FACTORS INFLUENCING THE UTILIZATION AND NON-UTILIZATION OF PRIMARY HEALTHCARE SERVICES IN BAURE LOCAL GOVERNMENT AREA OF KATSINA STATE

BY

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CERTIFICATION

I certify that this research work titled Factors Influencing utilization and non-utilization of primary health care (PHC) services in Baure Local government area of Katsina State, was conducted, written and compiled by me. I also certify that, to the best of my knowledge, this research work has never been presented wholly or partly for the award of any degree or for publication elsewhere.

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APPROVAL PAGE

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DEDICATION

I wish to dedicate this work to my beloved parents Mal. Abdulkadir B. Saleh and Fatima Binta Muhammad, in acknowledgement of their unending love and support as well as guiding me to the path of knowledge right from my infancy.

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ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immuno Deficiency Syndrome

APA: American Psychological Associations

BHSS: Basic Health Service Scheme

HBM: Health Belief Model

HCC: Health Council of Canada

HIV: Human Immune Virus

NSBAs: Non-Skilled Birth Attendants

PHC: Primary Health Care

SES: Socio Economic Status

UN: United Nations

UNICEF: United Nations International Children and Emergency Fund

WHO: World Health Organization

ABSTRACT

Since political independence, Nigeria has drawn up a number of health policy plans. The country adopted the WHO's primary healthcare policy in 1987, which was believed to be a mechanism through which healthcare services will be made universally accessible to individuals irrespective of geographical location and other indices of social inequality. However, available literature and exposition by key health sector stakeholders have shown that the utilization of the PHC services is far below expectation especially in the rural areas of the country. Thus, this study was conducted to find out the socio-economic factors that influence the utilization and non-utilization of the PHC services in Baure Local Government Area of Katsina State. The research study was guided by Rosentock's Health Belief Model and Andersen and Newman Framework of Health services utilization as its frame of analysis. A sample of 356 respondents was selected for the study using a multi stage cluster sampling and questionnaire instrument was used in collecting the data from the sampled respondents. The questionnaire contained open and closed ended questions in order to generate rich data for analysis. The results revealed an above average of 65% utilization level of the PHC services in the study area among the respondents. Income level was found to influence the utilization much more than non-utilization of PHC services in the area. Similarly the cost of services being charged at the PHC centers does influence non utilization of PHC services. It was also discovered that educational attainment influences the perception and understanding of illnesses and health as well as utilization and non-utilization of PHC services. The findings also indicate that distance of reaching a PHC facility is a significant factor influencing the utilization and non-utilization of the PHC services in the area, while traditional cultural values with regards to traditional medicine and its availability were found to influence the perception and understanding of illnesses of the respondents and the utilization as well as the non-utilization of PHC services. The research therefore recommends provision of more PHC facilities and manpower and intensification of public health awareness about health issues and primary healthcare services in Baure local government area in order to ensure more utilization among the populace of the study area.

CHAPTER ONE

INTRODUCTION

1.3 Background to the Study

Health is defined by the World Health Organization (1946) as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Though many definitions of health abound, this one by The WHO is seen as the most comprehensive because it embraces all aspects of life. Health is a major form of human capital and there exists substantial agreement in literature on the relationship between health and socio-economic development (Straus & Thomas, as cited in Awoyemi, T.T., *et' al.* 2011). In fact, it is assumed and established that improvement in heath status leads to improvement in life expectancy, which is a robust indicator of human and societal development. This makes health a universal value being cherished and promoted by states in both advanced and developing societies. Nigeria is the most populous nation in Africa, with an estimated population of 168.8millon people, more than 50% of which lives in rural areas where their main source of health care for the treatment of communicable and common illnesses among others are provided by primary health care workers (World Bank, 2015).

Primary health care is defined as essential health care that is based on practical scientifically sound and socially acceptable methods and technology that is made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self reliance and self determination (WHO, 1978). Primary health care is the first level of contact for individuals, families and communities with the health care system. Thus, rural people in Nigeria

should have been making optimum utilization of the services provided at the primary health care facilities available to them in their localities. However, recent report by WHO (2013), African region puts the level of PHC services utilization in the region at 5-7% which translates to about 95 under-utilization rate of the PHC services.

Rebhan (2008) observes that, cultural and socio-economic factors such as traditional belief, income and education are important in understanding why people utilize health care services. Other factors include, accessibility of the health care facility, people's perceptions of such services, knowledge or educational level and age of the user/patient, belief in efficacy of the medical service, gender roles, as well as social roles are all among the extensive list of factors influencing both the choice to seek health care and the assessment of which health care option to utilize for prevention and treatment of illness. Knowing that, the issue of PHC utilization by community members is determined by one or more of the above factors, the services are needed by the people despite that they are not equally patronized. In view of the above, the present study is designed to investigate the factors that influence the utilization and non-utilization of the PHC services in Baure LGA, Katsina State.

1.4 Statement of the Problem

Since political independence in 1960, successive governments, in an attempt to secure their citizens' opportunity to attain their health goals in Nigeria, adopted and implemented a mixture of policies, private sector driven health insurance schemes, and bilateral funding and credit facilities by international creditors. In August, 1987, Federal government launched the primary health care policy in the country in line with Alma-Ata Declaration. The goal of primary health care (PHC), as contained in the Alma-Ata Declaration to which Nigeria was a signatory, was to

provide accessible health for all by the year 2000 and beyond. It is however, unfortunate to note that Nigeria achieved little in the dispensation of such cheap medical service and it seems difficult to provide effective PHC services to especially the rural and suburban population even in a decade to come (Abdulraheem *et al*. 2012). This by implication means a lack of proper utilization of PHC services in different parts of the country. However, the utilization or otherwise of the PHC services might be influenced by various factors, depending on the location, level of awareness, cultural and socio-economic factors.

That was why Pate (2013) observed that, it is obvious that the primary health care centers are not doing well, because, in some states, the PHC centers only exist in name as a small number of people visits them for preventive or treatment purposes, which Baure Local Government Area, the study area for this research is not an exception. This is because a preliminary investigation and a visit to the PHC centers revealed that there are modern primary health care facilities that are being manned by trained primary health care workers providing services to the people in the area, but only an insignificant number of people attend the facilities to utilize the services. Some of the people resort to the use of traditional medicine while others choose to go to patent medicine vendors or even on the street drug-hawkers.

According to Ekwueme (2012), primary health care which is supposed to be the bedrock of the country's healthcare policy is currently catering for less than 20 % o the potential patients. This is also the same as obtained in Baure local government area where despite the existence of fifty four PHC centers across the twelve political wards of the local government, the utilization of these facilities for services by the people in the area is very poor as revealed by the health officers during our preliminary investigation as not many people are coming to the PHC centers immediately when ill for health services. This raised the question of why not the majority? But

also the need to find out why the few patronize the PHC facilities is another important subject of studying, and this study is concerned with the problems that are specific to Baure local government area and the factors that influence the utilization of PHC services in the area. As although, there are number of problems associated with primary healthcare such as user fees, distance of reaching a facility, poor attitude of personnel, lack of enough drugs, etc. yet, some people in the study area visits the PHC facilities and utilize the services provided. There is thus, the need to find out the factors that influence the utilization and non-utilization of PHC services by people of Baure local government area.

This is because; the essence of the BHSS in 1975 and the PHC policy in 1986 in Nigeria was to improve the healthcare access and utilization among the citizens. However the health care utilization of a population is related to the availability, quality and cost of services, as well as to socio-economic structure, and personal characteristics of the users (Chakraborty et al. 2003**;** Manzoor et al.2009; Onah et al. 2009). Thus, the achievement of this goal according to Benjamin (2006) requires among other things, the removal of the many barriers that hinder access to, and utilization of the health services.

This study was therefore aimed at investigating the influence of cultural and socio-economic, factors such as income, cost of services, educational attainment, and distance of reaching a PHC facility and availability of traditional medicine on the utilization and non-utilization of PHC services by people of Baure local government area of Katsina State.

1.3 Research Questions

1. Does people's level of income determine their utilization of PHC services in Baure local government area?

2. Do costs of services influence PHC services utilization in Baure local government area?
3. Does people's level of education influence their utilization of PHC services in Baure local government area?
4. Does distance of reaching PHC facilities determine people's utilization of PHC services in Baure local government area?
5. Does availability of traditional medicine influence people utilization of PHC services in Baure local government?

1.4 Aim and Objectives of the study

The broad aim of this study was to find out the socio-economic factors that influence the utilization and non-utilization of primary healthcare services in Baure local government area of Katsina State. The specific objectives of the study were:

1. To examine the influence of socio-economic factors such as income, costs of services and educational attainment on the utilization of PHC services among people in Baure Local Government Area.
2. To determine whether distance in reaching PHC facilities influence the utilization of PHC services by people in Baure Local government area
3. To explain the influence of the availability of traditional medicine on the utilization of PHC services in Baure Local Government Area.

1.5 Scope and Limitations of the Study

This study seeks to examine factors influencing the utilization and non-utilization of primary healthcare services among people in Baure local government area of Katsina state. Thus, the study was limited to the adult people living in Baure Local Government Area. Similarly, the study was limited to the twelve political wards of the local government area and therefore the findings of this research will be used to make generalization on the local government area. This geographical coverage (of only one L.G.A.) could therefore be reflected in the limitation of the study in terms of cogent conclusion if the study covers the entire Katsina State.

1.6 Operational Definitions

The following concepts will be used in this study and shall be understood as defined below;

Cost of Services: This refers to the monies that patients are being charged at the PHC centers for the services rendered to them and the drugs given to them for treatment of their illness.

Distance: This means the travel-time spent form home by an individual before reaching a PHC facility to obtain healthcare services.

Educational Attainment: This means the highest level of achievement of an individual in terms of western education or certificates a person possesses in terms from Primary to University

Income: This refers to the amount of money realized monthly by an individual through his particular occupation like trading, and which to a large extent determines his position within the social strata.

Non-utilization: This refers to failure or refusal of an individual to make use of the available PHC centers for services when ill or for illness preventive purpose.

Traditional medicine: This refers to any form of ill-health treatment or prevention that is rooted in the African cultural practices and traditions like herbs and spiritual medicines provided by herbalists and spiritualist respectively.

Utilization: This refers to making regular use of the available PHC facilities for ill-health treatment or medical advice as at when required.

1.7 Significance of the Study

The significance and importance of this research is twofold, the first being the contribution the findings of this study is going to make to the existing literature on health and health care utilization by supporting or negating the outcomes of researches conducted in other places on primary healthcare utilization. The second being the policy implications the outcome of the research is going to have, because ensuring equitable access to health services is a universal goal of governments in all nations. As such with a better understanding of why people use or do not use these services, healthcare organizations can seek to improve the quality of human life. Thus, the findings of this study stand to improve the understanding of people's utilization behavior towards primary healthcare services in Baure Local Government Area. This is because a better understanding of utilization behavior of the people can be used by health service planners to improve primary healthcare delivery in the local government area and other similar locations.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter deals with the review of related literature and theoretical framework. It presents the conceptual clarifications, the study objectives and the section on relevant theories reviewed and applied in explaining the factors that influence the utilization and non-utilization of the PHC services in the study area.

2.2 Conceptual Clarifications

2.2.1 The Concept of Primary Healthcare

The term “primary health care” is used interchangeable with the term “primary community care” to reflect the health and social services environment. It is the first level of care and usually is the first point of contact clients have with the health and social services system that is, in partnership with the client, services are mobilized and coordinated in response to clients needs to promote wellness, prevent trauma and illness, build capacity, provide support and care for community health and social issues and manage ongoing problems to sustain functional independent society at an optimal level (National Forum on Health 1997, in HCC, 2005).

According to the Institute of Medicine, primary care is the provision of “integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community APA, 2014.

According to the charter of General practice/Family Medicine in Europe, 1994; primary care system of care that provides accessible and acceptable care of patients; ensures the equitable distribution of health resources; integrates and coordinates curative, palliative, prevention, and health promotion services; rationally controls secondary care technology and drugs HCC, 2005.

Whereas, a primary Health Care Framework for Brunswick (Undated), defines primary healthcare as the first level of contact of individuals, a family, or the community with the health system and the first level of a counting health care process and may include health education, promotion and prevention at the individual or community level, assessment, diagnostic services, intervention and treatment.

World Health organization, Declaration of Alma-Ata 1978 defines primary healthcare as: Essential care based on practical, scientifically, sound and socially acceptable methods and technology made universally accessible to individuals and their families in the community through their full participation and at the cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO,1989). As such primary health care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people lives work, and constitutes the first element of a continuing health care process. Primary health care thus;

1. Reflect and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. Addresses the main health problems in the community, providing health promotion, disease prevention, curative and rehabilitative services accordingly;

3. Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; material and child health care; including family planning; immunization against the major infectious diseases; prevention and control of locally endemic disease; appropriate treatment of common diseases and injuries; and provision of essential drugs; Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular , agriculture, animal husbandry, food, industry, education, housing, public works, communications and this sectors; and demands the coordinated efforts of all those sectors;

4. Requires and promotes maximum community and individual self-reliance and participation in planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

5. Should be sustained by integrated, functional and mutually supportive referral system, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need (Muldong et'al (2006).

