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UTILISATION OF PRIMARY HEALTH CARE SERVICES AMONG RURAL DWELLERS IN OYO STATE

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ABSTRACT

Primary health care centres were established to facilitate health service delivery in local communities. The practices of alternative health services among other factors, especially in the rural areas, affect patronage of health care centres. The extent to which the health care services are used among rural dwellers needed to be determined. The study was conducted in Oyo state Nigeria. Simple random sampling technique was used to select 147 respondents. Primary data for the study were collected using questionnaires to elicit information on respondents' socioeconomic characteristics, ailments prevalent in the study area, level of awareness, sources of information, perceived effectiveness, constraints and level of utilisation of Primary Health care (PHC) services. Data were analysed using descriptive statistics such as frequency count, percentages, and mean. Pearson Product Moment Correlation was used to establish the relationships between variables in the stated hypotheses. Most (65.3%) of the respondents were between the ages of 35 and 54 years, 61.2% of the respondents were male. A poor economic status of most rural household with a mean of 1.13 was the greatest constraint faced by respondents in utilising PHC services in the study area and utilisation of PHC services among respondents (53.7%). There was a significant relationship between the age ($r = -0.337$, $p=0.000$), years of formal education ($r=0.566$, $p=0.000$), household size ($r =0.515$, $p=0.000$), ailments ($r=0.326$, $p=0.000$) and constraints encountered ($r=-0.0575$, $p=0.000$) towards the utilisation of PHC services in the study area. As poor economic status of the rural household is the major problems identified by the respondents as challenges to the utilisation of PHC services it is recommended that all three tiers of government should contribute to the funding of PHC to subsidise the services in order to ensure continual usage of the health care services.

Keywords: Utilisation, PHC services, respondents

INTRODUCTION

Sound health is a fundamental requirement for living a socially and economically productive life. Primary health care (PHC) as conceptualized by the Alma Ata declaration of 1978 is a grass-root approach towards universal and equitable health care for all (Litsios, 2002). The strategy is meant to address the main health problems in the community providing preventive, curative and rehabilitative services (Alenoghena, Aigbiremolen, Abejegah and Eboeime, 2014). It is the first level of contact of individuals, families and communities with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of the continuing health care process (Olise, 2007).

Access to health care services is a multidimensional process involving the quality of care, geographical accessibility, availability of the right type of care for those in need, financial accessibility and acceptability of services (Peters, Garg, Bloom, Walker, Brieger and Rahman, 2008). The utilisation of health care services is related to the availability, quality and cost of services, as well as social-economic structure, and personal characteristics of the users (Chakraborty, Islam, Chowdhury, Bari and Akhter, 2003).

Many of Nigeria's farm families usually have close contacts with plants, wild and domesticated animals, and agricultural chemicals such as inorganic fertilisers and pesticides. Thus, several farm activities do pre-dispose farmers to disease, infection and illnesses. The adverse effects

of illness/diseases on agriculture and rural development are manifest primarily in loss of labour supply, farm income and assets. Farmers' health has significant effects on agricultural productivity.

Ulimwengu (2009) indicated that healthy farmers were found to produce more per unit of inputs, earn more income and supply more labour than farmers affected by sickness. Production inefficiency increases significantly with the number of days lost to sickness. Ajani and Ugwu (2008) also found that one percent improvement in a farmers' health condition led to a 31 percent increase in efficiency. They also reported that farmers spent as much as 13 percent of their total household expenditure on treatment of malaria alone.

The state of the Nigerian health system is dysfunctional and grossly under-funded with a per capita expenditure of US\$ 9.44 (World Bank, 2010). As a result, Nigeria still has one of the worst health indices in the world and sadly accounts for ten percent of the world's maternal deaths. Many low income countries, Nigeria inclusive, have not been able to meet the basic health care needs of their people, especially those in the rural areas. There has been a growing recognition of the challenge of rural people's health issues and the need for it to be addressed (Hamid, Sadique, Ahmed and Molla, 2005).

