FACTORS INFLUENCING THE UTILIZATION OF PUBLIC PRIMARY HEALTH CARE FACILITIES IN KUMBOTSO LOCAL GOVERNMENT AREA OF KANO STATE, NIGERIA

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Abstract

This study is concerned with the examination of factors responsible for the utilization of public primary healthcare services in Kumbotso Local Government Area of Kano State. Primary health care (PHC) can be considered the first level of contact between the patient and the health care system. The Andersen Model of Healthcare Utilisation was used as theoretical guide and frame of analysis in the study. The model is a conceptual framework developed and used to understand health behaviour and possible reasons for utilization of available healthcare facilities and services. The study is a survey research design. A total of 295 respondents were sampled for the study. These include 285 members of the public who were sampled through a multi stage cluster sampling for questionnaire administration and 10 other respondents (Doctors, Nurses, and Community Health Extension Workers) who were purposively sampled for in-depth interview. The study utilized both qualitative and quantitative instruments for data collection. The findings revealed that awareness has influence on the utilization of PHC services in the study area. It also revealed that even though there is high rate of patronage of PHC facilities in the area, respondents reported facing problems associated with availability of drugs, healthcare personnel for effective PHC delivery. It recommended that the government should ensure compliance with the WHO benchmark for PHC delivery.

Key Words: Primary health care, Awareness, Availability, Access, Health workers behaviour.

1.0 Introduction

The fundamental aim of primary health care (PHC) is to ensure universal access to available resources in order to provide adequate coverage of the most important health needs of the people. In the last 40 years, primary health care has evolved and developed globally. In Nigeria, primary health care implementation started in 1992 with the commencement of the programme in the local government areas (LGAs). Nigeria therefore became one of the first countries in the developing economies to have systematically decentralized the delivery of the basic health care services through local government administration. This was incorporated in the National Health Policy of Nigeria which was implemented in 1988 as a collective responsibility of the

government and people of Nigeria to provide a comprehensive health care system (Federal Ministry of Health, 2010).

The provision of health care at the PHC level is largely the responsibility of local government with the support of states' ministries of health and within the overall provision of the national health policy. The primary health care centres are mainly located within communities at the local government level. In each of the 774 local government areas in Nigeria, there is a primary health care centre that provides services at the grassroots. This inarguably can have a large impact on the health of the community and Nigerians at large.

Primary health care as evident in the Alma-Ata declaration of 1978 is a lower level health care initiative directed at universal and equitable health care for all. It is an approach meant for addressing the main health problems in the community by providing promotive, preventive, corrective and rehabilitative services, the aim of which is to bring health care as close as possible to people as a basis for ensuring their continuing health care process. In other words, it is aimed at providing families, individuals and communities with all the necessary health services, other than those which can only be provided in the hospital (Federal Ministry of Health Nigeria, 2004). The primary health care as contained in the Alma-Ata declaration has five principles that have been designed to work together and be implemented simultaneously to bring about a better outcome for the entire population. Pemberton and Cameron (2010) outlined these principles to include:

a) Accessibility;
b) Community participation;
c) Health promotion;
d) Appropriate technology; and
e) Inter-sectoral collaboration.

Although PHC is globally embraced as a prerequisite for transformation in community health, the state of primary health care facilities and utilisation in some developing countries, especially in Nigeria contradicts international standards and best practices on PHC. Thus, the delivery of quality primary health care services (PHC) can have a large impact on the health of Nigerians, those in the study area inclusive. Many of the most cost-effective health interventions to prevent and treat the major causes of mortality and morbidity can be offered at this level of care, as the poor are more likely to seek care in PHC facilities than the rich.

Statement of the Problem

Quality health is a fundamental right of citizens globally, and Nigeria is not an exemption. The goal of primary health care was to provide accessible health for all by the year 2000, and beyond. Without a doubt, this is yet to be achieved in Nigeria. Though, primary health care centres were established in both urban and rural areas in Nigeria with the aim of ensuring equality and easy access. Most people residing in developing countries of the world, especially in Africa, have a poor understanding of their national health systems and programmes and therefore the tendency for putting the health facilities into non-proper utilization. More so, since the inception of PHC in 1992, in Nigeria, several studies have reported the rate of its utilization as low thereby contributing to poor health status of the people (Jaro and Ibrahim, 2012; Galadanchi, 2007; Cueto, 2004). Given that one of the major objectives of PHC in developing countries is to improve the health status of individuals and the community through health promotion and increased utilization of preventive, curative and rehabilitative health services, an understanding

of factors precipitating utilization of health care facilities, especially at the primary level thus became necessary. The study therefore seeks to address the following research questions:

1) What is the level of awareness of people on the existence of PHC services in the study area?
2) What are the organizational factors (availability, accessibility and health workers behaviour) responsible for the utilization of PHC in the study area?

