

**EXPLORING THE FACTORS THAT CONTRIBUTE TO POOR
UTILIZATION OF PRIMARY HEALTH CARE SERVICES: A STUDY OF
TWO PRIMARY HEALTH CARE CLINICS IN NASARAWA STATE,
NIGERIA**

BY

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ABSTRACT

Introduction

Nigeria operates a three tiered health care delivery system with a large percentage of health care delivery vested at the primary care level. There has been over the years a continued effort by the government to decentralize health care service thereby increasing the range of services provided at the primary care level. Despite all these efforts there is still low utilization of primary health care services. This study therefore seeks to explore the factors that may be responsible for poor utilization of primary health service in Nasarawa State, Nigeria using two primary health clinics in Lafia local government area as case studies.

Methodology

The study was carried out using the qualitative research methodology primarily using two data collection methods, the focus group discussions and individual interviews. A total of sixty participants were sampled, these consisted of ten members of staff, twenty non facility users and thirty facility users. Thirty individual interviews were conducted and four focus group discussions held with staff and facility users at the two clinics. Facility users were randomly selected as they attended the clinic on the data collection days and were invited to participate in the study. Every second patient attending the clinic was selected for the focus group discussion and every third person for the interviews. The staff participants were randomly selected based on their availability while non-facility users were selected using snowballing. Data was analyzed using thematic analysis method.

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Findings

Two major themes emerged following data analysis; these were perception and experiences of facility users and barriers to utilization of health services. Users had a good perception of the services they received and are reasonably satisfied but certain deficiencies in the health care systems compromised the quality of service. Several factors were however hindering the utilization of these services and these include mainly institutional factors such as lack of infrastructure, equipment and staffing constraints; household factors such as cost of service and responsibility of decision making and other factors such as stigmatization and beliefs.

Conclusion

Facility users of these clinics seem to have an overall good impression of services at the clinics; however there are certain fundamental deficiencies that need to be urgently addressed to improve the care provided at these clinics as these constitute barriers to utilization. These deficiencies such as the absence of electricity and water, lack of basic work equipment and inappropriate staff composition need to be addressed by the local government health department to ensure utilization and improved quality of service.

DECLARATION

I declare that, this study titled “*Explore the factors that contribute to barriers to the utilization of health services at the primary health care level – a study of two primary health clinics in Nasarawa State, Nigeria*” is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

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Signed:



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KEYWORDS

Health Services

Utilization

Primary health care

Barriers

Social Determinants

Facility

Infrastructure

Antenatal care

Nigeria

Nasarawa State



Table of contents

| | | |
|-----------------------|---|-----|
| Title Page | | i |
| Abstract | | ii |
| Declaration | | iii |
| Acknowledgement | | iv |
| Keywords | | v |
| Table of contents | | vi |
| List of Abbreviations | | ix |
| Chapter 1 | Introduction and study background | 1 |
| 1.1 | Introduction | 1 |
| 1.2 | Health care delivery in Nigeria | 2 |
| 1.3 | Problem statement | 4 |
| 1.4 | Purpose and significance of study | 4 |
| 1.5 | Research aims and objectives | 4 |
| Chapter 2 | Literature Review | 6 |
| 2.1 | Introduction of chapter content | 6 |
| 2.2 | Overview of key concepts | 6 |
| 2.2.1 | Primary Health Care | 6 |
| 2.2.2 | Service utilization and health seeking behavior | 6 |
| 2.3 | Challenges with the implementation of the PHC concept | 7 |
| 2.4 | Factors affecting health services utilization | 8 |
| 2.4.1 | Sociocultural factors that affect health service utilization | 9 |
| 2.4.2 | Socioeconomic determinants of health service utilization | 10 |
| 2.4.3 | Effect of accessibility of health services on service utilization | 10 |
| 2.4.4 | Availability of infrastructure and staffing and its effect on utilization | 10 |
| 2.4.5 | Other factors affecting utilization of health services | 11 |
| Chapter 3 | Study Methodology | 13 |
| 3.1 | Research design | 13 |
| 3.2 | Study setting | 13 |
| 3.3 | Study population | 14 |

| | | |
|-----------|---|----|
| 3.4 | Sampling | 15 |
| 3.5 | Data collection | 15 |
| 3.6 | Data analysis | 16 |
| 3.7 | Rigor | 17 |
| 3.8 | Ethical consideration | 18 |
| 3.9 | Limitation of study | 19 |
| Chapter 4 | Findings | 20 |
| 4.1 | Findings | 20 |
| 4.1.1 | Perceptions and experiences of facility users | 20 |
| 4.1.1.1 | Users satisfaction with services provided | 21 |
| 4.1.1.2 | Utilization of maternal services | 21 |
| 4.1.1.3 | Physical state of health facilities | 22 |
| 4.1.1.4 | Implementation of the PHC concept of care | 22 |
| 4.1.1.5 | Selective versus comprehensive approach | 23 |
| 4.1.1.6 | Utilization of health services | 24 |
| 4.1.2 | Institutional factors affecting service utilization | 26 |
| 4.1.2.1 | Lack of basic infrastructure | 26 |
| 4.1.2.2 | Non availability of basic hospital equipment | 28 |
| 4.1.2.3 | Staffing challenges | 29 |
| 4.1.3 | Household factors affecting service utilization | 30 |
| 4.1.3.1 | Affordability of services | 30 |
| 4.1.3.2 | Decision making power in the homes | 31 |
| 4.1.4 | Other contributing factors to service utilization | 31 |
| 4.1.4.1 | Role of other health care providers | 31 |
| 4.1.4.2 | Stigmatization | 31 |
| 4.1.4.3 | Beliefs | 32 |
| Chapter 5 | Discussion | 33 |
| 5.1 | Perceptions, implementation and utilization of PHCs | 33 |
| 5.2 | Barriers to service utilization | 36 |
| Chapter 6 | Conclusions and recommendations | 39 |

| | | |
|-----|-----------------|----|
| 6.1 | Conclusions | 40 |
| 6.2 | Recommendations | 41 |



LIST OF ABBREVIATIONS

| | |
|----------|---|
| ANC | Antenatal care |
| ART | Antiretroviral Therapy |
| CHEW | Community Health Extension Worker |
| CHO | Community Health Officer |
| CHW | Community Health Worker |
| DOTS | Direct Observation Therapy Short Course |
| FGD | Focus Group Discussion |
| FMOH | Federal Ministry of Health |
| FHI | Family Health International |
| GOBI | Growth monitoring, Oral Rehydration, Breastfeeding and Immunization |
| GOBI-FFF | Growth monitoring, Oral Rehydration, Breastfeeding and Immunization- Family Planning, Food supplementation and Female Education |
| HCT | HIV Counseling and Testing |
| HCW | Health Care Worker |
| HIV | Human Immunodeficiency Virus |
| JCHEW(s) | Junior Community Health Extension Worker(s) |
| LGA | Local Government Area |
| MPH | Masters in Public Health |
| MSS | Midwives Service Scheme |
| NPHCDA | National Primary Health Care Development Agency |
| NSHDP | National Strategic Health Development Plan |
| NYSC | National Youth Service Corp |
| PHC | Primary Health Care |
| PHCC(s) | Primary Health Care Clinic(s) |
| PMTCT | Prevention of Mother to Child Transmission |
| PNC | Postnatal Care |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendant |

UNICEF
WHO

United Nations International Children's Emergency Fund
World Health Organization



CHAPTER ONE: INTRODUCTION AND STUDY BACKGROUND

1.1 Introduction

The primary health care (PHC) concept is designed to be the first contact for health care needs for individuals in the community and a system that recognizes health as a complete state of being rather than just an absence of disease (Magnussen, Ehiri & Jolly, 2004). This concept also ensures that health care needs determination and is the responsibility of all stakeholders in the community and not just the government. Health care consumers surveyed during a global study uniformly agree that they expect health care provision to exceed just providing medical management but to be a holistic wellness tool (Keckley & Coughlin, 2011).

Primary health care providers are usually the gatekeepers that direct clients to appropriate treatment options where this is not readily available at the Primary Health Care Clinics (PHCCs). Referral is therefore one of the fundamental activities of PHCC health care providers, staff at the PHCCs must be able to determine what client needs can and cannot be met at the PHC level and institute the appropriate referrals in a timely manner to ensure that there is continuity of care and client's optimal health needs are met (Macdonald, 2004). The utilization of health services by the communities it is provided for is determined and affected by a variety of factors that have been described in several ways. Bernstein et al (2003) characterised these factors into three broad groups: enabling factors, predisposing factors and need determinants of care. Enabling factors refer to factors that encourage an individual to use health services such as good roads, newer technology or insurance; predisposing factors looks at natural inclination of individuals towards ill health, here culture and society expectation influence behavior and need determinants of care looks at the assessment of need for care, the individual makes a decision on where to seek care, this may be self-medication, use of chemists/patent medicine vendors or other means of receiving care (Bernstein et al, 2003).

Primary Health Care is recognized in Nigeria, as a fundamental element required in addressing the dismal health indices the country is grappling with (NSHDP, 2010). Average life expectancy in Nigeria is 54 years compared to a global average of 68 years; under five mortality rate is

143/1000 primarily due to malaria, pneumonia and diarrhea compared to a global average mortality rate of 57/1000 and maternal mortality rate is 630/100000 while the global average is 210/100000 (WHO, 2011). The Nigerian National Strategic Health Development Plan (NSHDP) for the period spanning 2010-2015 is fundamentally focused on improving the systems at the PHC level. It is anticipated that improved systems at this primary level will lead to an improvement in the health care indices of the population in several areas such as reduction of maternal and infant mortality, polio eradication and improved immunization coverage (FMOH, 2010). This is because activities at the primary care level are focused on these elements of care. If these plans are implemented, the country will benefit from this core strategic direction, but this benefit will only materialize when there is utilization of services provided at the PHC centres culminating in improved health status of the citizenry.

1.2 Health care delivery system in Nigeria

The health care system in Nigeria is the responsibility of the three tiers of government that comprises of the federal, state and local governments with each tier responsible for the coordination of tertiary, secondary and primary levels of health care delivery respectively though dependent on the immediate higher tier for financial provision and policy direction (Adeyemo, 2005). In the last few years in Nigeria, health service provision has been decentralized placing major health outcome responsibilities on the primary health care system (Gupta, Gauria & Khemani, 2003). Several fundamental health services provided in Nigeria are delivered through the primary health care system and it is therefore important that services provided at this level of care are functional, available and utilized by those for whom it is provided. The National Primary Health Care Development Agency (NPHCDA) is the national agency responsible for providing a coordinated response to the implementation of high quality and sustainable primary health care services through partnerships and development of community based systems and infrastructures. However, the actual implementation of this role is yet to be achieved especially with the deplorable state of primary health clinics nationwide probably due to poor financing of the general health care system. Health services are also provided through a variety of health care providers such as secondary, tertiary facilities and community health workers.