2.3 Brief History of Primary Healthcare

The idea of primary healthcare emanated in the late sixties beginning with the apparent failure of vertical health programs especially the failure of malaria eradication program. This led to the postulation of alternative health proposals by scholars of various disciplines, such as Bryant

(1969), Newell (1975), Illich (1976), McKeown (1976), who were all heavily criticizing the then existing health care programs and thus, opposes the transplantation of that type of healthcare to the developing world. Lalonde report on new perspective on health in Canada in 1974 also serves as a great influence.

Those criticisms were favored by the then new emerging world order, the declining US hegemony on the global scale and the independence of many African and Asian countries that were in search of alternative developmental trajectories and of course including healthcare alternatives. This coincided with the success of the rural medical services of "Community barefoot doctors" in China in 1969 and the Chinese entrance in to the UN.

However, the greater impetus to the emergence of primary healthcare was the election of Mahler, as the Director of WHO in 1973, who was a strong proponent of basic healthcare, and his collaboration with his counterpart of UNICEF, who also had the same vision. Their collaboration led to WHO-UNICEF joint report; *Alternative Approaches to Meeting Basic Health Needs in Developing Countries* in 1975. The report shaped the WHO ideas on PHC, and consequently the 28th World Health Assembly 1975 reinforced the trend, declaring the construction of National Programs in Primary healthcare a matter of urgent priority.

The landmark event for Primary healthcare was the International conference on primary healthcare that took place in Alma-Ata from September 6th to 12th 1978. The conference was attended by 3000 delegates from 134 governments and 67 international organizations from all over the world. Three key ideas permeate the declaration: appropriate technology, opposition to medical elitism, and the concept of health as a tool for socio-economic development. Finally, the World Health Assembly that took place in Geneva in 1979 endorsed the declaration, stating that

the primary healthcare was “the key to attaining an acceptable level of health for all by the year 2000”.

However, in Nigeria something similar to primary healthcare predates Alma-Ata Declaration. This is because, according to Akande, (2002), during the 1975-1980 Nigeria’s development plan, there originated some concerted efforts to meet the WHO’s standard of one Doctor per 1000 population ratio. The needs in the health sector led to the establishment of Federal and states’ health institutions and training of middle-level personnel and the establishment of Basic health services scheme (BHSS).

Thus, according to Sorungbe, (1989), primary healthcare in Nigeria started in 1975, When Gowon, the then Country’s leader announced the Basic Health Services as part of the national Development Plan (1975-1980). The objectives of the BHSS were to increase the proportion of the population receiving healthcare from 25 to 60 %, correct the imbalances in the location and distribution of health care institutions and provide infrastructures for all preventive health programs such as control of communicable diseases, family health, environmental health, nutrition and others, as well as the establishment of a healthcare system best adapted to the local conditions and to the level of health technology.

2.4 The Nigerian Healthcare System

The Nigerian health system operates three levels of healthcare, which correspond to the three tiers of government and interacts through a referral system. The National health policy recommends the primary healthcare as the entry point to healthcare system, as this is where the bulk of the people reside and therefore most challenging. Thus, the primary healthcare level is the most important aspect of the system because this is where the continuing healthcare process

begins. The provision of healthcare at this level is largely the responsibility of local governments with the support of state ministries of health and within the overall national health policy (Guardian Editorial, 2008).

The Secondary level of healthcare continues with the cases from the primary level with adequate feedback system. This level is mostly disease oriented and has facilities for laboratories and X-ray related services. These services are run in general hospitals manned by Doctors, Nurses/Midwives and diagnostic personnel. The responsibility of providing and maintaining healthcare at this level is that of the state governments, NGOs example, Missionary and Religious organizations, development partners, e.t.c.

Whereas the tertiary tier is the highest and most specialized healthcare system that continues with cases from secondary and primary tiers. The facilities at this level include Teaching hospitals and specialist hospitals manned by Doctors, Consultants, Physicians, Nurses/Midwives and diagnostic personnel. While some facilities at this level of care concentrate on only one specialty such as orthopedics, psychiatry, ophthalmology, etc. others cover services in many field. Facilities at this level also serve as training centers for Doctors, pharmacists and primary healthcare workers (Newman, & Omodi, n.d.). The responsibility for the provision, maintenance and management of healthcare at this level is that of the federal government.

It is however, worthy to note that, the organization of the delivery of primary healthcare services largely varies across States of the federation. The role of the private sector in service provision is larger in Southern States, particularly in Lagos state. The public PHC delivery system also varies significantly. For example, many states are progressively eliminated health posts and dispensaries which are the smallest PHC facilities offering only a limited set of services.

However, in the Northern States of the Federation, they represent an important share of the PHC facilities, “although now renamed as health clinics”, (World Bank 2010).

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2.5 The Components of Primary Healthcare (Primary Healthcare Services)

Health education: Knowledge about the prevailing health problems, their prevention and control, as well as education information, and communication that empower and enable people to live a healthy life.

Promotion of food supply and proper nutrition: This involves self help method of improving the availability of food and proper utilization (balance diet), storage (food preservation), and security (food hygiene).

Adequate supply of potable water and basic sanitation: This involves personal hygiene and environmental sanitation.

Maternal and child health including family planning: This involves healthcare of the child and childbearing woman who are the most at risk as well as family planning awareness and advice for couples to ensure healthier and happier homes.

Immunization against major infectious diseases and oral rehydration therapy: This involves vaccination for the prevention of child killer diseases and rehydration of dehydrated persons using the salt sugar solution.

Prevention and control of locally endemic diseases: This is the proper management of the parasitic and communicable diseases which are the most common causes of morbidity and mortality in Nigeria and other African countries.

Appropriate treatment of common diseases and injuries: This involves the use of standing orders and appropriate technology by technical community health workers for the treatment of common diseases and injuries.

Provision of essential drugs: This involves the provision of the needed drugs in line with the prevailing health problems of the people in the communities.

2.6 Factors Influencing Utilization of Primary Healthcare Services

Health determinants can be described as factors that raise or lower the level of health in a population or individual, determinant helps to predict trends in health and to explain why some people are healthy and others are not. They are the key to the prevention of disease, illness and injury (ALWH, 2004, PHAC, 2004, BlueShield, 2005 cited in Owoseni *et al.* 2014). Whereas the factors determining the health behaviors may be seen in various contexts: Physical, socio-economic, cultural and political, therefore, the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions, and the disease pattern and health care system itself (Sheikh & Hatcher, 2004 and Babar *et al.* (2004)). Thus, Health seeking behavior and utilization of health services is determined by a number of factors depending on time, place, and circumstances.

2.6.1 The Influence of Income Level and Cost of Medicine on the Utilization of PHC Services

The socio-economic status of the majority of a country's citizen will most likely reflect in their health situation generally, because the better the economic indicators of a country the better their health condition. Socio-economic status is a multidimensional concept; among the dimensions typically associated with socio-economic status (SES) are occupational status, educational achievement, income, poverty, and wealth etc. (Owonseni *et al.* 2014). In many societies whether rich or poor, those of greater privilege tend to enjoy better health than their counterpart.

According to Bour (2005), in Ghana and some other developing countries in Africa, the low expenditure on health has affected the provision of physical and consumable health facilities.

Low wages makes quality care inaccessible to a greater proportion of the population. Evans et al, (1994, citied in Owoseni *et al.* 2014), argue that economic condition n relate to environment, lifestyles and access to health services. According to Peters *et al.* (2008), people in poor countries tend to have less access to health services than those in better-off countries, and within countries, the poor have less access to health services.

Nowadays, it is possible to say every person could expect to live a long and healthy life, we could say its economic value is huge and health gains had the economic, consequences of widespread economic growth and an escape of ill-health traps in poverty (World Health Organization, 1999). Economic Factor is seen affecting the availability of treatment, when the cost of treatment rises above what an individual can pay or above what he considers appropriate for the perceived seriousness of the illness, then that form of treatment effectively becomes unavailable to such a person. User charges are factors that inhibit people from accessing health care facilities. According to Jegede (2010 cited in Owoseni *et al.* 2014), over the years this has been the advantages of traditional medicine over modern orthodox medicine. While in traditional medicine, the charges are very moderate and low in most cases, and users have access to credit facilities with traditional healers being members of the same community, the reverse is the case in modern medicine, while the physician sees him/her self as a professional, charges usually follow standardized rates as regulated by the medical council or the government agency in charge of such health facility.

Anderson *et al.* (1956, as cited in Health Sociology 2006) have highlighted the role of economic factors in the utilization of health services; family income is an important determinant of the pattern of use of health care institution because family unit take costs of care into consideration before their member seek care among the available channels of care. Patient may also opt for

costly services if they are convinced that they will receive prompt attention and/or have access to services, which they cannot afford. However, at nowadays the traditional healers charge more exorbitant fees than charged at modern health facilities. That is why it is believed utilization of medical facility is also affected by other socio economic variables of patients. For example, Okafor (1983) observed that civil servants utilize hospital services more than farmers, traders and craftsmen, and suggests that such differential utilization can be accounted for by time factor. He elaborates this by noting that while visits to hospitals by civil servants are not accompanied by loss of income, the same cannot be said of those that are self-employed. The implication of such finding for health shopping is a tendency for unemployed persons and those not in government services to seek medical services at later stage of illness.

Thus, in a study on the constraints to utilization of maternal health services at PHC level in Nnewi, Nigeria, Chinonso *et al.* (2014) found as one of the reasons adduced by the discussants for the utilization of material health services perceived high cost of services. In their study on understanding barriers to the utilization primary health care in low income settings Kurfi *et al.* (2013) found numerous reasons given for the non-utilization of the PHC facilities but the most common were non availability of essential drugs(27.6%) closely followed by the high cost of services (25.9%). Similarly Ibrahim & Abdulhamed (2012), in the study on accessibility problems of primary health care to rural people, found reasons like cost of transportation and low income level, distance, user fees cost and- availability of drugs were considered as factors of poor accessibility which have affected the utilization of the primary health facilities in Jigawa state, Nigeria.

In a study, the World Bank (1990) found that, Nigerians use the most costly cosmopolitan private health providers than those within the traditional healing centres because it is believed

that quality care is provided by the former. On the other hand non-literate patients are most likely to use traditional healer partly because of the perceived cost of care of cosmopolitan services, which they believe they cannot afford. Yet there is an indication that cost of care, which is rendered by traditional healers, is not necessarily lower in real terms than that provided by the cosmopolitan in view of the fact that patient expend large sum of money on a variety of items, which are use for rituals in the therapeutic regiment prescribed by the healers (Erinosho, 2006).

In Katsina State, the case might seem different because Usman (2010) noted that the State is one of the poorest states in Nigeria, alongside Jigawa and Yobe States. In order words, income can affect the utilization of the modern medical services by many households in Baure LGA. It could therefore be argued that many people, especially the rural and less educated ones in Katsina State (Baure LGA in particular) are relying on traditional medication for economic reasons, costs, or culture.

2.6.2 The Influence of Education Attainment on the Utilization of PHC Services

Education enhances peoples' knowledge of modern health care services, improves their ability to communicate with modern health care providers, increases the value they place on good health, results in heightened demand for modern health services. As noted by Caldwell (1979) illiteracy affects the use of health services. Because most of the people may lack enabling resources, and because of high rate of illiteracy, they might not perceive the need for health service use, especially rural people, resulting in the use of unscientifically tested traditional medicine, some of which have negative health implications.

In Nigeria, Caldwell (1990) found out that educated women benefited more from available public healthcare services than the uneducated mothers. Also in a study of child nutrition in

Philippines, Owoseni *et al.* (2014) found that access to healthcare services benefited children of educated mothers more than children of mothers with less schooling. Mothers that attained some level of formal and/or western education in Baure LGA can easily grasp the messages of the authority concerning maternal health and child immunization and can be willing to utilize the services as made available in the PHC. The non-literate mothers on the other hand, are skeptical of using modern methods of medication, family health, or maternal health.

Similarly, Adamu, (2003 in Yar'Zever & Sa'id, 3013), studies in Kano shows a low percentage of attendance for maternal health services in rural areas where most of the women did not pass through western education. In similar vein, a study of utilization of PHC facilities in rural areas of South-West Nigeria by Sule *et al.* (2008) found that education is positively associated with utilization of the primary health care services.

2.6.3 The Influence of Availability and Distance on the Utilization of PHC Services

Availability refers to the distance the patient lives from a health care facility, transportation and total travel time, wait time available services, (Hjortsberg & Mwikisa, 2002, Perry & Gesler, 2000, cited in Ebere, 2013). There is significant evidence that health care utilization is lower in rural areas compared to urban areas. While there are a number of possible explanations for these differences, such as differences in the number of physicians available or individual's characteristics, the longer travel distances and fewer transportation options available in rural areas could be a significant factor.