Objectives of the Study

The broad objective of this study is to examine factors responsible for the utilization of primary health care services. However, the specific objectives are:

1) To examine the level of awareness of people in the study area on the existence of PHC services.
2) To examine the organizational factors (availability, accessibility and health workers behaviour) responsible for the utilization of PHC in the study area.

2.0 Literature Review

PHC is the first level of contact of individuals, the family, and the community with the national health system, bringing health care, as close as possible, to where people live and work and constitutes the first element of continuing health care process. According to Cueto (2004), the term 'primary health care' was used probably for the very first time in 1970, in the journal, "*Contact"*, established by the Christian Medical Commission (CMC). The CMC was formed in the late 1960s by medical missionaries working in developing countries; with an emphasis on the training of village workers at the grassroots level, equipped with essential drugs and simple methods. In 1974, the collaboration between the CMC and the World Health Organization (WHO) was formalized.

It was, however, in 1978 that the formal shift in the paradigm of health care delivery, from hospital-based vertical to the grassroots primary health care approach was enshrined. The landmark event that gave birth to the primary health care concept was the International Conference on Primary Health Care (PHC), which was held in Alma Ata, Kazakhstan, USSR, from September 6 to 12, 1978, at which 134 countries were represented (Gideon, 2014).

The primary health care at present is the basic structural and functional unit of the public health services in developing countries. The establishments were made specifically to provide accessible, affordable and available primary health care to people in accordance with the Alma-Ata declaration of 1978 by the member nations of the World Health Organization (WHO, 2006).
In Nigeria, all three tiers of government (federal, state and local) share responsibilities for providing health services and programmes (National Health Policy, 2004). The federal government is largely responsible for providing policy guidance, planning and technical assistance, and coordinating state level implementation of the national health policy. More so, the responsibility for management of health facilities and programmes is shared by the state ministries of health, state hospital management boards, and the local government areas (LGAs). The 774 local governments oversee the operations of primary health care facilities within their geographic areas. This includes the provision of basic health services, community health hygiene and sanitation. This derived from the fact that local government is the closest to the people (Magnus, 2008). For equity, primary health care centres are usually located in each political ward of a local government area. However, the location (number of the PHCs in a ward)

however, depends on such factors as population and physical size of the wards. This is to ensure the optimal utilization of social facilities (Akhayere, 2002).

As was noted earlier, the goal of primary health care was to provide accessible health for all by the year 2000 and beyond. However, studies have shown the extent to which this has not been realized hence the very uncertainty of its realization (Abiodun, 2010). This submission derived from the evident state of disrepair of facilities and equipment being either absent or obsolete.

The findings of a study of primary health care in Nigeria conducted by World Bank in 2003 and 2010, in Nigeria which focused on performance and accountability, show that despite government commitment, effective primary health care delivery remains a challenge in Nigeria. Utilization of healthcare services is an important determinant of health, and has particular relevance as a public health and development issue in developing countries like Nigeria. In fact, utilization of healthcare services for the most vulnerable and underprivileged population has been recommended by the World Health Organization as a basic primary healthcare concept (WHO, 1978). It has been suggested that healthcare should be universally accessible without barriers based on affordability, physical accessibility, or acceptability of services.

There has long been interest in what influences people's behaviour in relation to their health (Suchman, 1965) and what prompts people not to use conventional health services. There exists therefore, a substantial body of literature examining multiple aspects of health or health care seeking. A review of these factors is presented. The current literature acknowledges there are multiple determinants of health care services utilization, which recognize the role of behaviour, culture, economics, psychological, environmental and social factors and the interconnectedness of these factors (Thistle, 2003).

Further to the above, certain factors have been identified to be associated with health care delivery in health facilities. These factors add up to promote the extent to which health care seekers utilize or underutilize health care facilities. According to Donabedian (1980), these include:

Quality Clinical quality refers to whether the provider's care conformed to best clinical practice for those who use the services of the organization. It also includes managerial quality and patient experience within the quality outcome domain. Managerial quality refers to the degree to which administrative systems such as procurement, human resources, and data management support the delivery of high-quality clinical care (Egger, 2005).

Utilization This is used to refer to the ways in which individuals react to ill health. Many factors may influence this reaction, including characteristics of the individual and their capacity to access the type of resources they may require in their quest to deal with their ill health (Green and Nguyen, 2001). From this perspective, an organization with chronically underutilized capacity would be considered a lower performing organization.