A total of 23, 641 health facilities are registered in Nigeria, 62% of these facilities are owned by the government while 38% are owned by faith based organizations and private individuals; about 86% of the total health facilities are primary health care providers (National Bureau of Statistics, 2009). There are 774 local government areas (LGA) and 9572 political wards in Nigeria. Each LGA (the equivalent of a district in global language) has an average population of 1-2 million people, but these are further broken down into wards and each LGA is made up of about 7-15 wards. Each ward consists of about 150,000 – 200,000 persons in population; operationally the wards are better compared to a typical district and every ward has a PHCC (Scott-Emuakpor, 2010 & WHO, undated).

Although there is a fairly good distribution of PHCCs at the local government levels, however the functionality of these facilities is non-existent in a good number of cases and it has been documented that some are poorly situated and may therefore affect accessibility of care in the affected areas (FMOH, 2010). This therefore means that availability has not directly translated to functionality or accessibility in certain wards. However because majority of health care will be delivered through the PHCCs, it can then logically be deduced that for the country to achieve its set goals for health, the primary health care services will form a key element in achieving this goal.

There is some documented studies that show the poor use of health services for maternal health services, only 45% of pregnant women use antenatal services at least four times during pregnancy and only 39% of women deliver in the presence of a skilled birth attendant (UNICEF, 2010). In the recent times, HIV centres such as the Prevention of Mother to Child Transmission (PMTCT) of HIV have been a core focus of the government in the fight for the eradication of HIV, this service has been decentralized to the PHCCs and despite this, a dismal 7% national uptake of PMTCT services was noted in a 2009 survey (NACA, 2010). Nigeria has the fourth largest TB burden in the world (USAID, 2009); TB treatment in Nigeria is delivered through the direct observation therapy short course (DOTS) centres located in primary health care facilities. Though there is 71% local government coverage for DOTS provision, low utilization of this service has been documented and attributed to the logistics of accessibility of care (HEFRON, 2006). The use of antenatal service can be directly related to maternal mortality rate and the

outcome of maternal and child health. Antenatal and immunization services are some of the core services available in primary health care facilities (National Bureau of Statistics, 2009).

1.3 Problem statement

Nigeria operates a three-tiered health care delivery system with a large percentage of health care delivery vested at the primary care level. The government has continued its efforts to decentralize health care services to the PHCCs to ensure that health services are located closer to the people and are also more affordable. This is expected to eventually lead to the improvement of a wide range of health indices that affect the quantity and quality of lives of the citizens. There has however been low utilization of health services at these points of services defeating the fundamental aim of decentralization; evidence of low utilization has been demonstrated by some studies in other parts of the country as in the case of Adeyemo, 2005; Katung, 2001 and Kabiru, 2005. This study therefore seeks to explore the factors that may be responsible for poor utilization of primary health service in Nasarawa State.

1.4 Purpose and significance of study

This study was undertaken mainly to understand the underlying factors that contribute to the utilization of primary health care services. The study will review these factors from the perspective of various stakeholders such as clinic attendees, non-clinic attendees and the service providers.

Information obtained from this study will help the local government responsible for service delivery at these facilities target their education and community messages to address the fundamental elements that act as barriers to utilization of health services. It will also help the service providers at the facility level to develop strategies and action plans that will encourage improved utilization of provided services. These activities will help initiate the process of improving access to health care services thereby improving the overall health outcome for every individual in the state eventually.

1.5 Research aims and objectives

The study aim is:

To explore and describe factors that influence the utilization of primary health care services in two communities in Nasarawa State, Nigeria, as well as the challenges, experiences and perceptions which shape these communities reluctance to use primary health care services

The study objectives are to:

- Investigate the users' experiences and the perception of the of primary health care services in these communities
- Explore and describe factors at the health facility level that may be affecting service utilization
- Explore and describe factors at the household level that limit utilization of primary health care services in this community
- Explore and describe other challenges and experiences that result in the reluctance to use primary health care services



CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction of chapter content

This chapter will review the key concepts related to this study, discuss studies related to primary health care and its importance, determinants of health, service utilization and problems affecting the utilization of health services at the primary health care clinics. It will review the various factors that can act as barriers to utilization of health services.

2.2 Overview of key concepts

2.2.1 Primary health care

The concept of Primary Health Care was greatly publicized after the 1978 meeting of the International Conference of Primary Health in Alma Ata where a joint decision was reached that urged all governments and the world communities in general to take responsibility for the promotion of the health of its people (WHO, 1978). The declaration reaffirmed the concept of health of an individual as that of complete wellbeing and not just an absence of disease, it also recognized the gross inequality in health when comparing the developed and developing countries and the right of individuals to be fully be involved in the process of planning and implementation of health care policies.

Primary health care system is designed as the first level of contact for individuals in the community and constitutes the first element in a continuing health care system based on practical, scientifically proven, socially acceptable methods and technology, made accessible to all families in the community at a cost that is affordable to the community and the country (WHO, 1978). In developing countries, primary health care system was seen as the avenue to achieve optimal health care for its population (Chatora & Tumusime, 2004).

2.2.2 Service utilization and health seeking behaviors

Utilization in the context of service delivery is the use of health services by the individuals the service is provided for (Manzoor, Hashmi & Mukhtar, 2009). Avan & Fatimi (2002 as cited by Manzoor et al, 2009) observes that utilization of health services is usually a consequence of the

health seeking behaviors of individuals in a community and these behaviors are affected by several determinants that could be physical, political, socio economic and socio cultural.

The pre requisite for bringing about change in human behavior and improving health practices is the understanding of human behavior which consist of attitudes, norms and other variables and only when this is understood can health care be provided in a manner that is acceptable to those for whom it is provided (Hausmann- Muela, Ribera & Nyamongo, 2003). Individuals may be motivated to seek care because of certain enablers, or demotivated due to some barriers or act/ utilize health service based on societal expectations or norm (MacKian, 2003). The health system utilization focuses on the act of seeking health care while the illness response process looks generally at the enablers or barriers to seeking health care. *“Health seeking behavior is not just a one off isolated event. It is part and parcel of a person’s, a family’s or a community’s identity, which is a result of an evolving mix of social, personal, cultural and experiential factors”* (MacKian, 2003).

2.3 Challenges with implementation of the PHC concept

Following the 1978 conference, most developing countries in the late 1970s and early 1980s were hit with severe economic crisis that resulted in several structural adjustments programmes thereby cutting government expenditure and consequently affecting the process of implementation of the primary health care system (Gilliam, 2008). In Nigeria, health facilities could not be built, drugs were hardly available and general expenditure for health care was cut down drastically to align with the requirement of these programmes that advocated drastic cuts in government spending (Brunelli, 2007).

The other challenges noted with the implementation of the primary health care system include:

- a) Lack of clarity of concept: The definition proffered during the Alma Ata conference has notable ambiguities; the conference describes primary health care service both as a level of care as well as a holistic care system involving health policy formulation and holistic service provision (WHO, 2003). There is a seeming confusion with the interchange of primary care with primary health care; certain quarters have continued to implement PHC mainly as a primary/first level of care whereas the Alma Ata declaration is focused on an

integrated approach to create a total package of care (Bhatia & Rifkin, 2010). Macdonald (2004; citing Tejada de Rivero, 2003) notes that a review Alma Ata description of primary health care in totality focuses on delivery of holistic health care, it was neither an isolated part of the health care system nor a system targeted at the poor only. The definition also includes primary medical care through the available cadre of staff, which could be doctors, nurses or community health workers and the use of referral systems and should not be seen only as a system that provides only curative services (Macdonald, 2004).

- b) Selective PHC delivery and donor priority: The selective primary health concept perpetuated by Julia Walsh and Kenneth Warren basically aims to select specific disease intervention and focus mainly on improving the health indices associated with that particular disease, this seemed like a viable option at the time to tackle diseases within the ambits of dwindling resources (Cueto, 2004). Following the introduction of the selective primary health concept, the first intervention was targeted only at women aged 15- 49 years and children not more than 5 years and consisted only of growth monitoring, oral rehydration, breastfeeding and immunization (GOBI), family planning, food supplementation and female education (GOBI-FFF) were later included (Magnussen, Ehiri & Jolly, 2004). International donors have embraced this selective programming probably because it is easier to measure results, however this has further eroded the PHC concept because little or no community or even the host government participation is involved in arriving at what should or should not be funded (Strasser, 2003).

2.4 Factors affecting health service utilization

Health service utilization is affected positively or negatively by a variety of factors categorized in a wide range of ways.

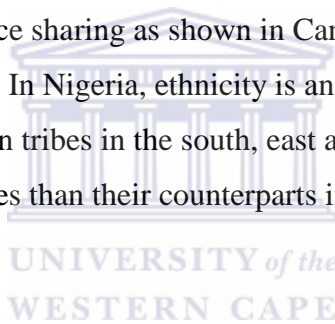
2.4.1. Socio-cultural factors that affect health service utilization

Culture is generally defined as the way of life of a group of people; it is usually an accepted code of behavior for the group of individuals or communities. This way of living or belief will affect the individual's attitude to health care or also will directly affect other factors directly or

remotely related to seeking care.

In most developing countries especially in the rural areas, women are given very limited decision making roles and this affects the act of seeking care. Pakistan is one of the many countries where women are accorded a low status in some communities and therefore women do not have access to family finances, cannot visit the health facility alone and are unable to make decisions regarding the need to seek care for any ill health (Shaikh & Hatcher, 2004). Cultural beliefs such as reduced exposure to medical care in early pregnancy; ingestion of herbs and use of traditional birth attendants were seen as means of protecting and preserving the unborn child in a community in South Africa (Ngomane & Mulaudzi, 2010).

Shared culture and language facilitate information sharing and influence service utilization within communities, sharing same language even in a multi ethnic setting usually will affect utilization through shared experience sharing as shown in Canada while studying some of the immigrant population (Deri, 2005). In Nigeria, ethnicity is an important determinant of utilization of health services; certain tribes in the south, east and middle belt region are more likely to use maternal health services than their counterparts in the northern parts of the country (Babalola & Fatusi, 2009).