Distances to regional health care centers in rural areas can often be great. The problem becomes compounded when a growing portion of residents in rural areas are older adults who need access to health care services but may have limited transportation options (Jeremy, 2010). According to

Lekan & Sanni (2010, as cited in Owoseni *et al.* (2014), there is a general consensus among researchers investigating the relationship between distance and utilization of healthcare facilities according to them, this relationship is that fewer people are willing to patronize a particular facility as the distance from it increases.

Empirical investigations revealed the existence of other factors, in addition to distance, as influencing the patronage pattern of healthcare facilities. For instance, Adejuyigbe (1973) demonstrated that attendance at each medical center in Ife region is a function of both type of service available there and the distance from other center providing similar services. However, this might be because, there are available facilities from which to choose. Okafor (1977, cited in Owoseni, *et al.* 2014) analyze the spatial distribution and efficiency of hospital facilities in the old Bendel (now Edo and Delta states). He found that there were discrepancies between the population distribution and the distribution of hospital facilities. In Zambia, 56% of surveyed rural households perceived distance as an obstacle (Hjortsberg & Mwikisa, 2002, citied in Ebere, 2013). In the same study, only 17% of individual living more than 40 kilometers from a facility sought care when sick compared to 50% of individual living less than five kilometers away.

Conclusively, as observed by Sina, Iyabo, & Ayodele (2014), socio-economic status of individuals greatly influenced their tendencies for health care services utilization. In other words, income is a determinant of primary health care utilization. On the other hand, Rumun (2013) opines that gender and age are two important social factors that influenced health care service utilization. In addition, Rebhan (2008) is of the view that, access to the health care facilities and educational levels are found to be important in individuals' health seeking behaviors. The present study thus, seeks to fill knowledge gap by investigating the influence of age, gender, income

level, educational level and distance on the utilization of PHC services by people of Baure Local government area of Katsina state.

2.6.4 Influence of Traditional medicines on the Utilization of PHC

The cultural practices of people not only affect their health but also affect all aspects of life, including social relationship, contribute to societal functioning and disease condition. Man living in an interactive society is affected by what happens in his environment and how he reacts to it. All people, no matter the race, have their beliefs and practices concerning health and disease. Each society or community has its peculiar way of doing things and these practices go a long way in influencing the people's perception, attitudes and behavior in the management of diseases and health related problems that befall them (WHO, 2007, cited in Ojua *et al.* 2013).

It is important to note that culture shapes not only illness treatment but also illness recognition, perception of illness severity and confidence in the efficacy of treatment for specific illnesses, for example, in many cultures, dementia in elderly is viewed as a normal process of ageing; thus it does not necessitate medical treatment, however, in the United States, dementia is considered an illness requiring professional medical care (Ikels, 2002). As such, variance in health care utilization can result due to cultural knowledge and understanding of illness. If an individual is a member of a culture that considers the self as heteronymous, they are likely to have their course treatment determined by people within their social network (Kleiman, 1980; Ikels, 2002 cited in Owoseni *et al*. 2014).

Conversely if a culture considers the individual as autonomous, the decisions for treatment are more likely to be made by the individual. In those cultures that consider the self as

heteronymous, as ill individuals treatment may be delayed as persons within their social networks for illness and advice. Social network can provide an impetus for health care utilization but may also press an individual to abstain from accessing health services. Gabrysch & Campbell, (2009, cited in Folashade & Isma'il, 2013) argued that socio-cultural beliefs in relation to age gender, and the need for immediate and specialized services has hampered women's and children's ability to access health services in many low and middle income countries including Nigeria.

The cultural perspective on the use of maternal health services suggest that medical needs is determined not only by the presence of physical diseases but also cultural perception of illness as in most African rural communities, maternal health services co-exist with indigenous health care services; therefore, women must choose between the options (Addai, 2000, citied in Onasoga *et al.* 2014). The use of modern health services in such a context is often influence by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women. In the northern Nigerian, where Katsina State or Baure LGA in particular belongs, cultural practices such as the practice of purdah system (i.e. wife seclusion) have been cited as a major barrier restricting women's access to health care in the Northern part of Nigeria (Adeniyi *et al.* 2014). Sometimes, the cultural belief and practice in the Baure LGA is viewed as a factor that distort the reality that health is an objective phenomenon. But because of superstitious beliefs, the people might held a fatalistic approach to health by adding complications to particular illness, such as whipping a mentally sick person or consulting soothsayers.

Alternative medicine, in other word called traditional medicine, has existed before the advent of scientific medicine which is called modern medicine. Okeke (2010:173) noted that modern hospitals exposed people to treatment other than the traditional ones. Prior to the introduction of

modern health care center, the various communities had their own indigenous health care traditional or ethno medicine. That is why Obasi, (2000), opined that rural peoples' conception of illness and therapeutic strategies were shrouded in mythology, theology and superstition. That is to say a lot of myths, religious explanations and superstitious beliefs existed concerning all manner of illnesses.

Hence, diseases were often conceived of as visitation of angry gods/goddesses or evil spirits or the machinations of evil people. Gertz (1973, cited in Fawole, 2008) discovered that in many part of Africa, sick people first consult a nearby traditional healer, and only later, if he cannot help, they try the often far away hospital. This is because their idea about the cause of illness governs their choice of who is able to cure it. Katung (2001), in his study of socio- economic factors for poor utilization of primary health care services in rural communities of plateau state, found easy access to traditional healers as the most significant factor (39%). Similarly in a study by Henry & Tukur (2010), on the utilization of Non-Skilled Birth Attendants in the three northern states of Nigeria, close to 90% of women surveyed were assisted by NSBAs during delivery rather than a trained medical technician in a health facility. However, as against the findings of the above researches, traditional healers are now far away from the people than the primary healthcare facilities. Thus, it cost more time and monies to reach a traditional herbalist than it cost in getting to PHC facility.

2.7 The Consequences of Poor Utilization of Primary Healthcare Services

The health status of most people living in developing countries of the world remains poor. Linked to this are some factors, of which low utilization of PHC services remain a major issue (Egbewale & Odu, 2012). Generally, health care utilization is limited in Sub-Saharan Africa

(Sunday *et al.* 2014). Most Nigerians ignore primary health facilities, some people, especially at the grass roots resorts to quacks, and majority of Nigerians go directly to the secondary or tertiary institutions for their health challenges, and the referral system has been made useless. And the effect of all these is that, the secondary and tertiary institutions are overburdened by conditions that can and should be treated at the primary healthcare facilities.

Available data showed that 70% of all ailments could be treated at the primary healthcare levels and just 20% need to get to the secondary level while 5% to the tertiary level (Ekwueme, 2012). But now, PHC which is supposed to be the bedrock of the country's healthcare is currently catering for less than 20% of the potential patients it is therefore no longer a doubt that despite the progress and achievements made so far in the implementation of the primary health care programmed, the services provided are grossly underutilized or inadequate (Ekwueme, 2012).

That is why after the introduction and implementation of the primary health care in Nigeria, due to poor utilization, the country is yet to witness the much desired impact of promoting and protecting health preventing diseases and reducing mortality, morbidity, and disabilities associated with diseases and illness. This is why the health system of the country was ranked 187th among the member states by WHO and lowest among the 146 countries that have failed to stem maternal mortality and child mortality ratio in 2008.

For example, Nigeria accounts for about 13% of global maternal death rates with an estimated 36000 women dying in pregnancy or at child birth each year (Chukwu, 2014). And according to gates, (2015), for many women in Nigeria, the official death may be recorded as postpartum hemorrhage or urine rapture, similarly, for the alarming number of newborns who perish, their mothers may be informed the cause was asphyxia or birth trauma. However in each of these

cases, the underlying cause of death is actually something far more fundamental: that the vast majority of the mothers and newborns who die in Nigeria are lost to preventable healthcare problems. In fact they would have survived had they live in communities that provide access to qualitative basic health services.

Similarly, according to UNICEF Nigeria (2015), every single day Nigeria loses about 2300 under five years olds and 135 women of childbearing age, making the country second largest contributor to maternal at the and infant mortality in the world. And preventable or treatable infectious diseases such as malaria, pneumonia, diarrhea, measles, and HIV/AIDS accounts for more than 70% of the estimated one million under five death in the country. Although, many of these deaths are preventable, these ugly incidences tend to happen due to poor coverage and quality of basic health care services. Because presently less than 20% of health facilities offer emergency obstetric care and only 35% of deliveries are attended by professional skilled birth attendants.

2.8 Theoretical Framework

This section presents theoretical viewpoints explaining factors influencing people's utilization of healthcare services, from which two were adopted as the theoretical frame of analysis for this research.

2.8.1 Rational Choice Theory (RCT)

The central explanation of this theory is a focus on individual rational action that helps to explain the aggregate behaviour in the society. According to the main proponent of this theory, James Coleman (1990), the main task of sociologists is to focus on social system, but that such macro phenomena must be explained by examining the factors internal to them, which centers on

behaviour of individuals at the micro level. He identified reasons for this argument. First, he argued that data are usually gathered at the individual level and aggregated or composed to yield the system level. Second, that the individual level is the point where interventions are ordinarily made to create social change in the society. Further, Coleman‘s rational choice orientation posits that a person acts purposively towards a goal, with the goal and the actions shaped by values or preferences. In other words, every person considers utilization of healthcare facility a rationalized choice, and perhaps the best available alternative course of action to achieve their pressing needs. The collection of the aggregate rational action helps to explain the macro social system.

Although rational choice theory recognizes that in the real world, people do not always behave rationally, but this makes little difference in the position of the theory. According to Coleman (1990) the implicit assumption is that the theoretical predictions will be substantively the same whether the actors act precisely according to rationality as conceived or deviate in the way that have been observed. Hence, given the theoretical orientation, it follows that the focus in terms of the micro-micro issue is the micro to macro linkage, or how the combination of individual actions bring about the behaviour of the system (Ritzer, 1996). While the theory is interested in micro-macro analysis, it is also interested in the macro-micro linkages, or how the system constrains the orientations of actors. On the whole, the argument of rational choice theory is the rational construction of social system from the lowest level of individual. That is knowledge of macro level is best understood from primacy of micro level. In other words, to gain adequate understanding of the utilization of healthcare facility in Nigeria, it is highly essential to understand the perception of individuals to the healthcare facility on available. However, this

model cannot be used to explain health behavoiur of the rural people who are yet to get out of the shackles of poverty and ignorance.

2.8.2 The Health Belief Model

The Health Belief Model (HBM) has the longest history of all the theories reviewed. It was originally conceived by social psychologists in the public health arena as a way of predicting who would utilize screening tests and/or vaccinations. According to the HBM, the likelihood that someone will take action to prevent illness depends upon the individual's perception that:

They are personally vulnerable to the condition;

The consequences of the condition would be serious;

The precautionary behavior effectively prevents the condition; and

The benefits of reducing the threat of the condition exceed the costs of taking action.

These four factors, which are influenced by mediating variables, indirectly influence the probability of performing protective health behaviors by influencing the perceived threat of the illness and expectations about outcome. The model's four key components are conceptualized as perceived: susceptibility, severity, effectiveness, and cost.

Perceived susceptibility refers to the probability that an individual assigns to personal vulnerability in developing the condition. The concept of perceived susceptibility has been found to be predictive of a number of health-protective behaviors. From an HBM perspective, the likelihood individuals will engage in precautionary behaviors to prevent cancer (e.g., quit smoking, eat a diet low in fat and high in fiber, exercise, get a mammogram or prostate exam)

depends on how much they believe they are vulnerable to or at risk for cancer. In general, it has been found that people tend to underestimate their own susceptibility to disease.

Perceived severity refers to how serious the individual believes the consequences of developing the condition are. An individual is more likely to take action to prevent cancer if s/he believes that possible negative physical, psychological, and/or social effects resulting from developing the disease pose serious consequences (e.g., altered social relationships, reduced independence, pain, suffering, disability, or even death). Models of Health Belief frequently refer to perceived health threats. The combination of perceived susceptibility and perceived severity constitute a threat.

Perceived effectiveness refers to the benefits of engaging in the protective behavior. Motivation to take action to change a behavior requires the belief that the precautionary behavior effectively prevents the condition. For example, individuals who are not convinced that there is a causal relationship between smoking and cancer are unlikely to quit smoking because they believe that quitting will not protect against the disease.

Perceived cost refers to the barriers or losses that interfere with health behavior change. The combination of perceived effectiveness and perceived costs constitute the notion of outcome expectation. Belief alone is not enough to motivate an individual to act. Taking action involves cognitively weighing the personal costs associated with the behavior against the benefits expected as a result of engaging in the behavior. Benefits have to outweigh the costs involved.

