FACTORS INFLUENCING PRIMARY HEALTH CARE SERVICE UTILIZATION AMONG WOMEN IN RURAL COMMUNITIES IN OGUN STATE NIGERIA

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Abstract

Primary health care (PHC) accelerates timely intervention during and after pregnancy and child birth. According to Olise (2007) the strategy is meant to address the main health problems in the community providing promotive, preventive, curative and rehabilitative services. The PHC has collapsed in Nigeria due to many factors leading to the collapse of the national health system in Nigeria. The evidence include the poor health indicators such as infant mortality rate of 69.4/1000 live births, under 5 mortality rate of 108.8/1000 live births, maternal mortality among others. The situation poses a threat in the nation's effort at achieving the SDGs. The core objective was to find out factors retarding the accessibility of primary health care services for expectant women among rural communities and to proffer policy recommendations to better health care delivery system. It was an exploratory study and covered all the 16 wards of Ado-Odo/Ota Local Government Area. 112 respondents were randomly selected and seven health personnel from each PHC constitute the sample size. They were interviewed through questionnaire on important factors affecting the health delivery at the grassroots and the data were collected and analyzed through SPSS. Regression analysis of selected variables showed significant relationship among basic operational necessities of PHC like availability of ambulance at the health facility (P = .000), state of road to health facility (p = .000), referral practice (P = .000), and presence of staff welfare and motivation scheme (P = .000); with respect to rating of services at the health facility among other factors inhibiting service delivery at the grassroots. The paper recommends funding, provision of infrastructure, adequate remuneration and effective awareness campaign through community involvement as a boost in health care provision in rural communities.

Keywords: Primary health care, health system, grassroots, maternal and child health, Community.

1. INTRODUCTION

The primary health care (PHC) system is the first level point contact between the individual and the health system and the bed rock of national health system. Nigeria adopted PHC as the cornerstone of her national healthcare system and a priority for national development in 1986 and decades after, the PHC lacks the capacity to achieve its objectives. Primary health care (PHC) accelerates timely intervention during and after pregnancy and child birth, a level for qualitative healthcare which is easily accessible and affordable to the rural masses. Maternal and child health status have become important indicators for socio-economic development as well as health of the people of a country (Azuh et al 2017). National Health systems in many sub Saharan African (SSA) countries including Nigeria are weak facing numerous challenges. Good antenatal care can prevent major cause of neonatal and maternal mortality especially among rural communities that are hard to reach through the PHC system. PHC is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Primary health care as conceptualized by the Alma Ata declaration of 1978 is a grass-root approach towards universal and equitable health care for all (World Health Organization-United Nations Children Fund, [WHO-UNICEF] 1978). Nigeria is still at the first stages of the epidemiological transition; where preventable complications of pregnancy and delivery result to several mortality and morbidity among women and children in the country. The situation poses a threat in the nation's effort at achieving the SDGs. According to Egharevba et al 2016 there cannot be meaningful development without good health and quality life. It is at the grassroots health care system that we can be able to reverse the unacceptable but ever increasing maternal and child mortality in Nigeria. While about one million children die each year before their fifth birthday, an estimated 52,900 Nigerian women die annually from pregnancy related complications out of a global total of 529,000 maternal deaths. In fact, Nigeria needs immediate intervention to reduce her unacceptably high levels of maternal deaths which is even grave in rural areas in Nigeria where the health care system is poor and overstretched coupled with high level of poverty (Azuh et al 2017).

According to Olise (2007) the strategy is meant to address the main health problems in the community providing promotive, preventive, curative and rehabilitative services. It forms an integral part of the country's health system and the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work (WHO Declaration of Alma Ata, 1978). Nigeria was among the 134 signatories to this invaluable idea which is essential for reducing congestion of secondary and tertiary healthcare facilities in addition it enhances early management of the health problems of the population. PHC is therefore entrenched as the first level contact of an individual and the community in the national health system, thereby bringing health care close to people's homes and workplaces and constituting the first element of a continuing health care process (Akinsola, 2003). In a study of primary health care centers in rural and semi urban communities in south-western Nigeria Olusimbo and Cynthia (2010) observed that the main reasons for dissatisfaction were waiting time and availability of drugs. Similarly**,** Ojeifo (2008) examines primary healthcare in Owan east and Owan west local government areas of Edo State, and found that only very few centers were adequately equipped leading to several people suffering from different sicknesses and diseases and sometimes death.