In Nigeria, the Federal Government coordinates that affairs of University Teaching Hospitals, the States manages the various General Hospitals while the Local Government Authorities



focus on Primary Health Centres (Dispensaries). (Gupta, Gauri and Khemani, 2004) explained that the rural populations in Nigeria are seriously underserved even as it caters for less than 20% of potential patients. Most Primary health care facilities are in a state of disrepair with equipment and infrastructure being either absent or obsolete and referral system almost non-existent. There are shortages of Physicians, Nurses and trained health personnel in most rural communities and where the services are available, difficulties associated with transportation, communication, illiteracy, nature of illnesses; family decision, traditional conservation, deep rooted traditional beliefs, customs and poverty tend to drive farm families towards traditional health care services in most rural communities in Nigeria (Okpara and Ellah, 2007; Etuk, Olatunji and Ekong, 2013 and Omotosho, 2010).

It is against this background that this research sought to know how rural households in Oyo State are utilising primary health care services available to them and the following research objectives were addressed:

1. describe the socioeconomic characteristics of the respondents,
2. identify the constraints faced by respondents in accessing these services.
3. determine the level of utilisation of respondents to primary health care services in the study area.

Hypotheses of the study, stated in null form, are as stated below;

- H₀₁ There is no significant relationship between the socioeconomic characteristics of the respondents and the level of utilisation of PHC
- H₀₂ There is no significant relationship between the constraints faced by the respondents and the level of utilisation of PHC.

METHODOLOGY

The study area was Oyo state. It was formed in 1976 from Western state, and included Osun state, which was split off in 1991. Oyo state is homogenous, mainly inhabited by the Yoruba ethnic group who are primarily agrarian but have a predilection for living in high-density urban centres. The indigenes mainly comprise the Oyos, the OkeOguns, the Ibadans and the Ibarapas, all belonging to the Yoruba family and indigenous city in Africa, south of Sahara. Oyo state consists of 33 local government areas.

Oyo state covers approximately an area of 28, 454 square kilometres and is ranked 14th by size. The climate is equatorial, notably with dry and wet seasons with relatively high humidity. The dry season lasts from November to March while the wet season starts from April and ends in October. Average daily temperature ranges

between 25°C (77°F) and 35°C (95°F), almost throughout the year.

Multi-stage sampling procedure was used in selecting the respondents for this study. In the first stage, ten percent (10%) that is, three out of thirty three (33) local government was purposively selected based on their rurality, and they were Orire local government, Ibarapa east local government and Olorunsogo local government. In the second stage, thirty percent (30%) i.e. three (3) of the ten (10) wards from Orire and Olorunsogo local government LGAs was selected using simple random sampling, while ten percent (10%) i.e. one out of the ten wards in Ibarapa local government was selected to give a total of seven (7) wards. The third stage was the random selection of three (3) communities from each of the wards, giving a total of twenty-one (21) communities. The final stage was the random selection of seven (7) households from each of the selected communities. A total of 147 respondents were used for the study.

Data were analysed using both descriptive and inferential statistics. Descriptive statistics such as frequencies, percentage distribution and mean were used to achieve the highlighted objectives while PPMC was used to test the hypotheses.

RESULTS AND DISCUSSION

Socioeconomic characteristics

Age - The result on age on Table 1 reveals that most (65.3%) of the respondents were between the ages of 35 and 54 years, 8.8% were between the ages of 25 and 34 years, while 25.9% were between 55 and 74 years. The mean age of 46.6±10.4 years implies that majority of the respondents were young and would therefore be able to access and make use of PHC services in the study environment.

Sex Table 1 also shows that majority (61.2%) of the respondents were male, while 38.8% were female. This implies that although PHC services are been utilized by both sexes, most of the male in the study area make more use of the services. This supports the findings of Adesiji, Dada and Komolafe (2012) who reported in their study of problems faced by rural people in accessing health care facilities in Akure north and Akure south local government areas of Ondo State that there are more males making use of PHC than the females.