2.4.2. Socioeconomic determinants of health service utilization

Affordability is a very important determinant of health service utilization and in this respect, the presence of user fees have been mentioned in several literature sources as a de-motivating factor in health service utilization. A comprehensive review of 25 published studies showed that removing user fees will cause an increase in the service utilization although the reverse may not necessarily be the case; the review observed that an increase in the user fees did not show a decline in service utilization (Lagarde & Palmer, 2008). Health expenditure determines the willingness of a person to seek care, this is evident in many developing countries such as Pakistan where at least 76% of health care expenses are out of pocket for the affected individual (Shaikh & Hatcher, 2004). In Tshwane, South Africa where primary health care services are provided at no cost to the individual, health services were utilized and patients reported satisfaction with services provided (Nteta, Mokgatle-Nthabu & Oguntibeju, 2010). It has also been noted that clients are willing to pay for services if the services are perceived to be of good

quality (Habbani, Groot & Jelovac, 2006). This is in consonance with what was discovered by Lagarde & Palmer (2004) , they observed that an increase in user fees may not necessarily translate to reduced utilization.

2.4.3 Effect of accessibility of health services on service utilization

Accessibility can be viewed from different points of view such as availability of services, transport costs to obtain service or the distance or state of road to be travelled. Where there is good access, there is usually a corresponding increase in utilization. Good access to primary health facilities in Vietnam with the average distance from provider to client being 1.85km and a travel time of 20 minutes has encouraged utilization; distance was therefore not perceived as a barrier to health service utilization (Duong, Binns & Lee, 2004). In Nepal, it was observed that clients who lived greater than 2km from the primary health clinics had low utilization of health facilities and will seek maternal health services such as deliveries at home (Yadav, 2010).

Availability will usually lead to high utilization as seen in rural villages of Pakistan, because of the availability of different health centres, 93% of respondents had utilized provided services (Rehman, Khan & Abbas, 2007). Long distances, lack of funds for transportation and lack of a transport system are reasons given by 68%, 54% and 77% of respondents for non-utilization of health care services in a middle belt Nigerian state, Rivers state. These same reasons were cited as the reason for non-utilization in southwestern Nigeria (Adeyemo, 2005).

2.4.4 Availability of Infrastructure and Staffing and its effect on utilization

Though distance and physical accessibility are critical to utilization of services, other barriers such as infrastructure and proper staffing are critical to encourage utilization. An effect of poor infrastructure was seen in a South African clinic where non-functioning diagnostic equipment in a clinic with high TB client load, had an X-ray machine that was described as forever broken down thereby affecting patient satisfaction with provided services (Nteta, Mokgatle-Nthabu & Oguntibeju, 2010).

Availability of staff, technical competence of available staff and the attitude of staff to clients all have an effect on utilization of health services at the primary health care level. A study in Guinea notes that technical competence of the health care personnel, interpersonal relationship between

patient and provider, availability of services and effectiveness of clinic personnel are important determinants of utilization (Haddad, Fournier, Machouf & Yatara, 1998). Communication between the patients and the provider is an important element in determining satisfaction with primary health care services provided (Anderson, Weisman, Camacho, Scholle, Henderson & Farmer, 2007). Another study in Uganda reported that poor staff attitude at the primary health care clinics; non-availability of drugs and perceived high cost of treatment are all barriers to utilization of health services at primary health facilities (Solome, Wamala, Galea, State, Peterson & Pariyo, 2009). Poor staff availability due to low staff numbers in primary health care facilities in Nigeria makes it almost impossible for facilities to operate on a 24 hour basis and women end up resorting to the use of traditional birth attendants or other providers even when they had attended antenatal clinics (Babalola & Fatusi, 2009).

2.4.5 Other factors affecting utilization of health services

The educational status of women and their partner seems to have a direct correlation to utilization of health services especially for childcare and antenatal services. In the Vietnamese study, mothers who had higher educational levels will take their children for care more readily than those with lower education (Hong, Dibley & Tuan, 2003). In rural northern Nigeria, a positive correlation between a higher level of education and utilization of primary health service was observed and same was also observed in middle belt region of Nigeria where mothers or husbands who had a primary school education will utilize antenatal services than those who had a lower level of education or no education at all (Kabiru, Iliyasu, Abubakar & Sani, 2005; Awusi, Anyanwu & Okeleke, 2009).

Home deliveries may be encouraged due to the belief, perceptions and culture of certain communities. While analyzing maternal and child services in primary health care centres in rural Vietnam; Duong, Binns & Lee (2004) observed there was an increased tendency for persons living with extended family members to have higher rate of home delivery, although these women would usually attend antenatal clinics and even bring back their children for immunization but would prefer to deliver at home.

Other factors that affect health service utilization include knowledge of the illness, disregard for illness or an unwillingness to disclose the illness, lack of time to seek for health service, caste discrimination, and gender of health service provider, onset of labor at night, non-availability of hospital staff at facilities and surprisingly, a previously uneventful delivery are all determinants of health service utilization (World Bank, 2001; Moore, Alex-Hart & George 2011).

The literature review has revealed that there are a limited number of studies in Nigeria especially northern Nigeria on the subject of utilization at the PHC level. Even fewer studies are available in the last five years; available studies have also mainly used quantitative methodology. This study expects to close the gap with respect to focusing on northern Nigeria, the poorer region of the country with worse health indices when compared to the rest of the country and also will use an exploratory qualitative methodology. Some of the identified issues will be explored for further clarification or hopefully new knowledge is gained that can help improve primary health service delivery.



CHAPTER 3: STUDY METHODOLOGY

3.1 Research design

This is a descriptive study that was done using the qualitative research methodology to explore and describe the factors that affect service utilization in primary health care facilities. Qualitative research methodology helps researchers understand population specific dynamics and effectively obtain culturally specific information (FHI, 2005). This study used qualitative methodology because the researcher wanted to identify and explore health service utilization peculiarities that are specific to this local area, it was also important that there was an avenue to probe and identify culturally sensitive information that ordinarily may not have been captured with other methods of study. The use of qualitative research methodology is more appropriate for exploratory studies like this study, because this study method makes room for flexibility and in depth questioning of the reasoning and experiences of the users and providers of health care services. This allowed for deep evaluation of possible perceptions that individuals may have about their experiences and possible barriers to service utilization enabling the researcher to retrieve a wide range of information from various categories of persons in a freely communicative environment. The researcher was able to probe deeper as the need arose and clarified any ambiguities instead of being restricted to a set of values, as would have been the scenario if quantitative methodology alone were used. Data collection using individual interviews, document analysis and focus group discussions produced findings related to individual ideas, concepts and differences and this was done in a natural convenient atmosphere where hopefully the real areas of concern were raised (Pope & May, 1995).

3.2 Study setting

Nasarawa state is in the north central region of Nigeria and has a population of 1,863,275 people (according to the 2006 census) and 13 Local Government Areas (National Bureau of Statistics, 2009). Majority of the population engage in agriculture and are resident in the rural areas. The state health indices are among the lowest in the country; HIV prevalence rate is 10%, the second highest in the country whose overall prevalence rate is 4.7% and the state government estimates that maternal mortality is about 1 per 100 live births (National Bureau of Statistics, 2009).

The study was carried out in Lafia local government area; Lafia has a population of about 330,217 based on the 2006 census (National Bureau of Statistics, 2009). Two primary health care clinics situated in the 2 rural communities of Obi and Nasarawa Egon were the study sites.

Below is a brief description of the study sites:

Facility 1:

Average Clients per Day: 10 – 15 (but 35 – 40 on antenatal and immunization days).

No. of Staff : 28 (comprising 4 Community Health Extension Workers(CHEW), 3 Junior Community Health Extension Workers(JCHEW), 1 Laboratory Technician, 2 Laboratory Assistants, 1 Record Officer, 15 Health Attendants and 2 Security Guards).

Rural or Urban: Urban-Rural (about 60% urban and 40% rural).

Main Activities/Services: Immunization, Baby Welfare Clinic, Malaria, Family Planning, ANC/PNC, STIs/HIV/AIDS, Delivery & New Born, HCT, PMTCT, Health Education, Traditional Birth Attendant (TBA) supervision and other general primary health care services.

Notes: This facility is located a few minutes away from the city highway and in close proximity to the a fully functional secondary care facility giving the community members in the catchment area access to other care services easily. It should also be noted that there is no doctor or midwife in this facility although aesthetically it has been recently renovated. This same community also has another PHCC which has also been recently renovated with better staff compliment; this other PHCC is not part of this study.

Facility 2:

Average Clients per Day: 10 – 15 (more on antenatal and immunization days).

No. of Staff: 20 (comprising 1 Doctor (NYSC), 1 Nurse/Midwife, 1 Community Health Officer, 4 CHEW, 2 JCHEW, 1 Lab. Technologist (NYSC), 1 Lab. Assistant, 1 Record Officer, 7 Health Attendants and 1 Security Guard).

Urban or Rural: Rural

Main Activities/Services: OVC, Immunization, Baby Welfare Clinic, Malaria, Family Planning, ANC/PNC, STIs/HIV/AIDS, Delivery & New Born, HCT, Adolescent and Reproductive Health, PMTCT, Health Education, TBA supervision and other general primary health care services.

Notes: This facility is located in the core of the community and has better staffing when

compared with Facility 1, there is a doctor and a midwife available, and there are no readily accessible PHCCs or secondary facilities in this rural community. This clinic has not been renovated.

3.3 Study population

The study population includes a selection of facility staff and facility users that had used the clinic within the last 6 months and non-facility users from each community. 10 facility staff, 30 facility users and 20 non facility-users participated in the study.

3.4 Sampling

PHC Users: The sample was made up of people who lived in the target communities and are aware of available health service at these facilities. This was to ensure that information gathering was rich through obtaining data from the segment of the population that is most affected (Rice & Ezzy, 1999). The persons who attended the clinics on the days scheduled for the interviews and focus group discussions constituted the sample frame. Every second person who came to receive care in the clinic was approached and asked if they would be interested to be part of the study participants and those that agreed were selected for the FGD while every third person that came for services that day was selected for interviews. None of the facility users approached declined. Our initial plan was to select clients from the clinic registers but this was difficult as we failed to get hold of them, as most had no mobile phone details. In each clinic, 5 facility users were selected for individual interviews and 10 selected for focus group discussions.

Non-PHC Users: Snowballing was used to select ten non-users of PHC services from the catchment area of each community. Snowballing was used because maps for these areas are not available to help map out houses and the researcher also has limited time to conduct the research because of the distance of the study location from her residence. Snowballing also helped ensure that individuals selected by study participants lived within same vicinity as those using the facility and yet chose not to use the facility. Only individuals who consented to participate in the study were interviewed after signing a consent form and participants were interviewed in their

homes.

Staff: Ten clinic staff made up of community health extension workers and a nurse participated in the focus group discussions, the officer in charge of the facility made the selected based on availability selected participants in order to ensure normal clinic activities are not adversely disrupted. Only the staff members willingly to participate were involved in the discussions.