Cues to action involve stimuli that motivate an individual to engage in the health behavior. The stimulus that triggers action may be internal or external. For example, angina may act as an internal cue to initiate action. External cues such as a spouse's illness or the death of a parent may also trigger health behavior changes in an individual who was not otherwise considering

them. HBM factors also interact to trigger action. For example, when perceptions of susceptibility and severity are high, a very minor stimulus may be all that is needed to initiate action. However, more intense stimuli may be needed to initiate action if perceived susceptibility and severity are low.

More recent formulations of the HBM have included *self-efficacy* as a key factor. Self-efficacy is influenced by mediating variables and in turn influences expectations. In addition, some forms of the HBM refer to *general susceptibility to illness* as a key factor in the model. However, substitution of the general case over specific consequences is only appropriate if the intention of the precautionary behavior is to improve health in general. The *value of health,* another variable which is sometimes included, refers to interest in and concerns about general health, the extent to which an individual values health. According to this view of HBM, individuals concerned about being healthy in general are more likely to exercise regularly than individuals who place little value on health. Although both cues to action and the value of health have been included in some forms of HBM, their importance in predicting health behavior is unclear since neither variable has been systematically studied. *Mediating factors* (demographic, structural, and social variables) have also been explored in applying the HBM. Mediating variables (e.g., educational level) are believed to indirectly affect behavior by influencing an individual's perceptions of susceptibility, severity, benefits, and barriers.9 Becker and Maiman added the concept of *motivation* to the HBM. This has also been interpreted as readiness to change behavior. This theory is relevant to this research because it could be used to explain people utilization behavior towards preventive and promotive health services which is one of the core services being provided in primary healthcare facilities.

However, this theory is criticized for assuming that everyone has equal access to information on illness and diseases. It is also criticized for not accounting for the environmental or economic factors that may promote or prohibit the recommended action, and in fact, the model seems descriptive rather than explanatory.

2.8.3 Andersen and Newman's Framework of Health Services Utilization

Determinants for use of primary health care services can also be conceptualized by applying a behavioral model proposed by Andersen that seeks to account for and predict the use of health services by individuals (Andersen, 1995). The purpose of this framework is to discover conditions that either facilitate or impede utilization. The goal being, to develop a behavioral model that provides measures of access to and utilization of medical care. The framework was first developed in the 1960s and has since gone through four phases. According to the model, such utilization is dependent on the interaction between individual traits, population characteristics, and the surrounding environment. Andersen proposes that the relevant factors can be grouped into three main categories: an individual's predisposition to use medical services; enabling or impeding circumstances (such as infrastructure); and the need for health care. Developed in the 1990s, the framework below represents the fourth phase. An individual's access to and use of health services is considered to be a function of three characteristics:

1) **Predisposing Factors:** The socio-cultural characteristics of individuals that exist prior to their illness.

Social Structure: Education, occupation, ethnicity, social networks, social interactions, and culture

Health Beliefs: Attitudes, values, and knowledge that people have concerning and towards the health care system

Demographic: Age and Gender

2) **Enabling Factors:** The logistical aspects of obtaining care.

Personal/Family: The means and know how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships

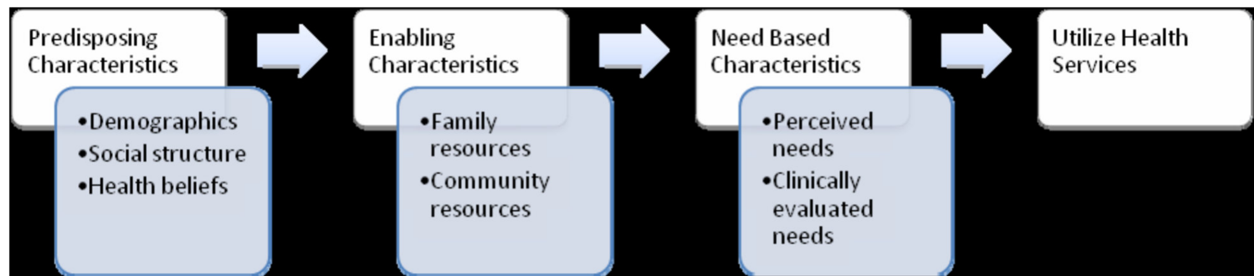
Community: Available health personnel and facilities, and waiting time

Possible additions: Genetic factors and psychological characteristics

3) **Need Factors:** The most immediate cause of health service use, from functional and health problems that generate the need for health care services. "Perceived need" will better help to understand care-seeking and adherence to a medical regimen, while evaluated need will be more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider." (Andersen, 1995) Thus, Perceived: "How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help; and Evaluated: "Represents professional judgment about people's health status and their need for medical care." (Andersen, 1995). Although this theory was criticized of not paying enough attention to culture, and social interaction, Andersen, argued that, that has been included in the predisposing characteristics component of the theory. Similarly, on the criticisms that the theory made emphasis on need at the expense of beliefs and culture, Andersen, argued that need itself is a social construct, which is

why need is split in to perceived and evaluated ones. Therefore, this theory is adopted as the frame of analysis for this research, because, of all the theories reviewed in this study it stand to provide basis of analyzing the problem of study and the specific objectives of the study. This is because, this model provide theoretical basis of explaining the variables raised in the questions for this research believed to be impediments to or an influence on the utilization of PHC services in the study area, which are income level, cost of services, level of education, distance, and the cultural practices.

Andersen's Behavioral Model of Health Services Utilization



Source: (Wolinsky, 1988: 63)

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This Chapter deals with information about the background of the study area. It also includes the population of the study, sample size and sampling techniques and the methods for data collection employed in conducting the research as well as the methods used in analyzing and discussing the data generated in the study.

3.2 Background of the Study Area

Baure Local Government Area is one of the thirty four local government areas in Katsina State. The area is situated at 12° North and 44° East in the extreme end of Katsina state to the East, and it covers an area of 707 Kilometers. The local government area is made up of twelve political wards: Agala, Babban-mutum, Baure, Faski, Garki, Hui, Maibara, Muduri, Taramnawa, Ungwar Rai,Yanduna, Yanmaulu. With regards to population, the local government area has one hundred and ninety seven thousand four hundred and twenty seven (197,427) people, according to the National Population Commission (2006). The population is predominantly Hausa/Fulani Muslims, who in terms of occupation are predominantly farmers with some of them combining farming and civil service, and some farming and trading, some farming and driving while others are engaged in labor intensive jobs, and with only very few Igbo and Egbira settlers most of whom are Christians, who are engaged in trading accordingly.

In terms of the primary healthcare facilities providing health services in the local government area, there are a total of fifty four (54) PHC facilities across the twelve political wards, among them nine (9) models primary healthcare facilities, one (1)comprehensive health clinic, and forty

four(44) health clinics equipped and manned by trained health technical personnel. The local government area has availability of traditional medicine providers such as herbalists and spiritualists spread across the villages.

3.3 Population of the Study

The population of the study consists of all adult people irrespective of sex, age or educational characteristics living in Baure local government area of Katsina State. This is because, the study is focused on finding out the factors that influence the utilization and non-utilization of the available PHC services in the area, so that to make suggestions on how to improve primary healthcare utilization rate and therefore improve people's health conditions. Thus, this study was interested in studying the entire population of adult residents in the local government area and therefore the study population does not include non-resident people coming to the area during the conduct of the research.

3.5 Sample Size of the Study

The sample for the study was three hundred and fifty six (356) respondents. Out of the total sample, 336 were respondents for quantitative data, which involve members of households living in Baure local government area. In addition, 20 respondents including traditional leaders in the local government area, technical health personnel, and the director of primary health care of the local government were selected for qualitative data. The total sample size for this study was therefore three hundred and fifty six (356) respondents.

3.4 Sampling Procedures

In selecting the sample for this study from the study population multi-stage cluster sampling was adopted in which the twelve political wards of the Baure Local Government Area serve as

clusters. The political wards are: Agala, Baure, Babban Mutum, Maibara, Faski, Yanduna, Yanmaulu, Taramnawa, Muduri, Hui, Garki, and Ungwar Rai. In the second stage, each political ward (cluster) was divided into sub-clusters from which two villages were selected from each of the wards using systematic sampling technique where each village in a ward was assigned a number and two were randomly selected and thus, each village represents a sub-cluster and it gives 24 villages (sub-clusters). In the third stage, systematic sampling was used to select two (2) streets from each of these 24 sub-clusters, which gives 48 streets. In the fourth stage, 7 houses were also selected systematically using probability sampling, this was done by starting with the first household in a village and then counting an interval of five to pick another respondent from another household, this gives a total of 336 houses. Finally, from each house, one male or female adult member was purposively selected. Thus, there is a total of (12x2x2x7=) 336 respondents for quantitative data. While 20 respondents for the qualitative data (in-depth interviews) were purposively selected, where one traditional leader was selected from each of the twelve political wards of the local government, two health educators, two community health officers, four social welfare officers, In sum, the sample for the study was (336+20=) 356.

3.5 Instruments and Methods of Data Collection

For the purpose of gathering data for the research, a structured questionnaire and in-depth interview (IDI) were used. However, due to the nature of the population of the study which comprises of people with formal education and those without, the questionnaires were distributed for those with formal education to fill it themselves, while the researcher and his assistants administered the questionnaires to those with no formal education. Interview guide was also used in conducting the IDI. The data were collected with the aid of four persons (research assistants).

3.6 Methods of Data Analysis

The methods for data analysis was mixed method; that is, quantitative and qualitative data. The data obtained in the field was processed, analyzed, and presented accordingly using relevant descriptive statistical tools in the form of tables, frequencies and percentages which were employed in addressing the research questions raised in the study. Cross-tabulations of the important variables was also used in order to examine how cultural factors and income influence PHC services utilization. Whereas, narrative and descriptive analysis was used for the data obtained from the in-depth interviews and was used to supplement the quantitative data analysis.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter presents the data collected as well as the discussion of the major findings. The responses from the questionnaires were presented in tabular form, the responses from the interviews were subsequently presented as complementary to the quantitative data. Out of the 336 respondents that were administered with the questionnaires, two hundred and ninety seven (297) were retrieved (83 % response) as at the time of compilation and analysis. Therefore the analysis for this research is based on the two hundred and ninety seven retrieved questionnaires and the responses from the IDI conducted.

Section A: The Socio-Economic and Demographic Characteristics of the Respondents

This section presents the socio-economic and demographic information of the respondents

Table 4.1: Sex Distribution of Respondents

Sex	Frequency	Percentage (%)
Male	214	72.5
Female	81	27.7
No Response	02	0.8
Total	**297**	**100**

Source: Fieldwork, 2016

Table 4.1 represents the sex distribution of the respondents in which, significant majority of the respondents (72%) were males, while 27.3% were females.

Table 4.2: Age Distribution of Respondents

Age	**Frequency**	**Percentage (%)**
20-30years	129	43.7
31-40 years	81	27.5
41-50 years	51	17.5
51-60 years	27	9.2
61 years and Above	09	3.1
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.2 presents the age distribution of the respondents where majority (43.4%) are between 20 and 30 years, 27.3 percent fall between 31 and 40 years, 17.2 percent are between 41 and 50 years; those between 51 and 60 years account for 9.0 percent and respondents of age from 61 years and above represent 3.0 percent. This shows that majority of respondents for are between 20 and 30 years.

Table 4.3: Marital Status of the Respondents

Status	**Frequency**	**Percentage (%)**
Single	141	47.7
Married	138	46.7
Divorced	12	4.6
Separated	6	2.03
Total	**295**	**100**

Source: Fieldwork, 2016.

Table 4.3 presents the distribution of the marital status of the respondents. Respondents that are single constitute 47.5 percent, those that are married represent 46.5 percent those that are divorced account for 4.0 percent and those that are separated constitute 2.0 percent. The results revealed that majority of the respondents are single.

Table 4.4: Educational Attainment of the Respondents

Qualification	Frequency	Percentage (%)
Non-formal education	39	13.2
Primary	42	14.2
Secondary	57	19.3
Tertiary	156	52.8
No response	03	1.1
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.4 presents the distribution of the educational attainment of the respondents. Respondents having attained tertiary education level constitute the majority (52.5%), those with secondary school educational qualifications were 19.2 percent, those with primary school education constitute 14.1 percent, respondents with non-formal education represent 13.1 percent and 1 percent of the sample did not respond to the question.

Table 4.5: The Occupation of the Respondents

Occupation	Frequency	Percentage (%)
Civil service	51	17.2
Farming	93	31.5
Driving	06	2.3
Petty trading	36	12.2
Others	97	32.8
No response	14	4.8
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.5 above presents the distribution of respondents' occupations. As shown in the table, those with unspecified occupations (ike casual staff) constitute 32.7 farmers are up to 31.3 percent; civil servants account for 17.2 percent, petty traders represent 12.1 percent; others (such as land agents, students, and percent and 4.7 percent of the respondents did not respond, drivers were up to 2.0 percent.