The PHC has collapsed in Nigeria due to many factors leading to the collapse of the national health system in Nigeria. It is beset with ill-motivated workforce, poor infrastructure, and poorly managed primary health facility leading to very poor health indices especially the maternal mortality and under-five mortality which form the vulnerable group of our population. The evidence include the ranking of the performance of Nigeria's health system in the 187th position out of 191 Member States (WHO 2000); very poor health indicators such as infant mortality rate of 69.4/1000 live births, Under 5 mortality rate of 108.8/1000 live births, maternal mortality, 814/100,000 live births, public expenditure of 0.9% of GDP (UNDP Human Development Report 2016); only 36% of births in Nigeria are delivered in a health facility, 38% percent of deliveries are attended by a skilled birth assistant, and 25% of children age 12-23 months were fully immunized (NPC 2014). Adejumo and Colleagues recently revealed a scary statistics on still birth and caesarean situation in Nigeria (Adejumo et al 2017). The achievement on health care services over the last three and half decades has been decimated, such health gains like childhood immunization, etcetera plummeted and has not improved much ever since. While about one million children die each year before their fifth birthday, an estimated 52,900 Nigerian women die annually from pregnancy related complications out of a global total of 529,000 maternal deaths (FMOH, 2007). In a study conducted by FMOH and UNFPA on the quality of care, only 18.5 percent of the 4500 facilities surveyed had the capacity to provide

emergency obstetric care (NFMOH, 2003).

Similarly, Okonofua (2003) found that antenatal coverage in Nigeria is as low as 40 percent even in those areas where the quality of services is often less than optimal. The fact that pregnant women still patronize untrained traditional birth attendants need not be over emphasized. According to Society of Gynecology and Obstetrics of Nigeria (SOGON) report (2004), larger proportion of pregnant women still patronize untrained traditional birth attendants during antenatal care and child birth. In fact according to Mezie-Okoye (2012) study on the status of the availability and performance of Emergency Obstetric Care (EmOC) in 12 functional public health facilities in Gokana Local Government Area of Rivers State found no facility qualified as Basic EmOC The coverage and quality of health care services in Nigeria continue to fail women and children through persistence low coverage of high impact interventions for maternal, new born and childbirth. Unfortunately, the responsibility of PHC is yet to be unveiled especially in the area of mother and child healthcare. No doubt, studies have been carried out on the health system but less has been directed towards maternal and child healthcare and that too with respect to PHC. Hence, the need for a community based survey to examine the role of PHC, particularly in providing maternal and child healthcare services. The main objective of the paper is to examine the influence of PHC on the community members particularly the vulnerable group (women and children) and to proffer policy recommendations to better health care delivery system. The hypothesis put forth is that good health environment enhances health care service delivery to mothers and children.

2. METHODOLOGY

Ado-Odo/Ota local government area was purposively chosen from the 20 local government areas in Ogun State Nigeria in the first phase based on anticipated cooperation from the respondents. The study covers all the 16 wards of Ado-Odo/Ota Local Government Area (LGA). In the second phase, all the 16 wards in the local government were listed and selected. The wards are as follows: Ota I, Ota II, Ota III, Ilogbo, Atan, Alapoti, Ado-Odo I, Ado-Odo II, Ere, Igbesa, Ketu Adie-Owe, Agbara I, Agbara II, Iju, Sango-ota and Ijoko. Finally all the primary health care (PHCs) in these wards were listed and selected. Thereafter, seven health personnel in each PHC were interviewed using the questionnaire instrument. The survey instruments were designed to collect data pertaining to basic socio-demographic characteristics of the respondents and health related issues. Overall, 112 respondents were randomly interviewed from the sixteen wards in the Local government area and three questionnaire were excluded for incompleteness. Hence the sample size was 109 respondents. The survey data were analyzed statistically using statistical package for social sciences (SPSS).

3. RESULTS AND DISCUSSION

A total of 112 questionnaires were administered, 109 respondents (97.3%) responded with sufficient information on various aspects of the study. The descriptive results of socio-demographic and health characteristics (see Table 1) show the location status to be 65.1% urban and 34.9% rural whereas an overwhelming proportion of the respondents were females (79.8%) and 20.2% were men. Educational attainment of the respondents show that those with post-secondary qualifications account for 62.4%, followed by respondents with secondary education (31.2%). The poor state of roads is even more worrisome as more than half of the respondents stated that the roads are bad (56.0%) and this could also cause further delay during emergency. This finding is in consonance with the World Bank Group (2008) study which noticed that infrastructure of PHC facilities is in very poor condition leading to many constraints in the delivery of PHC services in all the four states studied in Nigeria. Common ailments treated in the PHCs are (4.6%), hemorrhage (33.5%), malaria (33%), swelling of legs (13.8%), blood pressure (10.1%) and severe headache and waist pain (4.6%) The lack of access to ambulance was stated by slightly less than three-fifths (72.5%), Even though results show that substantial proportion of the respondents (76.1%) have access to referral facility, the poor state of the roads as earlier indicated lead to ineffectiveness of the facility. The rate of service satisfaction at the health center was impressive as overwhelming proportion of respondents stated (72.5%). However, those that stated otherwise (27.5%) may also lead to some level of dissatisfaction on service delivery at the PHC facilities which may lead to low patronage due to lack of confidence in the services of PHC. In addition, the study revealed that the supply of essentials (drugs and vaccines) is poor with almost half of the respondents accenting to poor supply of essentials in their health facility (49.5%). No doubt slightly more than two-fifths of those interviewed acknowledge satisfactory staff welfare and motivation (41.3%), an overwhelming proportion (58.7%) also registered their displeasure in this issue.