3.5 Data collection

Data was collected through focus group discussions and individual interviews that were conducted using the English and Hausa languages (through an interpreter that translated from English to Hausa for both the participants and the researcher when this was necessary). All focus group discussions were conducted in English and interpreted simultaneously in Hausa while individual interviews were conducted in English and a few of the interviews conducted in Hausa.

Focus Group Discussions

Focus group discussions (FGD) were used to allow multiple issues such as culture, belief, health facility and household issues to be explored and discussed broadly with a large number of people at the same time. The researcher, an assistant and an interpreter moderated the discussions. Four focus group discussions were carried out in the two facilities, for the staff and for PHC users. Participants were recruited by selecting every second client that came for hospital visit, each participant was given the option to opt out but all the selected participants had no objection. Five members of staff were also randomly selected by the officer in charge at each clinic to join the staff FGD and they were also given an option to opt out but none did. Participants were also offered refreshments and the environment was made as comfortable as possible.

Interviews

Individual interviews were conducted at clinics in a confidential and relaxed environment for facility users who had given their consent. Recruiting every third client that came into the clinic on that day, five patients were selected per facility and interviewed on the interview day. Interviews for non-facility users within the community were also done at their homes and clinics by the researcher and her assistants depending on personal preference and these category of

persons were selected through snowballing, a total of five persons per community Open-ended questions were used for maximum exploratory benefits and informed consent was sought from all participants and there were no withdrawals. Participants were led through the question guide and an interpreter was used for participants that preferred to be interviewed in Hausa. Leading answers were followed to logical conclusions.

3.6 Data analysis

Analysis of qualitative research involves reviewing, synthesizing and interpreting data in order to describe and explain a phenomenon (Fossey, Harvey, McDermott & Davidson, 2002). Collected data was analyzed using the thematic analysis method. The data analysis involved the breakdown of data to allow classification, creation of concepts and making connections between the concepts, and classifications provided the basis for fresh descriptions (Dey, 2005). The main stages of thematic analysis included reading, re reading, development of themes/patterns, coding of data, analysis/illustration of themes and relationship and finally summarizing themes (Neill, 2011).

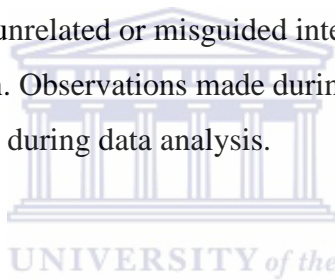
Data coding was inductive at the beginning to get a variety of options from the participants perceptive and the deductive approach was used later to narrow the scope and ensure research question was in the forefront.

Tape-recorded interviews were listened to several times and transcribed verbatim and detailed description of observations and notes written out to reflect the interview/ discussion settings. Observational notes were juxtaposed to corresponding sentences on the transcripts. To ensure familiarization with data, transcripts were read several times and compared with research notes intermittently. Repetitive words and phrases were noted and coded; these codes were grouped into similar categories bearing in mind the other factors that were noted in the researcher's notes that may have affected the responses. Words/ sentences/quotes were sorted by similarities and similar coded data grouped into categories that reflect the similarity of information and finally grouped into themes and non-thematic items also identified. Themes and patterns were identified through recognition of repetitive words, phrases or illustrations.

3.7 Rigour

Three data collection methods were used; these include observation, FGD and individual In-depth interviews. Research assistants are colleagues of the researchers and both already hold a masters degree, they were properly briefed on the research objectives and documentation of observations noticed during interviews and FGDs. Detailed documentation of the data collection and analysis process was maintained to ensure there is an audit trail. Reflexivity was not overlooked because the researcher was continually conscious of being part of the research and also aware that pre conceptions may affect data analysis and this awareness led to a more objective interpretation of collected data. The researcher had an interpreter of native Hausa language to help ensure that translations for non-English speaking participants are close to accurate as possible and tape-recorded discussions were further re interpreted by another person who was not part of the research process to ensure accuracy.

The discussions and interviews were tape recorded to ensure availability of the full transcript for audit purposes and also to prevent unrelated or misguided interpretation; research notes were also maintained for each discussion. Observations made during discussions and interviews were maintained in diary for comparison during data analysis.



3.8 Ethical consideration

Participation in this research (either in FGD or Key informant interviews) was voluntary. Participants were fully briefed at the onset of the research explaining in great detail about the research objectives and they were also given the participant's information sheet. An informed consent form was provided and explained to all participants before they signed. The FGD participants were asked to sign a confidentiality form. Confidentiality of information was guaranteed for all research participants through ensuring that individuals will be referred to as coded numbers instead of their names and also safely filing and locking up all research materials. Facilities were also coded as Facility 1 and Facility 2. Participants were encouraged to withdraw if they did not want to be part of the study and were constantly aware that they could withdraw at any time.

The study is not expected to cause any harm to the participants or community in general, and this was achieved through confidentiality and ensuring that participant was comfortable at every given time during the research process. Ethical clearance for this study was sought from

Nasarawa State Ministry of Health and the University of Western Cape. Individual written consent (Appendix 2) was sought from each respondent. All data was stored in a lockable cupboard with the researcher having sole custody of the key and the computer with electronic data was password protected.

The research findings will be shared with the facility owner that is the Nasarawa State Ministry of Health and the facility staff.

3.9 Limitation of study

Findings cannot be generalized because the study was limited to two PHCs in Nasarawa State and also the limited number of participants makes the need not to generalize even more pertinent. Use of FGDs was a double-edged sword because though it was advantageous as a member check, it may have limited a more honest expression of views. It is hoped that the interviews helped mitigate this limitation. Recruitment of staff by officer in charge instead of by the researcher at the facilities was also a limitation. The tight schedule of the researcher being a full time employee and also an MPH student as well as conducting most of the interviews and analysis may be a limitation because this all had to be done within a limited time frame. This is also the researcher's first study. The research also involved using an interpreter for some part of the study and this may have limited the depth of information recovered from participants.

CHAPTER 4: FINDINGS

4.1 Findings

In this section two major themes derived from the data are discussed. The first theme describes perception and experiences of facility users of health services at these facilities. It highlights the way the patients are treated at the facility and their understanding of the significance of care provided. The second major theme focused on the barriers to utilization which were mainly due to institutional deficiencies such as the lack of basic infrastructure, high treatment costs and poor staffing were identified as barriers to utilization while provision of free drugs was an enabler of utilization.

4.1.1 PERCEPTIONS AND EXPERIENCES OF FACILITY USERS

The two facilities provide a similar range of services targeted mainly at maternal and child health care such as antenatal care, delivery services, immunization, supervision of traditional birth attendants in the communities and malaria treatment. The way users of services perceive provided services determine if they will continue to use these services. Experiences of users will also determine if they will refer other members of the community to use the services.

Users described experiences where they felt that the health facility met their need such as when they were sick. There were however dissatisfied with certain aspects of care that they received at the facilities. There was also the absence of a holistic care system as is expected from a PHC rather there is a major focus on the curative element of care. The users from both facilities seem to have limited options and therefore have to use these facilities mainly because of the low cost of service provided when compared to their income; they are comparatively cheaper than the private sector in the cities. Selective programming for donor-funded centres is evident, as equipment provided is not freely used for documenting/monitoring diseases in the clinics. There was a general satisfaction with staff attitude to their work but there was a need to improve the overall cleanliness of the facilities.

4.1.1.1. User's satisfaction with services provided

In Facility 2, a greater majority of participants expressed satisfaction with services provided; this was targeted mainly at the attitude of health care workers. Users seem to enjoy their experience/visit to the health facilities and believed that they would receive the necessary treatment at the facilities. Relative satisfaction was attributed to the prolonged use of the same facilities through several generations though an accompanying reason for this will be the non-availability of alternate facilities that provide same service at same cost; they do not have access to any other facility they could compare with. Users described experiences where they had decided to seek care at alternative health providers specifically patent medicine vendors (chemists) and did not get cured as compared to when they used the clinic to treat their conditions. The clinic was generally said to be efficient in the provision of care, services such as immunization, malaria and HIV testing and treatment were provided at no cost to the users.

"This clinic has really helped us and has done wonderful things for me and my family"(Facility 2, FGD for patients)

This finding is different from what is available in most literature on utilization.

4.1.1.2 Utilization of maternal services

Pregnant women who are a majority of the clients for both facilities believed that the health care workers were doing their best to provide available services; they however had mixed feelings because their satisfaction with the staff was counteracted by the several inefficiencies of the health care system that resulted in unsatisfactory and frustrating experiences while seeking care. Users were asked to provide water when coming for delivery and this therefore resulted in families and even pregnant women who may be in labor going through the added stress of bringing gallons of water to the health facility and in a community where water is a scarce commodity, the cost of providing this additional request by the health facility increases the cost of care. This is also a risk to the woman who may have to carry this water by herself when she doesn't have anyone to assist her thereby risking her health and safety.

"...that is they either bring water or their husband goes and buy water"(Facility 1, FGD for staff)

As seen in the service utilization table below, women attend ANC frequently in both facilities but there is a decline in utilization for delivery services due to several systemic inefficiencies discussed subsequently.

4.1.1.3 Physical state of health care facilities

Facility 1 had recently undergone some renovations and upgrade and users were delighted with the improved conditions in the clinic specifically with regards to aesthetics such as painted surroundings and provision of furniture. This was an improvement compared to the previous state of the facility when no chairs were available for facility users. Facility 2 users were on the other side not happy with the physical condition of the facility and emphasized the need to keep the clinic environment. They also asked for provision of better furniture, free drugs, renovation of facility, provision of laboratory and delivery equipment to enable the staff perform much better than they are currently doing.



4.1.1.4. Implementation of the PHC concept of care

The PHC concept is an inclusive care approach that expects community and inter-sectoral participation in determining the health needs of the community. This aspect was visibly absent in these facilities, even though the staff of both PHCs is constituted mainly of community health workers, their involvement in the community is very limited. Community involvement of CHW seems to be limited to building alliances with traditional birth attendants and patient care. There are also no known fora for engaging community gatekeepers in decision-making regarding the health needs of the communities.