Table 4.6: The Monthly Income of the Respondents

Income	Frequency	Percentage (%)
N5,000 - N10,999	132	44.7
N11,000 - N20,999	66	22.3
N21,000 - N30,999	20	6.7
N31,000 - N40,999	21	7.1
N41,000 and above	25	8.4
No response	33	11.1
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.6 presents the distribution of the income earnings of the respondents. Respondents earning N5,000 - N10,999 constitute the majority (44.5%); those earning between N11,000 and N20,999 represent 22.2 percent; 11.1 percent did not respond, those earning between N41,000 and above per month represent 8.4 percent, those earning N31,000 - N40,999 constitute 7.1 percent; and those earning N21,000 - N30,999 represent 6.7 percent. The result revealed that majority of the respondents has a monthly income of USD 68.8, which is below the international acceptable measure of living above poverty of USD 3 per day.

Section B: The Influence of Traditional Cultural Values on the Utilization of PHC Services

This section deals with the influence Cultural traditional medicine on primary health care services utilization in Baure local government area.

Table 4.7: Whether the Respondents Use PHC Centers

Response	Frequency	Percentage (%)
Yes	195	66.1
No	18	6.1
Sometimes	72	24.4
No response	12	4.6
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.7 above presents data on whether respondents use PHC centers. The respondents who reported that they use PHC represent 65.7 percent; 6.1 percent of the sample responded that they do not use it; 24.2 percent of them reported that they sometimes use the PHC; while few of the sample (4.0%) did not respond. In an interview, a Community Health Technician in Baure LGA, mentioned that:

> The people seem to come to the PHC centres more frequent compared to general hospitals and the Federal Medical Centre. This might be attributed to the low-cost and propinquity of the centres while the general hospitals and the Federal Medical Centre are somehow more expensive and, sometimes, far from the rural population (IDI with a Community Health Technician, 2016).

Also, a community leader expressed that his subjects are patronising the PHC centres as follows:

> They are patronising the centres, though they are reluctant to take advantage of the services provided, including vaccinations for children and proper prenatal and post-natal examinations. With the use of media, this is also reduced (IDI with a Community Leader, 2016).

Table 4.8: Medical Services Obtained by the Respondents during Illness before Attending PHC Facility

Medical Service	Frequency	Percent (%)
Chemist	204	69.1
Traditional healers	34	11.5
Self-medication	39	13.2
No where	20	6.7
Total	**295**	**100.0%**

Source: Fieldwork, 2016

Table 4.8 above presents the distribution of the medical services obtained by the respondents during illness before attending any PHC facility. The results shows that respondents that reported going to chemists account for a majority (68.9); those that go to traditional healers are 11.4 percent; 13.1 percent responded that they adopt self-medication, while 6.7 percent don’t go to anywhere before attending PHC centers. The data from the table above therefore reveals that

although majority of the respondents utilize PHC services, their first point of visit for healthcare is mainly medicine stores popularly known as chemists. The data indicate that though table 4.7 reveals high PHC utilization level among the respondents but the data in this table 4.8 reveals that only very few of the respondents follow the Nigeria's national Healthcare standard of making the PHC centers the first point of contact for seeking medical attention. In an interview with a traditional leader, he pointed out that:

> There are long existing traditions that dominate our traditional medical institution from time immemorial and it is very difficult for us to be separated from this traditional way of health seeking (IDI with a community leader, 2016).

Table 4.9: Traditional or Religious Values Influence Perception of Illness

Response	Frequency	Percent (%)
Yes	147	49.8
No	72	24.4
Sometimes	75	25.4
No response	03	1.1
Total	**295**	**100.0%**

Source: Fieldwork, 2016

Table 4.9 presents responses of the respondents on whether traditional or religious values influence his/her perception of illness. Majority of the respondents (49.5%) of the sample indicated that traditional or religious values influence their perception of illness; 25.3 percent said traditional or religious values influence their perception of illness sometimes; 24.2 percent reported that traditional or religious values do not influence their perception of illness; while 1.0 percent did not respond. The data in this table thus, revealed that cultural, traditional, and religious are having a strong influence on the respondents' perception and attitude towards illnesses. This supports the revelation by WHO, 2007, cited in Ojua *et al.* 2013 that, each society

or community has it peculiar way of doing things and these practices go a long way in influencing the people's perception, attitudes and behavior in the management of diseases and health related problems that befall them. All people, no matter the race, have their beliefs and practices concerning health and disease

. The data on the above table means that the respondents are less likely to utilize primary health care, since according to the health belief model the perception of the cause and nature of illness by an individual determines the kind of health seeking behavior one adopt. A community leader also intimated that:

> The cultural values that hinder our people to the proper utilization of the PHC are not limited to *cire yar wuya* (i.e. the removal of a tissue in the throat of a new born baby) and other unhealthy traditions. Some of these practices affect the women more. Women are generally considered as the weaker sex and they are usually confronted with several health complications from menstrual periods to conception through to delivery. And there is problem that most of the men are not helping matters by not taking them to the hospitals and PHC centres, (IDI with a community leader, 2016).

A health educator also stressed that:

> Some people in this community are viewing modern medication as a negation to religion, but while there are few areas that are in contention with religion, the religion itself did not view the whole of modern medicine as alien. Allah and His Prophet (PBUH) said: "ask those who know if you do not know", i.e. *ahluzzikr* (custodians or companions of something). Thank God, people are now abandoning the fatalistic view of modern medication as too secular (IDI with a Health Educator, 2016).

Table 4.10: Influence of Traditional Medicine on the Utilization of PHC Services

Response	Frequency	Percent (%)
Agree	113	38.3
Strongly Agree	71	24.3
Disagree	62	21.0
Strongly Disagree	51	17.2
Total	**295**	**100.0**

Source: Fieldwork, 2016

Table 4.10 above presents respondents' views on the assertion that traditional medicine influences utilization of PHC services in Baure L. G. A". Respondents who agree constitute 38.0, those who strongly agree constitute who disagree constitute 23.9 percent, while those who do not agree constitute 20.9 percent; and those that strongly disagree represent 17.2 percent. The findings in the above table corroborate with the Andersen and Newman's model's postulation that one of the factors determining the utilization or otherwise of a healthcare service by a person is his level of attachment with or detachment from primitive traditional beliefs and practices. In line with the above, a health technician explained that:

> There is clear influence of cultural practices in terms of PHC usage, because some cultural practices create impediments to the utilization of modern medicine. Culturally speaking, there is promotion of the vulnerabilities of some family members on certain illness. After child-birth, mothers are instructed to use gruel prepared with potash (kunun kanwa) and it exposes the women to the risk of high blood pressure. Although nowadays the females tend to use the PHC centres more because of pregnancy and birth-related problems, they also bring their children that we notice their demand for PHC services is unparalleled, despite some cultural barriers (IDI with a Health Technician, 2016).

Cross-tabulations

Table 4.11: Influence of Traditional medicine on the Utilization of PHC Services and Sex

Utilization of Traditional Medicine		**Sex of the Respondents**		**Total**
		Male	**Female**	
Responses	Utilization	135 (62.9%)	47 (57.3%)	**182 (61.3%)**
	Non-Utilization	79 (36.7%)	34 (41.5%)	**113 (38.0%)**
	No Response	1 (0.4%)	1 (1.2%)	**2 (0.7%)**
	Total	**215 (72.4%)**	**82 (27.6%)**	**297 (100.0%)**

Source: Fieldwork, 2016

Table 4.11 above shows the cross-tabulation of sex difference of the respondents and the influence of traditional medicine on the utilization of PHC services. The table showed that

culture and the belief and availability of traditional medicines as an alternative healthcare services are determinant for unequal utilization of PHC in the study area. For example, more males (62.9%) and more females (57.3%) agreed that cultural traditional medicines influences the utilization of PHC services in the area, compared to 36.7 percent of the males and 41.5 percent of the females who did not agree

Section C: The Influence of Income and Cost of Services on the Utilization of PHC Services in Baure Local Government

This section seeks to address the second and third objectives of the study. That is, the influence of income and cost of services on the utilization of primary health care services in the study area.

Table 4.12: Saving Money in Case of Illness

Response	**Frequency**	**Percent (%)**
Yes	112	37.9
No	177	60.0
No response	08	2.7
Total	297	**100.0**

Source: Fieldwork, 2016

Table 4.12 presents respondents' views on whether they save money in case of illness. More than half of the sampled respondents (59.6%) reported that they could not save money in case of medical emergency, 37.7 percent indicated they do save money for medical emergency and 2.7 percent of the sample did not respond. Also, a traditional leader has added more light on the above data, thus:

> Majority of the people of Baure locality cannot save money in preparation for sudden illness, while few others, especially civil servants, do save and keep money for this purpose. Majority of Nigerians, in this recession period have no money to save even though health is a necessity. Some of the people depend on salary so they have to save money for contingency or in case of unexpected illnesses (IDI with a Community Leader, 2016).

Table 4.13: Income Serves as a Determinant for the Utilization of PHC Services

Response	Frequency	Percent (%)
Utilization	132	44.7
Non-utilization	105	35.5
None	60	20.3
Total	**295**	**100.0**

Source: Fieldwork, 2016

Table 4.13 presents respondents' views on whether income serves as a determinant of utilization of the PHC services in the study area. The data shows that 44.5 percent of the respondents revealed that their income do influence and determine their utilization of available PHC services, and 35.3 percent of the respondents believed their income level did influence their non-utilization of the PHC services. Whereas, 20.2 percent reported that their level of income has no bearing on either the utilization or non-utilization of PHC services. This finding corroborates with the assumption of Peters *et al.* (2008), that people in poor countries tend to have less access to health services than those in better-off countries, and within countries, the poor have less access to health services. The revelation from the above table supports the assumption of the Andersen and Newman Healthcare utilization model that enabling characteristics of individuals including income determines the utilization or non-utilization of healthcare services. According to a Community Leader thus:

> Sometimes, people have to beg in the mosques and other gatherings in order to be able to pay for the medical bill. This is despite the fact that the PHC centres are more affordable to the masses. As a result, children are at the risk of losing their lives because of the little money needed to purchase the drugs (IDI with a Community Leader, 2016).

Closely related to the above revelation, a Community Health Officer expressed the following remark:

> Of course there is lack of income nowadays, and the income is central to anything in the modern day. The poor people are even paid for by some of us if we have the means of aiding them. (IDI with a Medical Officer, 2016).

Table 4.14: The Cost of Using PHC Centers

Cost	Frequency	Percentage (%)
N10-N100	39	13.2
N101-200	101	34.2
N201-300	60	20.3
N301-400	65	22.0
N401-500	28	9.4
Above N500	4	1.3
Total	**295**	**100.0**

Source: Fieldwork, 2016

Table 4.14 presents respondents' views on the amount they usually pay as the cost of using PHC centers. From the table, 34.0 percent of the respondents reported that they usually spend N101-N200, 21.9 percent of the respondents usually spend N301-N400; 20.1 percent of the respondents usually spend N201-N300; 13.1 percent of the respondents usually spend N1-N100; 9.5 percent of the respondents usually spend N401-N500; while, 1.3 percent of the respondents usually spend above N500. In line with the above, a welfare personnel in the PHC centre stated that:

> There are drugs and services that are rendered free of charge, so people should be coming to the PHC centre. They should not bother on the cost; they should prioritize their health, because "health is wealth". In addition, we have social welfare unit; that is the unit which handles the complaints of the indigents (IDI with a Welfare Officer, 2016).

Another health personnel stressed that:

> Of course there is an issue of cost, but the cost is dependent on the quality of the drugs and the services. The cost of the drug and the services may hinder the people from coming, but it is better for those who think they do not have enough money to come to the PHC centre than to remain at home because that is why the centre is established, to serve the poor (IDI with a Health Technician, 2016).

Table 4.15: The Cost of Services Charged at the PHC Facilities

Response	Frequency	Percentage (%)
Yes	93	31.5
No	198	67.1
No response	06	2.0
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.15 presents respondents' views on whether the costs of services being charged at the PHC facility are too expensive to the clients (patients and their relatives) in Baure LGA. Out of the total sample, 66.7 percent believed the charges at the PHC centers is not too much, while 31.3 percent reported that the costs of services being charged at the PHC facility are too expensive;; and 2.0 percent did not respond. One of the medical officers met in a dispensary was asked on how the medical charges are intimidating the patients, and he revealed as follows:

> To be sincere, the drugs are not free but they are cheaper compared to other places, like chemists and hospitals. In fact, most of the people can afford to buy this drug. Another truth is that there are no enough drugs and this might be associated with the economic crises in the country. There is inflation and other problems like lack of income among the citizens.

