcare sector in the developing world. Patients, particularly the poor, in most of the global south, rely on them for a large proportion of their health care needs. More often than not, these informal providers operate outside a regulatory framework or are poorly regulated (Bloom *et al.* 2011). In the particular case of Nigeria, Sieverding *et al.* (2015) argue that national regulatory administration of health business procedures is ineffective, generally reducing the quality of care available to patients. Judging by the narratives we collected, the services of maternity care providers in Nigeria were generally poor, reportedly characterized by pervasive abuse, quackery, and lack of commitment and responsibility on the part of many providers. As Abimbola *et al.* (2016) observed, a major consequence of ineffective health governance in Nigeria is that patients traverse health care markets from one unsuitable provider to another, receiving poor quality care, while also sustaining costs. Also emerging from the study is the critical and amply documented role of convenience, availability, affordability, as well as sociocultural factors in shaping perceptions of and utilization patterns for existing maternal care services (Idris *et al.* 2013; Ononokpono and Odimegwu 2014; Fagbamigbe and Idemudia 2015).

Quality, in the context of maternity services pluralism, for the women we studied, connoted effective integration and coordination among providers and settings to meet women's multifaceted need for holistic, safe, and trustworthy care during pregnancy and delivery. While some of these themes closely mirror existing findings on quality of health care including the Institute of Medicine's (2001) definition of quality care, our study offers new perspectives. For instance, women's idea of an integrated maternity care system sharply focuses the need for properly linked formal and informal maternity care systems that are fully responsive to local cultures and contexts. Nigerian women's view of safety as a priority characteristic of quality maternity care challenges formal care quality notions that define quality primarily in terms of accident-free spaces and well-kept patient information (Institute of Medicine 2001). Our study reveals a broader notion of safety that encompasses positive social, economic, emotional, clinical and other outcomes.

Further, while generally reasserting the much-vaunted importance of person-centred maternity health services in quality (Uzochukwu *et al.* 2004), our data highlighted the embeddedness of women's quality of care notions in the vast social and other inequities that currently characterize access to maternity care in Nigeria. Research in Nigeria shows that the majority of health seekers experience immense personal and structural challenges in reaching and accessing quality care. Most public health facilities in Nigeria lack basic essentials, are poorly equipped (Ezeonwu 2014), and are sometimes staffed by hostile and uncongenial providers (Okafor *et al.* 2015). The country's health referral system is also weak and care-settings and providers remain poorly coordinated and resourced. The services of private medical providers in Nigeria are often costly and on a pay-before-service basis. In many instances, treatment cannot commence until patients make cash deposits. There are also widespread reports of pregnant women, among others, dying at the doorsteps of private hospitals and clinics for failure to meet the deposit requirements or while their companions are still haggling over deposits. When such deposits are exhausted, treatment is frequently withheld or women held hostage until additional payment is made (Alubo 1990; Izugbara *et al.* 2016). Nigeria's informal maternity health services sector is also poorly regulated with few efforts to address prevalent excesses and charlatanism (Izugbara and Krassen Covan 2014). The women we studied frequently reported their key constraints in the context of care-seeking to include extortionate health settings and providers; poverty; unsafe and poorly-resourced care services; distant facilities; and inexpert, unprofessional, and abusive providers. Interestingly, these key experiences and challenges were the common ingredients in the women's conceptualizations of quality care

services and settings. Popay *et al.* (1998) argue that lay notions reflect the social context of individual human experience and, in particular, the possibility for, and determinants of creative human agency. Through local notions, people locate themselves within the places they inhabit and determine how and what to act on.

These findings raise a number of policy, theoretical and research implications. The emerging evidence on widespread combined conventional, complementary and alternative maternal health services raises need for policy and programmatic efforts to strengthen the availability and accessibility of maternal health services, maternity care referral systems, and the monitoring of quality of care in Nigerian health facilities. Also needed are strategies to promote more positive perceptions of and trust in formal maternal care services among women in Nigeria. However, further research is needed to establish the scale and spread of these beliefs and experiences related to different maternal care services and to find ways to mainstream the emerging evidence into program and policy.

While this study is the first, to our knowledge, to focus directly on perceptions of quality maternity care in a context of medical pluralism, it has a number of limitations. The study relied on a non-representative sample of respondents whose views cannot be extrapolated to a larger sample of women in Nigeria. Data were also not collected from men who play a key role in health decisions at household levels in Nigeria or from providers of maternal health services. The bulk of the respondents was of low socioeconomic status and without much access to formal care in Nigeria and it is not clear how that influenced the views found in the study.

Conclusion

The lay notions of quality maternity care elicited in this study are not abstract conceptualizations; they derive strongly from the lived social and health experiences and realities of women in Nigeria. Essentially, the women's notions expressed both knowledge of the key issues they face as well as thoughts on how to reposition the health system for the good of women. At a different level, the findings of this study call attention to the critical importance of approaches that seek to illuminate the sociopolitical processes and issues that undergird lay notions. It is, indeed, by grasping the sociopolitical logic of the invariably limited and idiosyncratic opinions of patients that their (such opinions') full value to efforts to improve health and wellbeing can be harnessed.

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