Access This refers to the potential ability of an organization's potential clients to obtain its services. When this potential ability is realized, it results in observable utilization, which is why studies often use utilization as a proxy variable for access. Conversely, lack of utilization can signal the existence of barriers to access (Gideon, 2014). However, access and utilization are conceptually distinct intermediate outcomes, as an individual may have access to an organization but choose not to utilize services there, as evident in the case of most PHCs in Nigeria.

Learning This, according to Donabedian, refers to the process by which an organization acquires new knowledge and translates this knowledge into organizational practices. This performance intermediate outcome is not only learning by individuals within the organization but "the

assimilation of individual knowledge into new work structures, routines, and norms" that can outlast any individual staff member (Davies and Nutley, 2000).

Sustainability This entails the organization's ability to continue delivering needed and valued services. Dimensions of sustainability include sustained political support from government officials, sustained community and patient support, and predictable access to needed inputs such as financing, trained human resources (Olsen, 1998). As an organizational performance intermediate outcome, sustainability is measured in terms of both the organization's existing support and its strategies and efforts to secure future support (Gruen et al., 2008).

3.0 Theoretical Framework

The Andersen model of healthcare utilization was used as frame of analysis. Andersen (1968) developed a model of health care utilization which looks at three categories of determinants.

1) Predisposing characteristics: This category represents the proclivity to utilize health care services. According to Andersen, an individual is more or less likely to use health services based on demographics, position within the social structure, and beliefs of health services benefits.

2) Enabling characteristics: This category includes resources found within the family and the community. Family resources comprise economic status and the location of residence. Community resources incorporate access to health care facilities and the availability of persons for assistance.

3) Need based characteristics: The third category includes the perception of need for health services, whether individual, social, or clinically evaluated perceptions of need.

In the 1970's Andersen's model was later expanded and refined to include the healthcare system. The health care system includes health policy, resources, and organization, as well as the changes in these over time. Resources comprise the volume and distribution of both labour and capital, including education of health care personnel and available equipment. Organization refers to how a health care system manages its resources, which ultimately influences access to and structure of health services. According to this level of the revised model, how an organization distributes its resources and whether or not the organization has adequate labour volumes will determine if an individual uses health services. In addition, the updated model includes recognition that consumer satisfaction reflects health care use.

The use of the model as frame of analysis is premised on its flexibility and that it provides a robust analytical framework for discussion. More so, it examines psychological and psychosocial factors as they describe attitudes toward healthcare utilisation as well as beliefs about the healthcare system, all of which are central to the objective of this study. Thus, the utilization of primary healthcare facilities in Kumbotso local government area of Kano state could be explained using Andersen's model.

3.0 Research Methods

This study adopted survey research design using both quantitative and qualitative methods. The target population of this study includes all adult male and female residents of Kumbotso Local Government area, community health workers and health care service personnel (nurses and doctors) in the chosen primary health care centres in the study area. All of these are considered part of the study population considering the fact that they are stakeholders in primary health care. A total sample size of two hundred and ninety-five (295) respondents was used for the study. These include two hundred and eighty-five respondents for questionnaire administration to

obtain the quantitative data and ten participants on in-depth interview to generate the qualitative data. The sample size is broken down as follows:
Residents = 285
Community Health Extension Workers = 5
Nurses = 3
Doctors = 2
Furthermore, the study adopts dual sampling techniques (multi-stage cluster and purposive) in selecting the respondents for this study. In the first stage of the cluster, the study area was divided into (5) clusters on the basis of proximity using the (11) political wards which include Challawa, Chiranchi, Danbare, Danmaliki, Guringawa, Kumbotso, Kureken Sani, Mariri, Naibawa, Panshekara and Unguwar Rimi.
Cluster A: Challawa, Panshekara
Cluster B: Chiranchi, Danbare
Cluster C: Danmaliki, Kumbotso
Cluster D: Guringawa, Kureken Sani
Cluster E: Naibawa, Mariri, Unguwar Rimi
Lottery method of simple random sampling was adopted to select five clusters (Panshekara, Chiranchi, Kumbotso, Guringawa and Unguwar Rimi) from which the respondents were drawn. The third stage was directed at selecting areas covered in the selected clusters. In each of the selected clusters, 1 area was randomly selected using the same method providing a total of 5 areas. In each of the selected areas, 2 locations were selected thereby arriving at a total of 10 locations. However, 2 streets were selected from each of the 10 locations to provide 20 streets where the households were located. Moreover, in each of the streets selected, 14 copies of questionnaire were distributed to respondents by locating the respondents in the selected areas across the 10 locations. The final stage of the sampling was the selection of households for questionnaire administration. Eligible respondents (adult members, particularly household heads) in the selected households were given questionnaire.
The survey research method of data collection was utilized through the administration of copies of questionnaire. The survey questionnaire contains both closed and open ended questions. In addition, an interview guide was designed with questions bordering on the research objectives to conduct an In-depth Interview (IDI). More so, the community health workers, nurses and doctors were purposively selected on the basis of availability for In-depth-Interview (IDI). The interviews were conducted with the aid of a structured IDI guide containing relevant questions to realize the objectives of the study.