Table 4.16: The Cost of Services Charged at the PHC Centers Influence Non-utilization of the PHC Services

Response	Frequency	Percentage (%)
Strongly Agree	133	45.0
Agree	86	29.1
Disagree	51	17.2
Strongly Disagree	27	9.1
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.16 presents respondents' views on the cost of services being charged at the PHC centers leading to non-utilization of the PHC services. The respondents who reported that they strongly agree on the fact that cost of services being charged at the PHC center lead to non-utilization of

the PHC services represent 44.8 percent; those that agree represent 28.9 percent; 17.2 percent of the total sample disagreed; and 9.1 percent of them strongly disagreed. The data shows that majority of the respondents believed that the cost of services at the PHC centers influence their non-utilization of the PHC services, this is in line with the assumption of the health belief model which state that Perceived cost of healthcare services encourage non-utilization of such services. It also corroborate the assumption of the Andersen and Newman's model that logistics involved in obtaining medical care such as the cost of services hinders utilization of healthcare services.

Section D: The Influence of Educational Attainment on the Utilization of PHC Services

This section deals with the influence of educational attainment on the utilization of PHC services. It is aimed to address the fourth objective of the study.

Table 4.17: Whether Educational Attainment Influences Perception of the PHC Service

Response	Frequency	Percentage (%)
Yes	167	56.6
No	114	38.6
Sometimes	12	4.0
No response	04	1.3
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.17 presents respondents' views on whether level of formal education influences perception of the PHC services. From the table, 56.2 percent of the sample agrees it does, while those that did not agree that the level of educational attainment influences perception of the PHC services represent 38.4 percent. Other respondents (4.0%) reported that that the level of educational attainment influences perception of the PHC services sometimes while 1.4 percent did not respond. This means level of educational attainment has an implication on the majority of

the respondents on their perception of illness and the attitude towards such illness, which corroborate the view of Caldwell (1979) that illiteracy affects the use of health services. Because most of the people may lack enabling resources, and because of high rate of illiteracy, they might not perceive the need for health service use, especially rural people, resulting in the use of unscientifically tested traditional medicine, some of which have negative health implications. The revelation from the table also supports view of Andersen and Newman's healthcare model that an individual demographic characteristic such as level of educational attainment determines their perception and actions towards health and illness. In an interview, community leader stated as follows:

> You know, one should not make any attempt to compare educated and illiterate. Educational background of a person can shape the way she/he will think and act. The educated people tend to perceive good things and all developmental activities earlier than the uneducated. That is why we asks our children who went to school if we do not know things related to health, including the expiration dates of drugs given to us in the PHC centres (IDI with a community leader, 2016).

In another interview, a health technician mentioned that:

> The educational level of a person is cultivating means of interaction between medical experts and the patients; because they will feel to understand us and we understand better too. The manners and approaches of educated persons to health also differ (IDI with a Health Technician, 2016).

Table 4.18: How Lower Educational Level affects the Utilization of PHC Services

Effects Educational Level Utilization of PHC	Yes (%)	No (%)	Total (%)
Disbelief in modern medication	185(62.3%)	112(37.7%)	297 (100%)
Neglecting children's health complications	181(60.9%)	116(39.1%)	297 (100%)
Inability to explain symptom of disease	167(56.2%)	130(43.8%)	297(100%)
Improper application of drugs prescribed in PHC centres	166(55.9%)	131(44.1%)	297 (100%)
Resorting to unhealthy traditional medication	152(51.2%)	145(48.9%)	297 (100%)
Unwillingness to come to the PHC centre while sick	141(47.5%)	156(52.6%)	297 (100%)

Source: Fieldwork, 2016

Table 4.18 presents multiple responses on how educational level affects the utilization of PHC services. 62.3 percent reported that educational level affects the utilization of PHC services through disbelief in modern medication, 60 .9 percent reported that educational level affects the utilization of PHC services by neglecting children's health complications, more than half of the respondents (56.2%) reported that educational level affects the utilization of PHC services through inability to explain symptom of disease to a medical expert, 55.9 percent reported that educational level affects the utilization of PHC services through improper application of drugs prescribed in the PHC centers, while 51.2 percent reported that educational level affects the utilization of PHC services by resorting to unhealthy traditional medication and finally, less than half (47.5%) of them reported that educational level affects the utilization of PHC services through unwillingness to come to the PHC centre while sick.

Table 4.19: Educational Qualification and the Utilization of PHC Services

Educational Level	**Utilization and Non-Utilization of PHC Services**				
	Utilization	**Non-Utili**	**Sometimes**	**No response**	**Total**
Tertiary	93(55.7%)	55(48.2%)	8(66.7%)	0 (0.0%)	156 (52.9%)
Secondary	35(21.0%)	20(17.5%)	1(8.3%)	1(25.0%)	57(19.2%)
Primary	21(12.5)	20(17.5%)	1(8.3%)	1(25.0%)	43 (14.5%)
Non-formal education	18(10.8%)	19(16.7%)	2(16.7%)	2(50.0%)	41 (13.8%)
Total	**167**	**114**	**12**	**4**	**295**

Source: Fieldwork, 2016

Table 4.19 shows the cross-tabulation of educational qualification and the influence of educational level on the utilization of PHC services. There is little difference among the respondents with tertiary level of educational, as 55.7 percent reported that level of education influences non-utilization of PHC services, while 48.2% did not agree on this notion. There is significant difference in the opinion of those who have secondary school certificates as 21.0 percent agreed and 17.5 percent did not. The difference was also reflected among those with primary school education. The revelation from the above cross tabulation was expected, that those with higher education would utilize modern health services better than those without higher education, and the finding supports the findings of a study on utilization of PHC facilities in rural areas of South-West Nigeria by Sule *et al.* (2008) which found that education is positively associated with utilization of the primary health care services. The information from the above cross tabulation supports the assumption of the Andersen and Newman's model that people's background and demographic characteristics such as attainment of higher education determines and influence favorable attitude utilization of modern healthcare services.

Section E: The Influence of Distance on the Utilization of PHC Services in Baure LGA

This section deals with the influence of distance on the utilization of PHC services in Baure Local Government Area.

Table 4.20: Distance in Reaching the Nearest PHC Centres from Home

Distance	Frequency	Percentage (%)
1 - 5km	192	65.0
6 - 10km	51	17.2
11 - 15km	16	5.4
16km and above	32	10.8
No response	06	2.0
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.20 presents responses on the distance taken to reach the nearest PHC centre from respondents' home in kilometers. Those whose distance takes 1-5km represent 64.6 percent of the total sample; 17.2 percent has the distance of 6-10km represent 17.2 percent; 11-15km represent 5.4 percent; 16km and above represent 10.8 percent and 2.0 percent of the respondents did not respond. This shows that majority of the respondents are residing within 5 kilometers of reaching a PHC center, which means there are quite a number of PHC facilities in the rural areas of the local government.

Table 4.21: The Amount Spent to Reach the Nearest PHC Center

Cost	Frequency	Percentage (%)
No Cost	38	12.8
N1-N100	10	31.7
N101-N200	48	26.2
N201-N300	36	15.5
Above N300	69	13.8
Total	**295**	**100.0**

Source: Fieldwork, 2016

Table 4.21 presents responses on the amount of money usually spent by the respondents to reach the PHC centre. From the sample, 31.7 percent reported spending 1- 100 naira as cost of receiving PHC services, 26.2 percent reported spending 101-200 as cost of receiving PHC services, while 15.5 percent reported spending 201-300 Naira, where as 13.8 percent reported spending above 300 Naira, and finally a few of them 12.8 percent reported obtaining PHC services at no cost.

Table 4.22: Distance in Reaching PHC Facilities and Influence on Decision towards PHC Services Utilization

Response	**Frequency**	**Percentage (%)**
Utilization	156	52.8
Non-utilization	120	40.6
No	21	7.1
Total	**295**	**100**

Source: Fieldwork, 2016

Table 4.22 presents respondents' views on whether the distance in reaching PHC facilities influences the decision to utilize PHC services, whereby 52.5 percent of the respondents indicated that the distance in reaching the PHC facilities influence decisions to utilize PHC services, 40.4 percent reported that distance does influence their decisions not to utilize PHC services, whereas 7.1 indicated that distance in reaching a PHC center does not influence either the utilization or non-utilization of the PHC services. By implication this mean the closer a person is to a PHC facility the more he is likely to utilize PHC services. This finding support Darmstadt et al. (2005) who were of the opinion that accessibility of health services has been shown to be an important determinant of utilization of health services in developing countries and a World Bank report of 2002 which revealed that in most rural areas in Africa, one in three women lives more than five kilometers from the nearest health facility The findings similarly,

supports the assumption of the Andersen's and Newman's model that logistics involved in obtaining medical care including distance of reaching a health care facility influences people's decision to utilize or not utilize health services.

Table 4.23: Marital Status by Distance on the Utilization of PHC services

Marital Status	**Influence of PHC Distance on Utilization PHC Services**		
	Utilization	**Non-Utili**	**Total**
Single	109(43.9%)	32(65.3%)	141(47.5%)
Married	122(49.2%)	16(32.7%)	138(46.5%)
Divorced	11(4.4%)	01(2.0%)	12(4.0%)
Separated	06(2.4%)	00(0.0%)	06(2.0%)
Total	**248**	**49**	**297**

Source: Fieldwork, 2016

Table 4.23 shows the cross-tabulation matrix on marital status and the influence of distance on the utilization of PHC services. The responses of the married respondents revealed that distance of the PHC centre influences the utilization of PHC services. For as 49.2 percent of the married respondents revealed that distance does affect the non-utilization of PHC services. In contrast, majority of the responses of the single respondents showed that the distance influences as 65.3 % indicated that the further from PHC facility the more the non-utilization as against 43.9% of the respondents who think otherwise.

4.3 The Discussions of the Major Findings

This section deals with the discussion of the major findings, based on the objectives of the study. The objectives of the study are: to establish the influence of income level on people utilization of PHC services in Baure local government area; to find out the influence cost of services on utilization of PHC services by people in Baure Local Government Area; to ascertain the

influence of educational level on utilization of PHC services in Baure local government area; to determine if the distance of PHC facility influences utilization of PHC services by the people of Baure LGA, and to assess the influence of availability of traditional medicine on the utilization of PHC services in Baure Local Government Area In view of t his, the section is divided into four subsections: the influence of cultural values on the utilization of PHC services; the influence of income level and cost of services on people utilization of PHC services; the influence of educational level on utilization of PHC services; and the influence of distance of PHC facility on the utilization of PHC services, as well as the discussion of the research findings with the Andersen and Newman's Health care utilization model.

4.2.1 *The Influence of Income and Cost of Service on People's Utilization of PHC Services*

The findings indicate that income and cost of services influence the utilization of PHC services of the perceived cost of the drugs in the PHC centers. The study findings is in agreement with the Andersen and Newman's Healthcare utilization model's assumption that individual demorgraphic characteristics such as income influences people health care utilization, as well as The Health Belief Model's assumption that the perceived cost of healthcare services determines people utilization of such services. The study finding is in agreement with that of Rimin & Akpan (2012), who also found that the household income is a major determinant of healthcare spending. Rimin & Akpan (2012) also found out that excessive reliance on the ability to pay through Out-Of-Pocket payment (OOP) reduces health care consumption, exacerbates the already inequitable access to quality care, and exposes households to the financial risk of expensive illness at a time when there are both affordable and effective health financing instruments to address such problems in low income settings. Health care financing therefore does not only involve how to raise sufficient resources to finance health care needs of countries,

but also on how to ensure affordability and accessibility of healthcare services, equity in access to medical services as well as guarantee financial risk protection.

From the study as in the large body of other researches (Kaplan *et al.*1996; Kawachi & Kennedy, 1997; Rimin & Akpan, 2012), it is obvious that economic factor is seen affecting the availability of treatment, when the cost of treatment rises above what an individual can pay or above what he considers appropriate for the perceived seriousness of the illness, then that form of treatment effectively becomes unavailable to such a person. A user charge is therefore a factor that inhibits people from proper utilization of health care services, including PHC in Baure LGA as the area of the present study.

4.2.2 *The Influence of Educational Attainment on Utilization of PHC Services*

The study revealed that educational level of individuals increases their chances of better utilization of PHC services. The finding is closely related to the finding of Caldwell (1979) who concluded that illiteracy affects the use of health services. Also, Yar'Zever & Sa'id (2013), reported that there is a low percentage of attendance for maternal health services in rural areas which is largely associated with lack of western education, especially among the women folk. Ikechukwu (2010) observes that maternal education appears to be the most significant determinant of using ANC. Furthermore, the parity, the husband's education, exposure to mass media, hearing about pregnancy complications, permission to go to hospital or health centre, geographical region of residence and wealth index showed significant influence and effect on ANC utilization.