The consequences of this may lead to serious consequences as also revealed by earlier study (Adeniyi, Oladepo, and Soyibo 2003). The appalling inadequacy of vital equipment in the PHCs was also noted as

35.8% of respondents stated inadequacy of basic equipment. The inadequacy of or lack of basic medical equipment has equally been identified as one of the effects of low patronage especially of rural health centers (Ojeifo (2005 2008). Respondents enumerated numerous **c**hallenges faced by clients in accessing health care services and these range from cost of service (28.4%), low quality service (21.1%), low awareness level (16.5%), poor transport (14.7%), cultural practices (11%) and lack of amenities (8.3%). Furthermore, challenges limiting service delivery by health personnel was not left as respondents retorted, consumables (36.7%), storage facility (25.7%), manpower (22.9%) and poor amenities (14.7%). All these challenges must be addressed for PHC facilities to deliver better services. Visitation of medical director is not just too good as substantial proportion of respondents express their concern on this aspect (45%). The respondents revealed the dismal attitude of the masses with respect to community participation in the activities of these PHCs as huge proportion indicated the non-participatory nature of community members (75.2%). The importance of community involvement in PHC activities has also been observed by earlier studies (Hilary et al 2014, Azuh et al 2016) The scenario is against the health policy which is guided by the Bamako initiative to encourage and sustain community participation in primary health care services. In fact, community participation helps communities in identifying their health needs and shaping service development.

Regression analysis (see Table 2) of selected variables showed significant relationship among basic operational necessities of PHC like availability of ambulance at the health facility (P = .000), state of road to health facility (p = .000), referral practice (P = .000), and presence of staff welfare and motivation scheme (P = .000); with respect to rating of the services at the health center among other factors inhibiting service delivery at the grassroots. The paper recommends government commitment in terms of funding, provision of infrastructure, adequate remuneration and effective awareness campaign through community involvement as a boost in health care provision in rural communities.

4. CONCLUSION AND RECOMMENDATIONS

The funding of PHC should not be left to the Local Government alone, the Federal and State Governments should contribute in infrastructural provision particularly buildings and roads, staff of PHC should be encouraged by adequate welfare and motivational schemes to avoid their migration or relocating to industrialized countries where they will be adequately remunerated, provision adequate amenities and procurement of equipment including drugs and other consumables should be a matter of top priority. In addition, communities in the study area should be mobilized and given adequate orientation to participate in the activities of PHCs in their various places in order to maximize the benefits and sustainability of PHC delivery services within the local government and beyond.

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Table 1 Socio-demographic and Health characteristics of respondents

Variable	**No N=109**	**Percent**		**Variable**	**No N=109**	**Percent**
Status of Ward				Sex		
Urban	71	65.1		Male	22	20.2
Rural	38	34.9		Female	**87**	79.8
Educational Attainment				**State of road to Health facility**		
None	1	.9		Good	3	2.8
Primary	6	5.5		Fair	45	41.3
Secondary	34	31.2		Poor	61	56.0
Post secondary	68	62.4				

Common complications of mothers attending Antenatal care				**Availability of ambulance at the health facility**		
Hemorrhage	42	38.5		Yes	30	27.5
Malaria	36	33.0		No	79	72.5
Raised Blood Pressure	11	10.1				
Severe Headache & Waist Pain	5	4.6				
Swelling of Legs	15	13.8				
Availability of referral facility/networking at the Health center				**Rate of services at the Health center**		
Yes	83	76.1		Very satisfactory	32	29.4
No	26	23.9		Satisfactory	47	43.1
				Unsatisfactory	30	27.5
Status of supply of essentials (drugs & Vaccines)				**Level of staff welfare & motivation**		
Very satisfactory	20	18.3		Very satisfactory	3	2.8
Satisfactory	35	32.1		Satisfactory	42	38.5
Unsatisfactory	54	49.5		Unsatisfactory	64	58.7
Adequacy of vital equipment				**Challenges faced in accessing Health Care Services**		
Good	20	18.3		Cost of service	31	28.4
Poor	50	48.9		Poor transport	16	14.7
Very poor	39	35.8		Lack of amenities	9	8.3
				Low quality service	23	21.1
				Low awareness level	18	16.5
				Cultural practices	12	11
Challenges limiting service delivery				**Visitation of medical doctor to the Health center**		
Poor amenities	16	14.7		Yes	60	55
Storage facility & equipment	28	25.7		No	49	45.0
Manpower shortage	25	22.9				
Drugs, vaccines and consumables	40	36.7		**Community participation in this PHC**		
				Low	82	75.2
				Medium	24	22.0
				High	3	2.8

Source: Field Survey 2017

Table 2 Regression Analysis: Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.047	.196		20.601	.000
	Availability of ambulance at the health facility	-1.275	.066	-.755	-19.367	.000

	State of the road to the Health facility	.176	.039	.163	4.535	.000
	Availability of referral facility/networking at the Health center	.606	.062	.342	9.766	.000
	Level of staff welfare & motivation	-.484	.045	-.352	-10.773	.000

R Square .908; Adjusted R Square = .905; F = 256.997

Dependent Variable: Rating of the services at the Health center