The Alma Ata declaration identified eight basic elements of PHC implementation (WHO, 1978). These include:

- Adequate supply of safe water and basic sanitation
- Promotion of food supply and proper nutrition
- Maternal and child health care including family planning
- Immunization against major infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

Source: Alma Ata Declaration document (WHO, 1978)

During data collection, we also observed that at the two PHCs, there was a lack of provision of certain elements notably the lack of adequate supply of water and basic sanitation promotion of food supply and nutrition and provision of essential drugs. Water was scarcely available and the status of cleanliness of the facilities was within acceptable standards. Dustbins are filled up and not emptied on time while there is litter in most of the clinic surrounding; this was especially the case in Facility 2. The promotion of food supply and proper nutrition was reportedly nonexistent as there was no provision in the administration of the PHC to incorporate this into their programming. The facilities are beneficiaries of the essential drug scheme of the government, but our participants said the supply chain has been erratic and drug availability is not predictable. International donors however provide certain drugs at no cost to the clinics such as drugs required to treat malaria and HIV infection.

4.1.1.5. Selective versus comprehensive approach

The selective PHC programming approach gained popularity almost immediately following the Alma Ata declaration and is built on the foundation of specific disease or intervention while paying little or no attention to other health issues. The narratives of our participants shows that the two PHCs, seems to be focusing on HIV/AIDS centres and the maternal and childcare, this is in the area of subsidizing of services.. Prioritization of centres was said to be donor driven because donor supported services in both PHCCs received free laboratory tests and drugs and this was not the case for other diseases. The clinics are not male friendly and there are barely any men who come to seek care. Donors provide funding for these facilities for specific diseases such as malaria and HIV and therefore there are different standards of care in the clinics for the same individual who presents with multiple illnesses. Treatment for malaria was provided at no cost to the client but all the participants said they paid for hypertension or diabetes services. Some of

the patients especially the ones from Facility 2 (located in the rural area with low income earners) said they were not able to pay for some prescribed drugs, and this further jeopardizes their health.

“Government should please help us with drugs; more free drugs will help us. We don’t have money”. (Facility 2, Interview participant)

This same paradox applies for maternal and child health where there is provision for free HIV drugs, but the women said they pay for laboratory tests. Again some of the participants expressed frustration that when children are born they have access to free immunization but on the other hand there were no centres set up to help those who did not have food in their homes, nor to monitor child nutrition or reduce the cost of treating childhood diseases. The health care providers said the provision of a comprehensive PHC was difficult to achieve in their context. It seems the government is unable to fund a comprehensive PHC approach because there is a lot of dependency on donor funding which will be spent in a streamlined/vertical manner and thereby preventing the government from integrating PHC strategy across all services provided at the PHCs. There was high utilization of donor-funded services such as TB, HIV/AIDS, malaria and immunization is free.

4.1.1.6 Utilization of health services

Table 1: Service utilization pattern

Data source: Clinic registers

| Service area | Facility 1 | | Facility 2 | |
|---|------------|------------|------------|------------|
| | 2011 | 2012 | 2011 | 2012 |
| Total number of clinic attendance | 4540(378*) | 4613(384*) | 2373(198*) | 2361(215*) |
| Total number of immunizations | 1708(142*) | 1201(100*) | 2292(208*) | 5187(472*) |
| Total number of malaria treatment given | 1168(97*) | 1318(110*) | 2157(180*) | 2121(193*) |
| Total number of HIV tests done | 2030(169*) | 996(85*) | 321(27*) | 335(30*) |
| Total number of ANC attendance | 385(35*) | 306(26*) | 283 (25*) | 301(30*) |
| Total number of deliveries | 59(4.9*) | 60(5*) | 53(4*) | 62(7*) |

| | | |
|---|-------|-------|
| Approximate number of population served | 32801 | 17996 |
|---|-------|-------|

** : refers to monthly averages, averages for 2012 were divided by 11 since reports were as at 30th November 2012.*

Both facilities cater to about 13% of their target population. Service utilization has remained fairly same for most service areas in Facility 1 but with a notable decline in two services, HIV testing and immunization which recorded a decline of 50% and 30% respectively. In Facility 2 there was generally an increase in utilization for most service areas, most obvious of this is in immunization where an increase of greater than 100% was recorded and general clinic attendance increased marginally by 10%. Numbers of deliveries in Facility1 remain fairly constant although Facility 2 has an average increase of about 40%. Generally, there is a very low number of hospital deliveries.

Several reasons were attributed for the disparities in utilization; Facility 1 blamed the constant stock out of HIV test kits this year on the low utilization of this service at the PHC. The staff also explained that another PHC in the ward was renovated this year and that this newly renovated facility also has a better complement of staffing than they do so most people within their catchment area have been utilizing that facility. It should be recalled that Facility 1 though also renovated has issues with staffing. Although there were no significant increase for HIV testing utilization in Facility 2, the staff however attribute the slight increase to community activities focused on mobilization which increased the awareness of community members, however, they also laid credence to the fact that many times patients did not receive HIV testing because of constant stock out. Facility 2 also attributed the high immunization service utilization to the increased immunization drive by the National immunization Programme and also the provision of newer vaccines not previously available such as yellow fever, hepatitis B vaccine and tetanus. Utilization of malaria services showed a slight increase for both facilities and this was attributed to the consistently available drugs from the Malaria Control Centre accompanied with community awareness campaigns. The increase or seeming satisfaction with utilization was echoed thus by a staff:

“Utilization of this facility to me is very effective because especially the mothers, they turn up in great numbers to bring their children for routine immunization and even you, can see that as I am here now, the mothers still come in for their own family planning and more so, they come for minor treatment and diagnosis of their minor conditions through the laboratory. They receive antimalarial and reproductive health care in this health facility”

For maternal health services, specifically delivery, the health care providers said only 20% of the women who attended antenatal clinic delivered in the hospitals; the majority of them deliver at home or in the communities with the help of traditional birth attendants. This is worse than the reported percentage of 39% described by the national statistics although the national statistics is inclusive of women who are delivered by a skilled birth attendant regardless of location (UNICEF, 2010).

4.1.2 INSTITUTIONAL FACTORS AFFECTING SERVICE UTILIZATION

A good number of the factors that constituted a barrier to accessing care at these facilities are institutional factors. These factors are dependent on the respective health facility and based on responses slight improvements in these deficient areas will result in improved utilization of services at these clinics. These factors include inappropriately staffed clinics, poor infrastructural provisions and lack of equipment and drugs in the facilities.

4.1.2.1 Lack of basic infrastructure

The unavailability of basic infrastructure such as water and electricity was echoed in the two facilities and participants noted that this was a major hindrance to the proper functioning of the clinic. The absence of water especially seems to be so severe that mothers who come for delivery at the facility are asked to bring water as part of the requirements for delivery. This was an added cost for the families who are finding it hard already trying to make ends meet and an extra burden to the women. The ability of the women to provide water during the delivery period determines if the delivery will be carried out or not, however all the women interviewed said they were able to provide the needed water by buying from the water vendors in the community. The staff were also very worried about the water situation as this was affecting the quality of

care delivered at the facilities. The staff noted that the absence of water affected their ability to sterilize their equipment, wash hands in between patients or even provide water for use in the toilets by the patients. The hospital buys water and stores in storage tanks frequently but this is usually not enough to meet the needs of the hospital. This lack of safe water generally affects the quality of services provided at the clinics and also their ability to maintain standard cleanliness requirements. The staff noted that the water crisis is not as severe during the rainy season because at this time rain is usually collected for use and this also a cause for worry because of the degree of sterility of collected water. This lack of water in the facilities is not specific to the facility but a general problem being faced by most of the communities in the local government area.

“Our greatest problem in this health facility is water and we say water is life. You can see women when they arrive during the dry season for delivery; water is listed as part of what they have to bring along for delivery” (Facility 1, Staff FGD).

The problem of this local government area is water. Government should please come to our aid” (Facility 2, Individual Interview).

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Another infrastructure that is lacking in these communities is electricity, this was a major complaints noted by individuals that were interviewed. Facility users of the two facilities, especially pregnant mothers are discouraged from coming to the clinic at night because they know that there may not be alternative power supply if the national grid did not supply electricity. Respondents also noted that this infrastructural deficiency was also a problem that is experienced by the entire Nasarawa State. This has affected service utilization especially at night, when deliveries occur the clinics use candles and lanterns because the generator is either broken down (in Facility 2) or not available like in Facility 1. Clients also have difficulty navigating the dark villages and would rather stay at home than go through the dark paths. They explained that this is one of the reasons why they will use a TBA in the community if labor commences at night even if they had attended antenatal services at the facility.

“Most of the time, there is no light in the clinic and even at home, most of the villages don't have

light and also the roads are not good”(Facility 2, Individual interview)

“..... the road is also not good and if the government can help us with transportation that will be good”(Facility1, Individual interview).

Bad roads are another infrastructural glitch that has affected service utilization; the roads are bad and the stress of transportation is high. Facility users have to travel on badly constructed worn out roads that are not maintained and have a lot of potholes but this was not really a concern that was expressed by the non-users of the facilities.

4.1.2.2. Non availability of basic hospital equipment

Basic work equipment such as delivery facilities like elbow length gloves, delivery beds and kits needed to carry out delivery are not available in the facilities. The health care providers complained that the absence of these equipment which are major accompaniments to the provision of maternal services, specifically during labor and delivery lead to poor quality of service delivery and the concomitant effect of poor utilization. The situation is worse in Facility 2, located in the rural area and serving more communities whereas there is a slight improvement in Facility 1 which is located in a semi-rural community next door to the LGA administrative office. Facility 2 is a much older facility built decades ago and has been poorly maintained by the local government council, no renovations are seen as is present in facility 1 and most of the equipment are worn out.

A good number of non-users of both facilities cited the absence of functioning laboratory equipment as reasons why they were not using the facilities. Laboratory equipment available are old except a few supplied by the donors and these are mostly restricted to be used for donor financed services. These facilities cater to 40 – 80 women monthly for antenatal services, however only one delivery bed is available for use in both centres. One member of staff expressed her frustration with the situation thus:

“We don't have a delivery bed, we are only using a bed donated by ECWA for MDG (another centre) so we have converted the bed for the two objectives MDG and delivery and also the delivery kits are worn out because it was supplied a long time ago and has not been

renewed” (Facility 2, Staff FGD).

The case is slightly different in Facility 1 where participants seem excited about the renovations and improvement in furniture at the clinic. One of the respondents while trying to explain why he thinks patronage to the facility has improved said that previously the clinic had no chairs and now chairs were no available at the clinic. He put it simply this way,

“There were no chairs, now we have chairs”.

Other respondents also confirmed the improved infrastructure in the areas of renovations, paintings of the clinic, more staff employed and cleaner clinic environment. This facility is located next to the local government administrative office and received infrastructural upgrade because the LGA chose the facility as one of those to benefit most likely for political reasons.