Education is important in tackling health-related complications, sanitation, disease prevention, and curing of illnesses. In other words, education influences how one perceives to modern health

care services and determines his/her readiness to utilize the PHC services. As related to the finding, Sule *et al.* (2008) found education to be positively associated with utilization of the primary health care services. That is why Erinosho, stated that non-literate Nigerians prefer to seek treatment in the compounds of traditional healers rather than in the premises of cosmopolitan western-style health care facilities largely because they find formalities like Queuing for cards, registration, physical examination etc inconvenient to them.

4.2.3 *The Influence of Distance of PHC Facility on the Utilization of PHC Services*

The study revealed that distance of PHC locations from the place where health seekers will commute does not significantly influence utilization of the health services rendered by PHCs in Baure LGA. The finding is in agreement with the postulation of Okeshola & Sadiq (2013) and Nnebue *et al.* (2014) who found that people are facing some barriers to health services due to some factors including distance of reaching a facility. Among others, access barriers would be considered better indicators to utilization of health services than population per facility. The commonly noted barriers to proper utilization of the health care services offered by the PHC include lack of roads, time spent in accessing a facility, absence of convenient and affordable public transportation, conditions that prejudice clients' access. For Rimin & Akpan (2012), the distance to health facilities is a determinant of even the people's demand for health services. Distances to the nearest health facility has mainly an effect for the treatment of rural rich people since the rich have higher education and higher wages.

The importance of closeness of the health facility has also been noted elsewhere within Africa. For instance, Lavy & Germain (1994, as cited in Rimin & Akpan, 2012) also found out that distance to health facilities affect the take-up of the ill and the choice of health facilities in

Kenya, Ethiopia and Ghana. In their own view, Okeshola & Sadiq (2013) also recognized the development associated with antenatal care (ANC). However, distance to health facilities, inadequate Transportation and the need for immediate and specialized services have hampered women's ability to access these services in many less developed countries and northern Nigeria in particular.

4.2.4 *The Influence of Traditional medicine on the Utilization of PHC Services*

The findings of the research revealed that culture and other related belief systems such as religion and traditional medicine have a very strong influence on the perception of health and illness and consequently influence the utilization and non-utilization of the PHC services in the study area. This is not surprising going by the submission of the proponents of Health Belief Model. According to this model, the likelihood that someone will take action to prevent illness depends upon the individual's belief and the perception of the illness itself; that is the tendency of the severity of the consequences of the condition among others. In addition, culture is independent of improving the wellbeing of the members of the society. It is however the level of civilization of a particular culture that will either favor the health conditions of the members or to subject their health condition at the risk of deterioration by shaping their attitude towards an alternative medical practice which may be harmful. Although the implications for health services utilization of men's and women's social and cultural roles are a key factor in understanding women's health care experiences, the exploration of factors beyond the biological remains a serious challenge for women's health (Kazanjian, 2004).

The study also came up with an important finding that availability of traditional medicine plays significant role in the way and manner the services of the PHC centre would be accepted because the people in the area are strongly attached to their traditional and religious values in relation to

health and illness as well as their health-seeking behavior. This finding concurred with that of Ojua *et al.* (2013), as it has been observed that irrespective of racial or geographical differences all people as social beings have their unique cultural practices and beliefs. These practices are also shaping the way we perceive health and diseases as well as how people will seek for the health. Thus, Ojua *et al.* add, each society or community has it peculiar way of doing things and these practices go a long way in influencing the people's perception, attitudes and behavior in the management of diseases and health related problems that befall them. Consequently, some of the traditional beliefs of the people hamper their health by shunning the services rendered by the PHC centres. This is similar to the argument of Folashade, & Sadiq (2013). They (Folashade, & Sadiq, 2013) argued that socio-culture beliefs and the need for immediate and specialized services have hampered women's ability to health access services in many low and middle income countries including Nigeria.

It is therefore important for the health care providers in the PHC centers to have respect for people's values, preferences, and expressed needs; coordination and integration of care; information, communication, education; physical comfort; emotional support and alleviation of fear and anxiety; and to be careful with involvement of family and friends in health matters.

Thus, the findings of this study which revealed that individual's educational attainment as well as the availability of traditional medicine, influences and determines utilization and non-utilization of PHC services supports this model's assumption under predisposing factors that an individual's position within the societal structure in terms of education and occupation as well as individual's traditional beliefs determines his utilization or otherwise of healthcare services.

Similarly, the findings of this study which revealed that income, cost of services and distance of reaching a PHC facility determines and influence both the utilization and non-utilization of PHC services concurred with the assumption of this model under enabling factors which state that the logistics of obtaining healthcare services including the income of an individual, the cost of obtaining the services and the travel time spent to reach the health facility determines and influence the utilization and non-utilization of the health services.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

In this chapter three issues are addressed. Section one dealing with the summary of the major findings based on the objectives of the research; section two dealing with the conclusion remarks of the research study; and finally section three containing the recommendations derived from the findings of the study.

5.4 Summary

This study was aimed at investigating the socio-economic factors influencing utilization and non-utilization of PHC services in Baure local government area of Katsina State. The stated objectives of the study were; to assess the influence the availability of traditional medicine on the utilization of PHC services in Baure local government area, to identify the influence of income on people's utilization of PHC services in Baure local government area, to find out the influence cost of services on utilization of PHC services by people in Baure local government area, to find out the influence of educational level on utilization of PHC services in Baure local government area, determine if distance of reaching a PHC facility influences utilization of PHC services by people in Baure local government area.

On the socio-demographic characteristics of the respondents for the research study, sex distribution of the respondents showed that, male respondents were more than female respondents. The age distribution of the respondents also revealed that, majority of them were between 20 and 30 years with few of them above 51 years of age; respondents with tertiary

education were the majority and those with least educational qualification have primary leaving certificates; singles had the largest representation, followed by married; majority of the respondents are those engaged in other businesses such as grocery butchering e.t.c. followed by farmers and civil servants while others are engaged in petty trading. Similarly, respondents earning less income of N5,000-N10,999 constitute the majority of the respondents, with less of those earning N41,000 and above.

On the influence of availability of traditional medicine on the PHC services utilization in Baure local government area, the study found that; although majority of the respondents admitted frequent utilization of the available PHC centers in the area, however, cultural values attaché to traditional medicine and it's availability heavily influenced both the perception of illnesses, and utilization and non-utilization of the PHC services by the majority of the people in the area. Most of the people in the area although are making use of the PHC centers but they do not seek medical care immediately from the PHC centers as they prefer Chemists, Traditional healers, and sometimes engaged in self medication as their first line of action when sick.

While on the influence of income on the PHC services utilization, the study found that income influences and determines the utilization of PHC services by people in Baure local government area, as some of those with an income below the international standard of one dollar per day could not afford to pay for the services being provided at the PHC centers.

Similarly, on the influence of the cost of services being charged at the various PHC centers on utilization, this study found that majority of the respondents squeeze to save some of their incomes in case of illness, because user fees are being charged in most of the PHC centers in the area. Although majority believed that the amount being charged is not much, however the view

of the majority of them shows that the cost of the services is influencing the non-utilization of the available PHC centers. On the influence of level of formal education on the utilization of PHC services in Baure local government area of Katsina State, this study found that level of education does not only serve as a factor determining the perception and thinking of individuals towards illnesses but also their decisions and actions towards Primary healthcare utilization.

Finally, on the influences of distance in reaching PHC facilities on the utilization of PHC services in Baure local government area of Katsina State, this study found that majority of the respondents reside within the 5 km radius to a PHC facility. However, majority of them were of the view that distance in reaching a PHC center is a factor influencing non-utilization of PHC centers in the area with singles more reluctant to travel a distance to reach a PHC center than the married ones.

5.5 Conclusions

The study concludes that there is an above average utilization of the PHC centers by the people of the area, however sometimes being influenced by the availability of traditional medicine, and the regular utilization of the services is more among the highly educated than among those with less formal education. Similarly, the user fee charges (cost of services) and the income level of the respondents is influencing the utilization of the PHC services by those with higher income and the non-utilization by those with lower income level. As well, the distance spent before reaching a PHC center is serving as a factor determining utilization and non-utilization of the services by people in the area, with those within the radius of 5 km travelling a distance utilizing the services more than those who have to spend more travel time before reaching a PHC center.

5.6 Recommendations

Based on the findings of the study, recommendations have emerged focusing on tasking the State, and particularly the local government, NGOs and other donor agencies, community and religious leaders on specific roles to play in order to maximize the utilization of PHC services being provided at the centers which will significantly help in improving the health standards of the people in the area and consequently avoid the complications likely to occur when using untested and sometimes unhygienic traditional medicines usually taken by the people in the area.

5.6.1 The role of the State and Local governments

a. The *State and Local* governments should ensure intensification of health information awareness campaign on the importance of immediate and regular utilization of the available PHC centers and neutralize their negative cultural values towards health issues which are influencing their use of traditional healers, chemists, and self medication.

b. The governments should ensure the provision of free or subsidized essential drugs in all the PHC centers in the area in order to encourage and motivate those with less income to utilize the available PHC centers.

c. The governments should also ensure the construction of more PHC facilities and the provision of the required equipments and more qualified technical personnel as well as provide free drugs in the PHC centers in order to deal with the perceived cost of services by some people in the local government area in order to increase access to and maximum utilization of the services by the teeming population in the area.

d. The governments should ensure the incorporation of religious and community leaders in the campaign for the rural people to wholly embrace the PHC services as the most efficient and harm-free healthcare.

5.6.2 The role of the NGOs and other donor agencies

a. The various NGOs, other donor agencies and the organizations with corporate social responsibility in the state should focus on the improvement in the provision of the general PHC services in the PHC centers rather than emphasis on specific services such as polio vaccination.

b. These NGOs and other donor organizations should collaborate with the government in ensuring the provisions of more PHC facilities in the local areas and subsidized or free essential drugs which the majority of the poor rural populace can easily afford.

5.6.3 The role of the community leaders

a. The community leaders should use their influence to enlighten the people on the harmful effects of some traditional medicine being used and encourage people to embrace the services being provided at the PHC centers in the area.

b. The community leaders as fathers of all in the local communities and a bridge to the formal authorities should solicit for the provision of the required equipment needed for subsidized PHC services for their people, and where necessary help their people with the monies for some expensive drugs.

5.6.4 The role of the religious leaders

a. The religious leaders should use any opportunity available to them and enlighten the people in the communities on the need to abandon some of the harmful traditional medical practices and embrace the modern PHC services available to them.

REFERENCES

Abdulraheem,I.S., (2012*),* Primary health care in Nigeria: *Critical issues and strategies for enhancing the use by rural communities*: Journal ofpublic Epidemiology.Vol.4(1)PP5-13S

Abodunrin, O., (2014), Client's satisfaction with quality of health care Received: *Study Among mothers at healthy infants welfare clinic Semi-urban community in South-western Nigeria*: Journal of Medicine and Medical Sciences. Vol.2 (7)

Abodunrin, O.L., (2010), Awareness and perception toward referral in health care: A *Study of adults residents in Ilorin, Nigeria*: Annals of Africa medicine. VOL.9(3).

Adesina, S.A., (2014), *Barriers to accessing health care in Nigeria:* Implications for child Survival: Global Health Action

Akande, T. (2002), *Enhancing community ownership and participation primary Health care in Nigeria*: Nigeria Medical PracticePractitioner.VOL.42(1)3-7

Alan,F. (2004), *Cost and utilization of primary health care in Albania*: A National perspective On a facility- level analysis: Abt Associates Inc.

APA Center for Psychology and Health, (2014*). Briefing series on the role of psychology in Health care (primary care)*

APNA, (2012), *Definition of primary health care nursing*: supporting nurses in primary HealthCares.

Awoyemi, T.T., (2011), *Effect of distance on utilization of health care Services in rural Kogi State, Nigeria*: Journal of Human Ecology.VOL.35(1).

Barba, T. S. and Hatcher, J., (2004), *Health seeking behavior and health services utilization in Pakistan*: challenging the policy makers: Journal of public Health.

Bashiru, I.I.S, Abdulaziz, A.R. and Xicang, Z. (2013), *Accessing the influential factors on the use Of HealthCare*: Evidence from Ghana:, international Journal of Business and social Sciences.

Baliu, P.M. (1997), *On the Laminations of Rational choice theory for sociology*: the American Sociologist:VOL:28(2)pp 16-12

Bour, D., (2005) *Determinants of utilization of healthcare services by women in rural and urban areas in Ghana*. Geo Journal

Caldwell, J., (1990*), Education as a factor in mortality decline:* An examination of Nigeria data. Population Studies

Chakraborty N, Islam MA, Chowdhury RI, Bari W W,Akhter HH 2003. *Determinants of the use of maternalhealth services in rural Bangladesh. Health Promotion International*, 18(4): 327-337.

Chakaraborty, (2003), *Dererminants of the use of maternal health services in rural Bangladash*: Health promotion international.

Chinonso,C.N., (2014), *Constraints to utilization of maternal health services at the primary health care level in Nnewi, Nigeria*.