Education - Educational level on Table 1 reveals that majority (63.9%) of the respondents had between 4 and 7 years of education, 29.3% had 12 and 16 years, 5.4% had 0 and 3 years, while 1.4% of them had between 8 and 11 years of education. This implies that since most of the respondents had basic primary education, this will help them know about services rendered by PHC and would have informed their health care choices. This is in tandem with Odetola (2015), who



reported that majority of respondents have their choice of health institution influenced by their level of education.

Household size - Table 1 also shows that majority (61.2%) of the respondents had between 5 and 8 members in their household. Also, 19.1% of them had between 1 and 4 members, 18.4% had 9 and 12 members while 1.4% had between 1 and 4

members in their household. Mean of 6.6 persons of household size suggests a large household which implies that most of the respondents had more than two members in their households which could make them use PHC services on a daily basis. This substantiates the findings of Olajide (2013) that the household size of respondents in the study area was between 2 and 4 persons.

Table 1: Distribution of the respondents by socioeconomic characteristics

Variables	Percentage	Mean
Age		
25-34	8.8	46.4
35-44	38.1	
45-54	27.2	
55-64	21.1	
65-74	4.8	
S.D=10.4		
Sex		
Male	61.2	
Female	38.8	
Education level		
0-3	5.4	
04-07.	63.9	
08-11.	1.4	7.6
12-16.	29.3	
S.D=3.5		
Household size		
01-04.	19	
05-08.	61.2	
09-12.	18.4	6.6
13-16	1.4	
S.D=2.3		

Source: Field survey, 2016

Constraints faced by respondents in the use of PHC services

Result on Table 2 shows that poor economic status of most rural households with the highest mean (1.13) which is ranked 1st was the major constraint faced by the respondents followed by inadequate health personnel which was ranked 2nd based on the mean (1.03) and the least constraints faced by the respondents was absence of standardised measurement of drugs which possess the least mean (0.24) and was ranked 13th.

This means that most rural households are far away from PHC centres which could hinder respondents from making use of PHC services. Also, the absence or inadequate health personnel may discourage respondents from making use of PHC services in the study area. This supports the work of Abdulraheem *et al* (2012) which shows one of the hindrances to the development of health especially in Nigeria has to do with insufficient number of medical personnel as well as their uneven distribution.

Table 2: Distribution of respondents based on constraints faced in the use of PHC services

Constraints	Severe	Mild	Not	Mean	Rank
Poor economic status of most rural households	30.6	51.7	17.7	1.13	1 st
Inadequate health personnel	25.9	51.7	22.4	1.03	2 nd
Inadequate drugs and vaccines in health centres	30.6	41.5	27.9	1.02	3 rd
Inadequate health care centres	28.6	44.2	27.2	1.01	4 th
High cost in accessing PHC	21.1	53.7	25.2	0.95	5 th
Distance to health centres	19	51.7	29.3	0.9	6 th
Insufficient information about health issues	10.2	61.2	28.6	0.82	7 th
Lack of awareness of services provided	12.9	48.3	38.8	0.74	8 th
Wastage of ample time in assessing treatment	7.5	53.7	38.8	0.69	9 th
Preference for medical herbs	11.6	32.7	55.8	0.56	10 th



Constraints	Severe	Mild	Not	Mean	Rank
Quality of services provided by health personnel in health centres	7.5	22.4	70.1	0.37	11 th
Lack of belief in health personnel	6.1	14.3	79.6	0.27	12 th
Absence of standardised measurement of drugs	85	6.1	8.8	0.24	13 th

Source: Field survey, 2016

Respondents' utilisation of PHC services

Result on Table 3 shows that majority of the respondents always utilised the following PHC services: Immunisation against infectious diseases (89.8%), maternal and child health care services (70.1%), supply of safe water and basic sanitation

(66.7%), treatment of diseases (62.6%), prevention of diseases (57.1%), while majority of the respondents rarely utilised normal delivery services (47.6%). This implies that respondents have faith in PHC services and trust it to keep them safe from preventing diseases/ailments and also, curing it.