4.1.2.3 Staffing challenges

The non-availability of a regular doctor seems to be a major determinant to service utilization at Facility 1, the majority of the non-facility users were unhappy about the absence of a doctor at this facility. Facility 1 is located within a walking distance from a secondary level facility that is able to provide full complement of health services with some specialization; therefore it is easy to understand why participants can demand for more. This facility is also located within areas of easy access to other care providers. In the context of provision of services at the PHC level in Nigeria, the availability of doctors is not a necessity except in comprehensive PHCs and this clinic is not one of such. The staffing challenge is quite critical as the caliber of staff predominantly available are community health workers, the national minimum ward package requires a midwife to be available at any clinic where deliveries are carried out but this is not the case here. The participants in Facility 2 did not emphasize this staffing deficit because of the better staffing structure in this facility, the clinic is provided with a doctor who is rotated yearly while on national service, therefore every year a doctor is posted to the clinic from the NYSC, the clinic also has a midwife and some CHEW. In terms of staffing Facility 2 has a good advantage over the newly renovated Facility 1. It is possible that the fact there is readily available, other health care provider choices for communities around Facility 1, the government

planning team may have neglected to address this need, nonetheless it is an important factor when determining what needs to be done to encourage utilization in this facility especially for those not currently using the facility.

“I do not come to the clinic because there is no constant doctor and that is why many people are discouraged to come for treatment in the clinic” (Facility 1, Non PHC user individual interview)

“I come to the hospital because they take good care of me but many of the people in the village don’t like coming because there is no light and water and also no doctor” (Facility1, Individual interview)

4.1.3 HOUSEHOLD FACTORS AFFECTING SERVICE UTILIZATION

4.1.3.1 Affordability of services”

Non facility users in Facility 1 cited affordability as one of the reasons for not using the clinics, services that were not related to malaria and HIV were said to be expensive and the use of chemists located in the rural communities seemed to be a faster and less expensive option for these respondents. This is a community where majority of residents are not as economically challenged as Facility 2 where they are mainly peasant farmers, further probing however revealed that they could not compare the fees which are being charged with the kind of service they would receive.

“ I don’t go there because the cost of treatment in that clinic is high and they don’t even have water and light most times(Facility 1, Non PHC user individual interview).

The user fees charged cannot be categorically described as high even for people of low socio economic class, the issue here is that these respondents are willingly and ready to spend money only when they believe that they are getting the worth of their investment. It should be remembered that this is the facility with poor staffing even though it is aesthetically reformed. In

Facility 2 community, cost was however not one of the deterrents of utilization, this may be because there are no options to compare care received. Other calls by respondents with respect to cost include:

“Government should provide more free drugs because it is not all the patients that can afford the money to treat their condition” (Facility 2, Individual Interview)

“More drugs should be supplied so that it can reduce the expenses patients have to bear when they come for treatment” (Facility 2, FGD).

4.1.3.2 Decision making power in the homes

Who makes the decision to seek care in the home is another important factor affecting utilization of services. In both communities, a good number of the clients, mainly women said they were responsible for making such decisions. However, some women said that their husband decided where and when they would seek care. When the husband was responsible for deciding, the chosen health care facility will depend on severity of illness. However, this was not considered a major deterrent to seeking care, as the decision will usually tilt towards the use of Facility 1 and Facility 2 for the regular clinic users.

4.1.4. OTHER CONTRIBUTING FACTORS TO SERVICE UTILIZATION

4.1.4.1 Role of other health care providers

Other places where community members seek for care include the use of traditional birth attendants (these are unskilled persons in the community who help mothers deliver their babies although retired health care workers may be seen fulfilling this role in some instance), patent medicine vendors and herbalists. Participants said that it is common practice to use herbs first before turning to western medicine, people will also easily walk into patent medicine stores and pick up drugs quickly with ease rather than go to the clinics and when these fail then you find these persons in the clinic.

4.1.4.2 Stigmatization

Stigmatization of persons living with HIV and the lack of acceptance of the disease as another

disease that can be treated has resulted in people attributing such illness to witchcraft thereby refusing to seek care. There is ongoing community mobilization activities that have improved utilization of these services but there is still a huge number of community members who continue to attribute this disease to witchcraft. One of the participants believe that religious institutions may be worsening the stigma by insisting that members of such institutions who wish to get married be tested because after people get tested and one person is found to be positive, the religious institution will refuse to wed these persons. This used to be commonly practiced throughout the country though this practice is gradually disappearing.

“The way we are here, when they know you have HIV, they discriminate against you so people don’t want to come and know their status” (Facility1, Individual interview)

“.....Christians (they have been doing it before) but now even Muslims now say that everyone must test before they can marry them” (Facility 2, Individual interview).

One of the respondents suggested that the integration of services and intensified community awareness will help reduce stigmatization.

4.1.4.3 Beliefs

The major beliefs in the surveyed communities that affected the use of health services at the PHCs include the belief that immunization will affect the fertility of the child in future and also that mothers who receive immunization will also have problems with future fertility plans. This affects the utilization of immunization services by some members of the communities. One of the respondents noted that women would usually give birth at home because culturally they take pride in having achieved that feat by themselves at home.

CHAPTER 5: DISCUSSION

This study explored the user experiences at the PHCs and the factors that affect utilization of health services at two primary health clinics in Lafia local government area in Nasarawa State, Nigeria. Users had a good perception of the services they received and are reasonably satisfied but certain deficiencies in the health care systems compromised the quality of service. Several factors were however hindering the utilization of these services and these include mainly institutional factors such as lack of infrastructure, equipment and staffing constraints; household factors such as cost of service and responsibility of decision-making and other factors such as stigmatization and beliefs.

5.1 Perceptions, Implementation and Utilization of PHCs

Generally, the clients have a good relationship with the staff and do not have complaints about staff attitude. There was however some conditions present at the PHC that deter the total embrace of care at these facilities and therefore affected service utilization and these will be discussed subsequently. Staff attitude has been identified as a barrier to care utilization in several literatures, poor attitude of staff was a major deterrent to use of facility but this barrier is absent in the facilities involved in this study (Adeyemo, 2005).

The NPHCDA in 2007 proposed a minimum health care package for every PHC at the ward level and it stipulated that at the ward level, PHCs should provide the following health care package (NPHCDA, 2007):

- Child Survival (Integrated Management of Childhood Illnesses and Routine Immunization)
- Safe Motherhood (ANC, Delivery, PNC, Family Planning)
- Control of communicable diseases of public health importance(Malaria, TB, HIV)
- Health Information and education
- Nutrition
- Non communicable diseases

These are similar to the components of PHC as proscribed globally, however essential

components which include availability of essential drugs are not listed as a priority for the country for this year, this is unfortunate since lack of commodities including drugs were identified in this study as a barrier.

The facilities under review had a fair representation of these priority components although the nutrition component was conspicuously absent. The control of communicable diseases, a component of child survival- immunization and safe motherhood is implemented at almost no cost to the client except the transportation cost of coming to the clinic and \$1 (N150) charge for buying the hospital card. These services are heavily subsidized by the donor agencies and the government, however other health services such as non-communicable diseases and other childhood diseases are not subsidized and patients will have to pay for those services and these range from \$10 (N1500) to about \$20 (N3000) excluding the costs of laboratory investigations. In most PHCs, it is common to find maternal and child services readily available than when compared with the other components of care (World Bank, 2010)

The absence of implementation of a comprehensive PHC approach is evident as the rehabilitative and education components of PHC are not well developed, safe water and sanitation have also not been given the needed priority. Each ward has a ward development committee which is expected to act as the vehicle for community participation in health decision making and strategy formation, these committees are not functional but efforts have been put in place in the last few months by NACA to make it functional by provision of stipends for the required meeting, these committee meetings discuss ways to improve the uptake of HIV services in the wards. This may be praised in some quarters as a welcome development as it is a good starting point to revive the system but this however propagates the selective PHC concept since the decisions made at these forums will be targeted at donor funded programmes, by donors who wants to meet their targets and not necessarily what the community needs to ensure the health of its members. Selective PHC delivery is seen in other areas of care provided by the PHCs, health care costs are almost nonexistent for certain donor funded diseases while other clients who may present with other diseases that are not currently donor focused will have to pay out of pocket expenses for these drugs. There is also various reporting requirements from several donors for the centres they support, these PHCs have about five different donor funded programmes and

each has a different set of reporting tools, there is no streamlining of data and therefore this creates a disjointed data collection system and an exhausted HCW.

Decentralization of ART services to PHCs is a new initiative of the government and this has affected these PHCs as they are expected to provide ART to pregnant women who are positive, however the necessary systems required to ensure a successful decentralization strategy have not been put in place. Although this is government initiative, government is once again dependent on the donor to provide the necessary funds that will make this a success. On review of its achievement after two years of decentralization implementation, the government noted that stigma, poor infrastructure, high staff attrition, limited technical capacity and poor logistics for health commodities are the major impediments to the success of the decentralization dream. Supply chain system is still poorly developed; Facility 1 had poor utilization of its services because of constant stock out of HIV tests and immunization vaccines. Poor staff structures to support the strategy are also evident as no midwife was available in Facility 1 to provide the quality of ANC and delivery services expected from that facility. It should however be noted that the two facilities however have a good referral system and understand that referral of cases is an important element of care at the PHC level.

The utilization of delivery services is remarkably low in both facilities and this is because clients prefer to use TBAs based in the community, this is not surprising as this is commonly seen in many studies (NBS, 2009, NACA, 2010 & Moore, Alex-Hart & George 2011). The high prevalence of TBA in these communities has led to donor agencies establishing linkages with these TBAs through the HCWs at the facilities. In these facilities, CHEWs liaise with TBAs and encourage them to send their clients for HIV testing, also TBAs are provided protective gears like elbow length gloves as part of incentives to test and positive clients are referred to the clinic for follow up and treatment. This liaison is a good initiative but also continues to stress the selective PHC implementation strategies that donor funding creating. Although this is a good initiative to test more women and thereby meet the national target from the donors, it is important that such interventions are done holistically rather than vertically and focused on one disease.

5.2 Barriers to service utilization

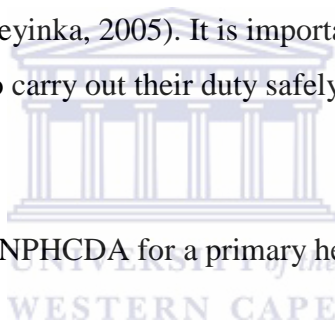
Several factors were identified as barriers to service utilization; these barriers could be classified as:

- Institutional barriers: These are somewhat dependent on the health care system and the facilities; they include lack of infrastructure, poor staffing, lack of equipment and health care commodities at the facilities.
- Household barriers: These consisted mainly of poor household income.
- Cultural/Community dependent barriers: These included the stigma associated with HIV, varied beliefs in the communities and the dependence on TBAs and herbalists.