4.0 Research Findings

The research findings are presented below:

Table 1: Respondents Awareness of the PHC

Awareness	**Frequency**	**Percentage**
Aware	259	90.8
Not Aware	26	9.2
Total	**285**	**100**

Source: Field Survey, 2017

Table 1 shows responses on whether the respondents are aware of the existence of primary health care facilities in the community. The table indicates that 90.8% of the respondents are aware of the existence of primary health care facilities in the community and 9.2% are not aware. This

implies that majority of the respondents are aware of the existence of primary health care facilities in their community.

Table 2: Sources of the Awareness of the Existence of PHC Facilities

Sources	Frequency	Percentage
Chiefs and Local Heads	43	16.8
Doctors/Medical Professional	20	7.7
Television	7	2.7
Radio	21	8.1
Internet	2	0.7
Print Media	23	8.9
Family and Friends	90	34.7
Community Groups	24	9.3
Mosques/Churches	29	11.1
Total	**259**	**100**

Source: Field Survey, 2017

Table 2 shows the respondents' sources of the awareness of the existence of primary health care facilities. The table indicates that 34.7% of the respondents got to know about the existence of the primary health care facilities in their areas through family and friends, 16.8% through chiefs and local heads, and 11.1% through their worship centres (Mosques). It also indicates that 20.4% of the respondents put together, got to know about the existence of the primary health care facilities in their areas through the media i.e. television, radio, internet and print media. This implies that majority of the respondents got to know about the existence of primary health care facilities through their relations and close associates.

Table 3: Utilization of PHC for their Healthcare Needs

Responses	Frequency	Percentage
Yes	236	91.1
No	23	8.9
Total	**259**	**100**

Source: Field Survey, 2017

Table 4.11 shows the responses on whether the respondents utilize the primary health care facilities for their health care needs. The table indicates that 91.1% of the respondents claimed that they utilize the primary health care facilities for their health care needs, while only 8.9% did not agree with the claim.

A Doctor in charge of the PHC in a particular village during the in-depth interview said:

> Residents of this community do take their families to the nearby public primary health care facility for their health care needs. This is probably because of their advantages of affordability which they have over the private ones. Basically, affordability of services rendered encourages the members of the public to access them for their health care needs (IDI: Doctor, 2017)

Table 4: Factors Influencing the Utilization of the Public Health Care Facility

Factors	Response	Frequency	Percentage
Availability of healthcare personnel	Yes	214	82.6
	No	45	17.3
	Total	**259**	**100**
Availability of drugs	Yes	104	40.2
	No	155	59.8
	Total	**259**	**100**
Timely service delivery	Yes	191	73.7
	No	68	26.3
	Total	**259**	**100**
Accessibility of service with ease	Yes	180	69.4
	No	79	30.6
	Total	**259**	**100**

Source: Field Survey, 2017

Table 4 shows the respondents opinion on the factors influencing the utilization of the public health care facility. The table indicates that 82.6% of the respondents opined that availability of health care personnel influence their utilization of the public health care facility, while 17.3% of the respondents said no. While, 40.2% of the respondents opined that availability of drugs influence their utilization of public health care facility, 59.8% of the respondents opined that non-availability of drugs influence them non-utilization of public health care facility. Similarly, 73.7% claimed that timely service delivery influence their utilization of public health care facility, while 26.3% disagree with such claim and 69.4% of the respondents claimed accessibility of service with ease influence their utilization of public health care facility, while 30.6% disagree. This implies that certain factors influence the utilization and non-utilization of health care facility in the study area. In other words, there are myriads of factors that affect the utilization of PHC.

Corroborating the findings above, a Nurse interviewed opined that:

> To the best of my knowledge, people troop in here on daily basis with healthcare problems that are not beyond the capacity of the PHCs and they usually leave with joy especially when they don't have to spend much for consultation and drugs where necessary. For example, we charge a token of N50 for consultation which is provided for exorbitant amount in private and even other public tertiary hospitals. In fact, they are not even readily available atimes (IDI: Nurse, 2017).