Table 3: Distribution of respondents based on utilisation of PHC services

Level of utilisation	Always	Rarely	Not at all	Mean	Rank
Immunisation against infectious diseases	89.8	9.5	0.7	1.89	1st
Maternal and child health care services	70.1	27.2	2.7	1.67	2nd
Treatment of diseases	62.6	34.7	2.7	1.6	3rd
Prevention of diseases	57.1	40.8	2	1.55	4th
Provision of essential drugs	49.7	49	1.4	1.48	5th
Supply of safe water and basic sanitation	19.7	66.7	13.6	1.06	6th
Normal delivery service	18.4	47.6	34	0.84	7th
Family planning counselling	14.9	42.2	42.9	0.72	8th
Health education	8.2	46.9	44.9	0.63	9th
Routine check-up, vital signs and general health	6.8	45.6	47.6	0.59	10th
Blood pressure check (BP)	4.8	40.8	54.4	0.5	11th
Nutrition education	5.4	36.7	57.8	0.48	12th
Blood test	2	32	66	0.36	13th
Urine test	0.7	23.8	75.5	0.25	14th

Source: Field survey, 2016

Furthermore, result on Table 4 shows that majority (53.7%) of the respondents had high utilisation of the PHC services, while 46.3% had low utilisation. This implies that respondents in the

study area would continue to utilise the PHC services as they could be benefiting more from the services rendered.

Table 4: Distribution of respondents based on level of utilisation of PHC

Level of utilisation	Frequency	Percentage	Mean	SD
Low (0-13)	68	46.3	13.6	5.6
High (14-27)	79	53.7		
Total	147	100		

Minimum=0, Maximum=27

Source: Field survey, 2016

Hypothesis 1: Relationship between selected socioeconomic characteristics of the respondents and utilisation of PHC services

Table 5 also shows that there was a significant relationship between age ($r=-0.337$,

$p=0.000$), educational level ($r=0.566$, $p=0.000$), household size ($r=-0.515$, $p=0.000$) and utilisation of PHC services. This implies that age, educational level and household size had a significant influence on the utilisation of PHC services in the study area.

Table 5: Results of Pearson distribution of selected socioeconomic characteristics of the respondents and utilisation of PHC services

Variables	r value	p value	Decision
Age	-0.337	0.000	S
Education	0.566	0.000	S
Household size	-0.515	0.000	S



Hypothesis 2: Relationship between constraints and level of utilisation of PHC

Result on Table 6 shows that there exists a significant relationship between constraints ($r = -0.0575$, $p = 0.000$) and level of utilisation of PHC services. This implies that constraints faced by the

respondents influence their utilisation of the PHC services. The lesser the constraints they face, the more they utilise the services. This supports the work of Aide *et al.* (2014), where it was reported that respondents experience difficulties in accessing PHC services.

Table 6: Result of correlation distribution between constraints and level of utilisation of PHC services

Variables	r value	p value	Decision
Constraints	-0.575	0.000	S

Source: Field survey, 2016

CONCLUSION AND RECOMMENDATION

The study revealed that poor economic status of the rural household was the major problem identified by the respondents as the challenge to the utilization of PHC services. There is high level of utilization of PHC by respondents in the study area. Based on the findings of this study, the following recommendations are made towards the utilization of primary health care services:

- There should be an establishment of public health centres by Government at all tiers in the core rural areas. This will increase the proximity and accessibility of rural people to public health facilities.
- Governments at all tiers should ensure equitable accessibility to health care delivery across the rural areas by deploying more medical staff to the rural areas.
- Rural development policies should promote the creation of enabling environment to enhance participation in modern health care delivery.

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