The absence of portable water supply is a major issue in Nasarawa State and these facilities do not have an alternative source of water supply such as boreholes to mitigate the effect of this absence. This has therefore affected the utilization of these facilities and also the quality of care provided at the facilities. The state government admits to its failure to meet the water needs of its citizens despite having the conducive geological environment to do so, it further states that most local government have facilities to provide only 10% of its water needs (NASEEDS, 2005). The government recently constructed/refurbished 58 model PHCs and these were provided with a borehole and 20,000L overhead tanks. The government has not put in place any alternative sustainable system of providing water at these PHCs involved in this study and therefore this problem may not be corrected in the near future.

The lack of electricity is also another prominent infrastructural deficiency in these study facilities; this problem may be considered a nationwide problem and usually solved by the use of generators or alternative power sources. However, it seems that these facilities do not have generating sets. As previously discussed it is surprising that though the government is increasing the array of services offered at these facilities through decentralization, there is no evidence of attempts to strengthen these fundamental needs of the PHCs. There is a continued lack of taking complete control and ownership of issues at these facilities. The government of Nasarawa State in its NASEEDS document also acknowledges lack of electricity as an issue in the state but

readily dismisses it by saying it is a federal government problem and the state has no funds to deal with the issue effectively, showing clearly that no one wants to take responsible for this inaction. There is no clear-cut line of accountability. The dismal admittance of its inability to meet this basic need is regrettable and this shows the inability of the government to meet the basics required to ensure an efficient and reliable health system especially with a huge push to decentralize health services. The Nigeria Health Report 2006 identifies the lack of electricity and safe water as a norm in most developing countries including Nigeria, it also identifies that; poorly maintained facilities, lack of basic infrastructure, medical equipment and health commodities are common findings at PHCs in Nigeria (HEFRON, 2006). The general lack of delivery equipment in the facilities was also a factor that hindered utilization. The lack of basic equipment to carry out their daily duties such as delivery beds and delivery sets are synonymous with what was obtained in similar studies in Nigeria as documented (Odunbanjo, Badejo & Shokunbi, 2009; Ajala,Sanni & Adeyinka, 2005). It is important that staff working at these clinics have the appropriate tools to carry out their duty safely and effectively without harm to the client or the staff.



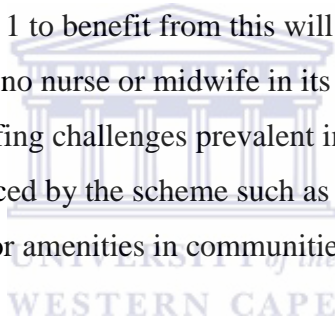
The staffing structure approved by NPHCDA for a primary health care centre is this:

- 1 CHO
- 1 Public Health nurse
- 3 CHEWs
- 6 JCHEWs
- 3 Nurses/Midwives
- 1 Medical assistant
- 1 Medical Officer OR NYSC Doctor where available

Source: Ward Minimum Health Care Package in Nigeria (NPHCDA, 2007)

Based on this set guidelines, it is evident that Facility 1 is grossly understaffed, however the guideline does not expect that there will be a medical doctor at these primary health care clinics, however when the PHC provides maternal and child services, it is expected to have a midwife, this is not the case in Facility 1. It would seem therefore that due to the access of the population to other health care providers, staffing has not been given priority although there was a

renovation of this facility. It is however a deterrent to utilization because most non-users pointed out the unavailability of doctors as reason for non-utilization. The issue may be much more than unavailability of a doctor but a fundamental lack of staff of appropriate cadre of staff at this facility. Poor staffing is a common cause of underutilization and patients also question the qualification and ability of available staff to appropriately handle their ailment (Bakeera et al, 2009). The Nigerian government recognizing the need for appropriate staffing for PHCs introduced the Midwives Services Scheme (MSS) to improve the staffing structure at these clinics. The criteria for selection of PHCs that will benefit from the MSS include availability of portable water supply, provision of 24 hour basic health services with available minimum equipment (Abimbola, Okoli, Olubajo, Abdullahi & Pate, 2012). This criteria set for a clinic to benefit has automatically disqualified the PHCs in this study and therefore further challenges the government to correct the fundamental deficiencies in the primary health care system in Nasarawa state, the lack of Facility 1 to benefit from this will further worsen the current utilization status as it currently has no nurse or midwife in its current staffing pool. The MSS is not a fool proof solution to the staffing challenges prevalent in rural PHCs as seen by the challenges currently been experienced by the scheme such as high attrition of recruited midwives because of language barriers or poor amenities in communities of service (Abimbola et al, 2012).



Affordability was documented as a major contributor to service utilization (Lagarde & Palmer, 2008; Shaikh & Hatcher, 2004; Nteta, Mokgatle-Nthabu & Oguntibeju, 2010). Health insurance is still young in Nigeria and available to a few who have a stable paying income and also is available at the secondary and tertiary facilities currently, the health bill is however expected to cater for users of PHC and reduce the cost of seeking care for these people through improving financing for health care (Nigeria Health System, undated). Although a good number of services are provided at these facilities, users still need to pay for complementary services such as laboratory investigations for typhoid, hepatitis or blood investigations and have to spend between \$10 to \$20 to treat certain diseases. Cost of transportation to seek care is also a burden for these facility users most of whom are low-income earners. It is important here to say that the effort made by government and the donors to ensure that certain services are free especially maternal and child health services is commendable and will contribute to the reduction of the current poor maternal and child mortality indices in Nigeria.

Use of TBAs are widespread in Nigerian rural communities and this practice is obvious in these facilities, only a tiny fraction of women who attend antenatal clinic actually deliver in the hospitals therefore the outreach to these care givers in the community should be encouraged on a broader scale and not just limited to testing their clients for HIV. With the knowledge now as evidenced in several studies of the fundamental role TBAs play in maternal health care in Nigeria, it is necessary that appropriate steps are taken to incorporate them into the health care system and train them appropriately, there has recently been continued efforts to ensure they receive some training to improve their current practices especially since there is staff paucity at the PHCs (Ofili & Okojie, 2005). The issue of stigma especially with respect to HIV is still a global issue and is a factor in these communities. Apart from stigmatization in the community, studies have recognized stigma by health care providers as an element that needs to be addressed (Nyblade et al, 2009).



CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

There has been a steady increase in utilization for Facility 2 which is a major health care facility for the communities it caters for where there is little choice of health care facilities especially for the low income earners, however Facility 1 has grappled with improving utilization because of variety of options that surrounds it including a newly renovated PHC which has better staff complement than it does. The issues of poor logistics for health care commodities are also another factor that affected the utilization of health care at Facility 1. However, Facility 2 showed that the availability of services would translate to utilization, as was the case with immunization although this was accompanied by community drive through increased community mobilization.

The major barriers to care are the poor state of the infrastructure specifically access to clean water and electricity, lack of medical equipment, relative high cost of services and continued dependency of traditional birth attendants to provide maternal services. Other factors cannot also be neglected such as stigmatization and cultural beliefs that discourage seeking care at the clinics.

There is a need for the government to ensure that systemic improvements accompany the drive for decentralization, this helps ensure that the implementation is anchored on a strong foundation. The quality of care provided must be a priority and all that is needed to ensure good quality care such as adequate safe water, delivery equipment, nurses/midwives and general infrastructural improvements must be addressed.

The government should ensure that their vision for the country in health is at the forefront when it comes to accepting donor funding to help address the gaping gaps in health care delivery while also identifying the challenges associated with implementing a comprehensive PHC approach.

6.2 Recommendations

State Government/ Ministry of Health:

1. The government of Nasarawa State should determine strategies that will provide safe water at all health facilities and the entire state to ensure improved health for its citizens
2. The Ministry of Health or the state government should provide alternate sources of electricity such as generators and solar panels to all PHCs within its domain. This can be requested as part of the support provided by donor agencies where the government may not have the required funds to provide these.
3. Appropriate staffing should be provided, the state ministry of health should carry out a survey of current staffing needs across all PHCs in the state and determine the gaps present and find ways to fill identified gaps.
4. Cost of services should be reconsidered and more funding should be provided for health in the budget.

Community:

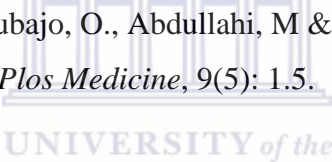
1. The community leaders should form an advocacy team/body that will strongly present these issues to the appropriate government agencies
2. Fundraising activities targeted at wealthy individual who are from these communities even if they do not reside there should be planned to raise alternate funds to improve the facilities and infrastructure.
3. A joint committee of community members, influential community leaders and the government should design a culturally sensitive awareness strategy that encourage community participation in achieving stigma reduction

Health facility:

1. Strategies should be devised that incorporates TBA holistically and thereby improve maternal health care in the state
2. PHCCs should incorporate stigma reduction messages in all their health talks
3. Staff should also be trained on stigma reduction strategies

4. Health facilities should also use their current data as an advocacy tool to encourage the government to invest more in its institutions.

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APPENDICES Appendix 1: Participant Information Sheet (English)



UNIVERSITY OF THE WESTERN CAPE School of Public Health

Private Bag X17 • **BELLVILLE** • 7535 • South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872

PARTICIPANT INFORMATION SHEET

Dear Participant,

The study hopes to identify the factors that affect the utilization of health care services that are available at your primary health care clinic. I am doing this research as part of my qualification requirement to complete my mini thesis at the University of Western Cape, South Africa.

Your participation will help us work as a team and arrive at possible conclusions on why the community may not be fully utilizing these services and also serve as a template that will help your leaders in the community and government determine ways with improve this situation.

I will be asking you questions in a group or at your house individually and will need your response to the questions and we will discuss the answers. Please note that at no time will your name appear on any of the data collection tools and therefore all information you give will be confidential.

I will also be giving a letter that shows that you accept to be part of this study and please note that anytime you feel uncomfortable with this study, you will be excused from participating and please be assured that if you decide not to participate, there will be no consequences whatsoever. There is no known harm this study will cause you as far as we know and if you know of any such harm please let me know.

My contact details are Zeluwa Maikori; phone no: +2348033458258 and email:

zelmaikori@gmail.com

And you can also contact my supervisor Dr Thubelihle Mathole; phone no: +272195929384 and email: tmathole@uwc.ac.za

Thank you



Appendix 2: Participant Information Sheet (Hausa)

UNIVERSITY OF THE WESTERN CAPE

School of Public Health



Private Bag X17 • **BELLVILLE** • 7535 • South Africa
Tel: 021- 959 2809, Fax: 021- 959 2872



PARTICIPANT INFORMATION SHEET

Saanu,

Binciken fata da suna da gargajiya al'amari daga cikin utilization da kiwon lafiya hidimomin da ake samu a makarantar firamare kiwon lafiya asibiti. Ina yin wannan bincike da rabu da qualification alkawarina da cikasa mini manufa a Jami'ar yammacin yankin cape, kudu Afirka.