A Community Health Extension Worker (CHEW) also shared his own view that:

> In most PHCs around Kumbotso, it is a common issue to wake up and see people coming for healthcare services they can't afford in many other hospitals. For instance, most patients suffering from acute illnesses such as malaria are provided with tests and result within minutes to ascertain the best medication to use. Unlike in many other hospitals, this could have taken time (IDI: CHEW, 2017).

Table 5: Respondents' Views on the Behaviour of Health Care Personnel

Respondents' Views	Frequency (f)	Percentage (%)
Excellent	37	14.3
Very good	61	23.5
Good	36	13.9
Satisfactory	46	17.8
Unsatisfactory	79	30.5
Total	**259**	**100**

Source: Field Survey, 2017

Table 5 shows the respondents' views on the attitude of staff at the health facility. It indicates that 30.5% of the respondents view the attitude of the staff at the health facility as unsatisfactory, 23.5% views their attitude as very good and 17.8% view it as satisfactory, respectively. Also, the table indicates that 14.3% of the respondents view the attitude of the staff as excellent while 13.9% reported the behaviour of health care personnel as good.

Table 6: Respondents Satisfaction with the Services Provided

Responses	Frequency (f)	Percentage (%)
Very satisfied	54	20.9
Satisfied	85	32.8
Neutral	44	16.9
Dissatisfied	24	9.3
Very dissatisfied	52	20.1
Total	**259**	**100**

Source: Field Survey, 2017

Table 6 shows the responses on whether the respondents are satisfied with the services provide at the healthcare facility. It shows that 32.8% of the respondents are satisfied and 20.9% are very satisfied with the services provided at the health facility. The table also indicates that 20.1% of the respondents are very dissatisfied and 9.3% are dissatisfied with the services provided at the health facility. This implies that more than average of the respondents are satisfied with the services provide at the public health facility.

5.0 Major Findings of the Study

5.1 Level of Awareness on the Existence of PHC

From the findings of the study, utilization of PHC services is largely an outgrowth of the extent to which people are aware of the existence of such services in their locality or elsewhere. This is largely a function of the health education programmes being conducted in the locality by the PHCs. However, social networks such as family and friends, religious organizations and elders were also found to be of influence in raising awareness among the people concerning available healthcare services. In essence therefore, increase in people's level of awareness, can help promote the utilization of available health facilities.

5.2 Organizational Factors Responsible for the Utilization of PHC

Primary health care system is a vital tool for functional health care services in any society. The findings of this study points to the influence of health work organization as a motivation for PHC utilization. Thus, organizational factors such as availability of health services, average

population covered by health facilities, less waiting time, availability of drugs and their functional status according to Jaro, *et al.* (2012) significantly determine the utilization of health services.

On the behaviour of health workers and the utilization of PHC services, the bulk of respondents cited that positive behaviour of the workers has an influence on the utilization of PHC in Kumbotso even though some have reported witnessing the negative side of the health worker's behaviour. The findings concur with earlier findings by Payne (2006) who asserted that communication challenges between care givers and patients have a negative impact on participation in preventive measures, quality of healthcare, including, hospital admissions and diagnostics. Thus, positive behaviours and attitudes are very likely to influence utilization of PHC services for healthcare needs.

Given the theoretical frame of analysis in this study, the findings of this study have shown that utilization of PHC services in Kumbotso local government area is among other factors, a function of the associated benefits especially taking into consideration the availability of services, awareness and satisfaction. These factors are aptly covered in the proposition of the Andersen's Model of Healthcare Utilization.

6.0 Conclusion

Based on the study findings, it is evident that there is a significant level of awareness and patronage of PHC services among the people of the study area. More so, the PHC services are available even though some respondents reported problems associated with non-availability and ease of access. Nevertheless, staff attitude and satisfaction with the services rendered also help in the utilization of PHC services.

7.0 Recommendations

The following recommendations are made based on the research findings:

1) The Governments should partner with local/community heads, through their worship centres and media to create more awareness of the existence and utilization of the public primary health facilities in the study area. Although the findings of this study point to an appreciable level of awareness of PHC services in the area of study, it is suggested that policies enhancing improved health education can further promote more awareness.
2) Although the behaviour of the staff of the public health facilities is quite appreciable as shown by the findings of this study, it can be greatly enhanced by providing avenue for the training and retraining of healthcare workers especially in line with best global practices associated with patient and care giver relationship.
3) Finally, PHCs should strive to ensure continuous organization of healthcare services in order to make it easy for patronage, especially in the area of manpower, access, quality and timely delivery.

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