Ka ki zaburarsu za ta taimaka mana aiki da 'yan wasan da kai mai yiwuwa ji tsoro a kan me ya sa a yi amfani da shi asibiti da kuma taimako shugabanninku, da kuma tabbatar da hukumar hanyoyin da kara inganta wannan hali.

Zan yi tambaya ka tambayoyin da za su bukace kuka faɗa. Za su ga ta bullo da takarda, saboda haka ba wanda zai ga ɗuriyarka.

Zan kuma ba da wasiƙar da ke nuna cewa dauka a rabu da wannan nazari, kuma ka duba, koyaushe ka ji rashin sakewa da wannan, za ku tafi, kuma Ka tabbatar da cewa, idan ka yanke shawara ta je gaba, ba su da wata matsala. Wannan abu ba zai sa ku da wata matsala, faɗa mini idan ka zaci za a da wata matsala.

Ka iya kawo mini : Zeluwa Maikori; phone no: +2348033458258 and email:
zelmaikori@gmail.com.

Ka iya kawo mai gidana da :Dr Thubelihle Mathole; phone no: +272195929384 and email:
tmathole@uwc.ac.za.

Nagode

Appendix 3: Informed Consent for interviews (English)

Date: _____ Interviewer: _____

Location of interview: _____

Explanation of Process and Purpose of Interview:

Thank you for agreeing to allow me to interview you. The study hopes to identify factors that affect the utilization of health care services that are available at your primary health care clinic. I am doing this research as part of my qualification requirement to complete my mini thesis at the University of Western Cape, South Africa. I will be asking you questions individually and will need your response to the questions and we will discuss the answers.

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. See name above. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected. The interview may touch on issues which you do not feel comfortable discussing. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

I shall keep the contents of the above research interview confidential, your name will not appear in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

If you are fine with this, kindly sign below:

Signed by interviewer:

Signed by participant:

Date:

Place:

Appendix 4: Informed Consent da magana(Hausa)

Rana: _____ Mai Tambaya: _____

Wurin Interview: _____

Bayani a sarrafa, kuna da nufi da hira:

Na gode muku da yarda da ya ganawa kai. Binciken fata da suna da gargajiya da tauri da relevant da rungumarka al'amari daga cikin utilization da kiwon lafiya hidimomin da ake samu a makarantar firamare kiwon lafiya asibiti. Ina yin wannan bincike da rabu da qualification alkawarina da cikasa mini manufa a Jami'ar yammacin yankin cape, kudu Afirka.

Zan yi tambaya ka tambayoyin da za su bukace kuka faɗa.

A kowane lokaci, zan yi bayani bobboye, Za a kira sunanka. Zan kulle wani rubuta a kowane lokaci, Zan hallaka su bayan yin amfani da su. Idan na ce kome ba rashin jin dadi. Idan akwai abin da zai fi so a yi, ka kai faɗa. Ba zan kara yin fushi da kuma babu komi, idan ba ku amsa tambaya. Za su yi farin ciki da ka gaya mini da ba na son tambayoyi.

Zan cika abin da bobboye da Sunanka ba zai bullo da takardu. Za su yi amfani da wannan abin da na bayyana, Amma a yi nazari a bayan wani hali ba tare da faɗa. Idan tafiya sake na labarta maka. Idan kana tara da wannan, alheri rattaba hannu a Kasa.

Na sa hannu interviewer:

Na sa hannu participant:

Rana:

Wurin:

Appendix 5: Informed Consent for Focus Discussion (English)

Date: _____ Interviewer: _____

Location of interview: _____

Explanation of Process and Purpose of Interview:

Thank you for agreeing to allow me to interview you. The study hopes to identify factors that affect the utilization of health care services that are available at your primary health care clinic. I am doing this research as part of my qualification requirement to complete my mini thesis at the University of Western Cape, South Africa. We will be discussing this in a group and it will be good if you participate fully.

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. See name above. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected. The discussion may touch on issues which you do not feel comfortable discussing. If there is anything that you would prefer not to discuss, please do not . I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

I shall keep the contents of the above research discussion confidential, your name will not appear in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

If you are fine with this, kindly sign below:

I have read the information about this research study on the participant information sheet, or it has been read to me. I have had an opportunity to ask questions about it, and all the question I asked, have been answered to my satisfaction.

I consent voluntarily to be participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study and I will keep everything discussed in the focus group discussion confidential.

Researcher’s SignatureConsent Date

Signed by interviewer:

Signed by participant:

Date:

Appendix 6: Informed Consent for Focus Discussion (Hausa)

Rana: _____ Mai Tambaya: _____

Wurin Interview: _____

Bayani a sarrafa, kuna da nufi da hira:

Na gode muku da yarda da ya ganawa kai. Binciken fata da suna da gargajiya da tauri da relevant da rungumarka al'amari daga cikin utilization da kiwon lafiya hidimomin da ake samu a makarantar firamare kiwon lafiya asibiti. Ina yin wannan bincike da rabu da qualification alkawarina da cikasa mini manufa a Jami'ar yammacin yankin cape, kudu Afirka. Za mu yi shawara a cikin jiki, kuma za a yi idan Kwazonku Masani ne.

A kowane lokaci, zan yi bayani bobboye, Za a kira sunanka. Zan kulle wani rubuta a kowane lokaci, Zan hallaka su bayan yin amfani da su. Idan na ce kome ba rashin jin dadi. Idan akwai abin da zai fi so a yi, ka kai faɗa. Ba zan kara yin fushi da kuma babu komi, idan ba ku amsa tambaya. Za su yi farin ciki da ka gaya mini da ba na son tambayoyi.

Zan cika abin da bobboye da Sunanka ba zai bullo da takardu. Za su yi amfani da wannan abin da na bayyana, Amma a yi nazari a bayan wani hali ba tare da faɗa. Idan tafiya sake na labarta maka. Idan kana tara da wannan, alheri rattaba hannu a Kasa.

Na sa hannu interviewer:

Na sa hannu participant:

Rana:

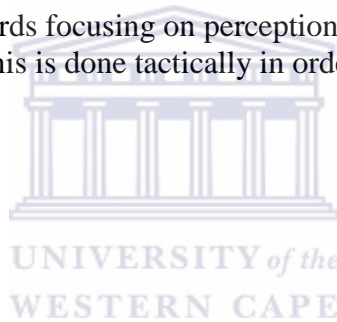
Appendix 7: Interview sheet (English)

Interview Questions for the Interview with the Patients

Greet and exchange pleasantries and make respondent as comfortable as possible

1. How long have you been using this clinic?
2. What changes have you see occur in these years in terms of staffing, infrastructural improvement and other physical changes?
3. How would you relate the changes with patient patronage of the facility?
4. What do you think encourages patient influx to the clinic?
5. What do you think stops patients from utilizing services at this clinic?
6. Do you know of any rumors going on in the community about the clinic?
7. Do you think there are certain traditional beliefs in the community that affect patient's uses of the clinic?
8. Do you know of anything the government can do to improve patronage?
9. How would you rate the quality of care in the clinic?
10. Do you have any thoughts on what we can do to encourage community utilization of health services?

(General Rule: Steer patients towards focusing on perceptions, beliefs and practices and other household related causes. Ensure this is done tactically in order to avoid de-motivation of participants).



Appendix 8: Interview Sheet (Hausa)

Hira tambayoyin da hira da su sanya tausayin marasa lafiya

Gayar da musayar pleasantries, ya yi respondent da lilwantacce gwargwandon hali

1. Tun yausha ka yi amfani da wannan asibiti?
2. Abin da canje-canjen da ka ga sabo a cikin 'yan shekarun nan da su staffing, infrastructural daidaituwar da sauran ba ya sake?
3. Ta yaya za ka yi canjin da hakuri patronage, wato?
4. Abin da ka gani yana hidimar hakura kwarara zuwa asibitin?
5. Mene ne yakan mahukurtan daga amfani hidimomi a wannan asibiti?
6. Ka san abin da jita-jita tafiya yadda ya jama'a a asibiti?
7. Ko kuwa ba makkana sarakunan gargajiya a jamaata da shafe hakura da amfani da shi asibiti?
8. Abin da gwamnati kara yin haka ba za ka zo?
9. Ba kamar yadda za a nan?
10. Ko game da abin da muka yi taitaya al'umma utilization kiwon lafiya hidimomin?



Appendix 9: Focus Group Guide for facility users (English)

Guide for conducting focus group discussions for clinic attendees

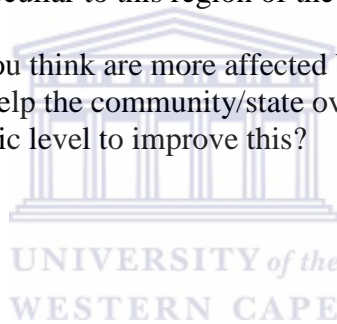
The researcher will introduce the topic describing the findings in the latest health report from the state and concern about the level of service utilization at the primary health care clinic level especially when more than 90% of healthcare provided by the state is through this means.

The session is expected to last not greater than 2 hours and everyone will be encouraged to be an active participant. Questions will be same as Nos 5 – 9 of the individual one on one question with an additional introductory question that asks why attendees choose to use this clinic.

Guide for conducting focus group discussions for clinic staff

The researcher will introduce the topic describing the findings in the latest health report from the state and concern about the level of service utilization at the primary health care clinic level especially when more than 90% of healthcare provided by the state is through this means. The session will last approximately one and half hours and the following questions will guide the discussions:

- Describe how you feel about service utilization at the facility?
- How do you think it can be improved?
- What beliefs/perceptions peculiar to this region of the country or in general may be affecting service utilization
- What group of people do you think are more affected by this
- What do you suggest will help the community/state overcome this?
- What can you do at the clinic level to improve this?



Appendix 10: Interview Questions for non- clinic users in the community

(Selection criteria of participants): Clinic users can refer interviewer to any non -clinic user they know within the community)

Name:

Age:

Sex:

1. How long have you lived in this community?
2. Have you ever heard of the clinic?
3. Can you tell us why you do not use the clinic?
4. What do you think discourages people from using the clinic?
5. Do you know of any stories in the community about the clinic?
6. Do you think there are certain traditional beliefs or practice in the community that prevent people from using the clinic?
7. What do you think we can do to make you use the clinic?
8. Do you have any other you will like us to know?