Chukwu, O.(2014*), Nigeria accounts for 13% Global Maternal Mortality Rates*: This day Newspaper, July, 12, 2014

Deaton, A. (2003), *Health inequality and economic development*: Journal of Economic literature, XXI:113-58

Ebere, Z.O.(2013), *A Review of the barriers and socio-cultural factors influencing access to Maternal healthcare in Nigeria*.

Elkana, C.N.(2014), *The place of public health nurse in National health policy in Nigeria :* A review: international of medicine and medical health services:vol.2(2),pp. 51-55 June, 2014

Darmstadt GL, Bhutta ZA, Cousens S, Adam T, Walker N, de Bernis L (2005). *Evidence-based, cost-effective interventions: how many newborn babies can we save?* Lancet 365:977–88.

Daniel, K. (2004), *Organization and management of health care services Nigeria:1960-2014*: A study of federal ministry of health, Abuja, Nigeria: st. Clement University.

David, P.R. (undated), Healthcare utilization: understanding and applying theories*: and Models of health care seeking behavior*: Case western Reserve University.

Egbewale, B.E. and Odu,O.O.(2012), Perception and utilization of primary healthcare services in semi-urban community in south-western Nigeria: *Journal of Community Medicine and primary Health Care. Vol. 24(1)*

Ekwueme, O.C. (2012), *Health consumers' perception on increasing primary health care services utilization and quality enhancement at the primary health centers in Enugu, Enugu State, Nigeria*: Nigerian Open Access Scientific Report53.

Fawole, O.A. (2006*), Sociological factors affecting perception of ill-health in Nigeria*:Ilorin Journal of Sociology.vol.(2)

Folashade, B.O. and Ismail, T.S.,(2013*),* Determined of home delivery among Hausa in Kaduna south local government area of Kaduna state, Nigeria: *America international Journal of contemporary Research. Vol. 3(5).*

Gates, M.(2015), *Reducing maternal, newborn mortality to advance Nigeria's future*: Vanguard Newspaper: October, 30, 2015.

Gobir, A.A., (2014*),* The effect of free drugs on utilization of health care Services in rural community in Northern-western Nigeria: *international Journal Medicine and Biomedical Research. Vol.3*

Guardian Editorial, (2008), the collapse of primary healthcare: Friday 25, July, 2008.

Health Council of Canada, (2005), *Primary healthcare: a background paper to accompany Health care Renewal in Canada*: Accelerating change

www.healhcouncilcanada.ca

Henry, V.D. and Tukur, D.(2010), *Utilization of non-skilled birth attendants in Northern Nigeria*: A Rough terrain to the Health related MDG's: *Africa Journal of Reproductive Health.Vol.14(2):36).*

Kaplan, G. A., Pamuk, E. R., Lynch, J. W., Cohen, R. D., & Balfour, J. L. (1996). *Inequality in Income and Mortality in the United States:* Analysis of Mortality and Potential Pathways. *British Medical Journal, 312*, pp., 999–1003.

Kawachi, L. & Kenned, B.F. **(**1997**)** The Does the Choice of Indicator Matter? *Social Science and Medicine, 45*, *1121* -1127.

Kazanzian, A. (2004). *Health Care Utilization by Canadian Women*. Women's Health Surveillance Report. Canada.

Ibrahim, M.J. & Abdulhamed, A.I.(2012*), The accessibility problems of primary Healthcare to rural people in Jigawa state, Nigeria*: Global Advanced Research Journal of social Sciences. Vol. 11(4)

Jeremy.A ,(2010*), Transportation distance and healthcare utilization for older Adults in rural and small urban areas*.

Kurfi,A.,(2013), *Understanding barriers to the utilization of primary Healthcare in low-income Setting*. Implication for healthy policy: journal of public health in Africa. Vol.4 (el3).

Katung, P.Y.(20:01), Socio-*economic factors responsible for poor utilization of primary healthcare services in a rural community in plateau State, Nigeria*: Nigeria journal of Medicine.

Manzoor I, Hashmi NR, Mukhtar F (2009,. *Determinants and pattern of health care services utilisation in post graduate students*. *J Ayub Med Coll Abbottabad,*21(3): 100-105

Marcos, C. (2004), *The origin of primary healthcare and selective primary healthcare*: American journal of public Health. Vol.94(11):1864-1874

Menizibeya, O.,(2011), *The Nigerian healthcare system: need for integrating Adequate medical intelligence and surveillance systems*: journal of Bio allied Sciences.vol.3(4).

Mohammed, A.S., (2010), *Structure of primary healthcare :lessons from a rural area in south-western Nigeria*: journal of Clinical Medicine.Vol.3(1).

Muldong K.L., Hogg W.E., Levitt M., (2006), Primary Care (PC) *and Primary Healthcare (PHC): What is the Difference*: PubMed Sept.-October 2006

Newman, E. and Omodu, S., (Undated*), Under-utilization of modern healthcare Facilities and practices of alternative medicine in rural areas of Rivers State*

National Primary Healthcare Development Agency,(2015*), Our History*.

Nnebue, C. C., Ebenebe,U.E., Nwabueze,A.S., Obi-okaro, A C., Ubajaka, C. F., Ilika, A. (2014). *Constraints to utilization of maternal health services at the primary health care level in Nnewi, Nigeria*. *Orient Journal of Medicine Vol 26 [3-4]*pp. 99-106.

Odetola, T.D. (2015*), Health care utilization among rural women of childbearing age*: a Nigerian experience: the pan –African Medical journal.

Ojua, T.A., (2013*), African cultural practices of health implications for Nigeria rural development*: international Review of Management and Business Research .vol.2 (1)

Onah H, Ikeako L, Iloabachie G 2009. *Factors associatedwith the use of maternity services in Enugu, southeastern Nigeria*. *Social Science and Medicine*,63(7): 1870-1878.

Onasoga, O.A., (2014), *Awareness and barriers to utilization of maternal Healthcare services among Reproductive women in Ammaso Community, Bayelsa State, Nigeria*: international journal of Nursing andMidwifery.vol.6 (1).

Owoseni, J.S., (2014), *Socio-economic status and utilization of healthcare Facilities in rural Ekiti, Nigeria*. Standard Research Journal of Medicine And Medical Sciences. Vol.2 (1):001-043

Pate, A.M. (2013), Improving *primary healthcare centers in Nigeria*: Pharmanewsonline vol. 37 (6).

Peters, D.H., (2008), *Poverty and access to healthcare in developing Countries*: AnnalsN.Y. Academic Sciences. Principles of primary health care (2005),www.networklearning.org/books.html.

Rebhan D.P., (Undated), *Health Care Utilization: Understanding and applying theories and models of health care seeking behavior*: Case Western Reserve University

Riman, H.D. & Akpan, E. S. (2012). *Healthcare Financing and Health outcomes in Nigeria:* A State Level Study using Multivariate Analysis. International Journal of Humanities and Social Science. Vol. 2 No. 15.

Sani, A.M. (2011), *Management of primary healthcare in local governments in Nigeria*: Between Community and Environmental Health Officers.

Sorungbe, O.O. (1989), *Utilization of primary healthcare at local government Level*: Lagos Academy press ltd.

Sule, S.S., (2008), *Utilization of primary healthcare facilities: lesson from a Ruralcommunity in south-western Nigeria*: Nigeria journal of Medicine.Vol. 17(2).

Sunday, A.A., (2014), *Barriers to accessing healthcare in Nigeria*: Implications for child survival.

Steve, M. (2009), *Primary healthcare services for effective healthcare Development in Nigeria*: Journal of Research in National Development.Vol.7 (2).

The college of family physicians of Canada, (2013), *The role of the federal Government in Healthcare*: Report card 2013.

The Health Belief Model, (2013), Boston University of Public Health/mobile page

UNFA NIGERIA COUNTRY OFFICE,(2010), *Healthcare services in UNFA assisted States of Nigeria*: Lagos State Report

UNICEF Nigeria, (2015*), Maternal and Child Health*

United for sight, (2015), *primary healthcare:* Global Health History online Course.

Usman, A. M. (2010). *How to end Poverty in Jigawa State*. www.peoplesdaily-online.com/opinion/opinion/1448 19th December,2010.

www.baurelga.kts-ng.org, 2008

www.who.int/about/definition, (2015)

WHO (1946), *The Constitution of the World Health Organization*: Principles

WHO (1978), *Declaration of Alma-Ata: International on Primary Healthcare*: Alma-Ata, USSR, 6-12 Sept. 1978

WHO (2013), *World Health Report* 2013: Research for Universal Health Coverage

WHO 2015 (2015), *Tracking Universal Health Coverage*: First Global Monitoring Report: June 2015

Wikipedia,2012.

World Bank (2002). Health Systems Development Project II. Washington, DC: World Bank.

World Bank, (2010), *Improving primary healthcare in Nigeria: Evidence from four states*: World Bank Working Paper No:187

World Health Organization (WHO1989):Alma-Ata primary healthcare *(Report of The international Conference on Primary Healthcare, Alma-Ata,USSR*).

Workforce Taskforce, (2008), *Working together for better primary. HealthCare: overcoming barriers to workforce change in innovation*: Wellington Ministry of Health, new Zealand.

Yar'zever, I.S. and Said I.Y. (2013), *knowledge and utilization of maternal healthcare services in Kano State, northern Nigeria*: European Journal of Biology and Medical Science Research. Vol1 (1)-14.

APPENDIX I

RESEARCH QUESTIONAIRE

Dear Respondent,

I am an M.Sc. candidate in the Department of Sociology, Bayero University, Kano. I am conducting a research on the factors influencing the utilization and non-utilization of Primary healthcare services in Baure Local government area of Katsina state. Kindly spare your time and respond to the following questions. The research is purely for academic purpose and your responses will be treated with utmost confidentiality.

Socio-demographic information of the respondents

1. Sex distribution of respondents

Male ☐ Female ☐

2. Age distribution of respondents

20-30yrs ☐ 31-40yrs ☐ 41-60yrs ☐ 61years and above ☐

3. Marital status of respondents

Married ☐ Single ☐ Divorced ☐ Separated ☐

4. Educational attainment of respondents

Primary ☐ Secondary ☐ Tertiary ☐ No formal education ☐

5. Occupation of respondents

Civil service ☐ Farming ☐ Driving ☐ Petty trading ☐ Others ☐

6. Monthly income of respondents

5,000-10,999 ☐ 11,000-20999 ☐ 21,000-30999 ☐ 31,000-4099 ☐ 41,000 & above ☐

Respondents' view on utilization and non-utilization of PHC centers

7. Do you make use of PHC centers?
   Yes ☐ No ☐ Sometimes ☐
8. Where do you first go when ill before attending PHC facility?

Chemist ☐ Traditional healers ☐ Self Medication ☐ None ☐

9. When do you usually present yourself to a PHC facility

Immediately when ill ☐ When I feel severe pain ☐ When it get worse ☐

Respondents view on the influence of cultural values on the utilization of PHC services

10. Does any of your traditional or religious values influence your perception and understanding of illnesses?

Yes ☐ No ☐ Sometimes ☐ If yes how?……………………………………………………

11. Your attitude towards cultural traditional medicine influence your Utilization of the PHC services
    Strongly Agreed ☐ Agreed ☐ Disagreed ☐ Strongly D ☐

Respondents view on the influence of Income on their utilization of PHC services

12. Do you save money in case of illness

Yes ☐ No ☐

Why?…………………………………………………………………………….………..

13. Does your income serve as a determinant of your;

    Utilization of PHCservices ☐ Non-utilization of PHC services ☐ None ☐

Why?…………………………………………………………………..…………………

Respondents view on the influence of cost of services on their utilization of PHC services

14. What is the minimum you usually spent for PHC services? …………………………………………………
15. Do you consider the cost of services being charged at the PHC center as too much or excessive?

Yes ☐ No ☐

Why?…………………………………………………………………………………………

16. The cost of the services being charged at the PHC center determines utilization of the PHC services?

    Strongly Agreed ☐Agreed ☐isagreed ☐rongly Disagreed ☐

Respondents view on the influence of educational attainment on their utilization of PHC services

17. Does your level of formal education influences your perception and understanding of the PHC services?

Yes ☐ No ☐

Why…………………………………………………………………………………………?

18. Do you think your level of formal education influence your decision to towards PHC services utilization………………………………………………………………………….?

Respondents view on the influence of distance in reaching a PHC facility on their utilization of the PHC services

19. What is the distance of reaching the nearest PHC centre from your home

1-5km ☐ 6-10km ☐ 11-15km ☐ 15km & above ☐

20. How much do you spend to reach the nearest PHC center?..

21. Does nearness to a PHC center reduces the cost of obtaining PHC services?............................
22. Does the distance of reaching the PHC center influence your decision:

Utilization PHC services ☐ Non-utilization of PHC services

Why?………………………………………………………………………………………..

APPENDIX II

BAYERO UNIVERSITY, KANO
FACULTY OF SOCIAL AND MANAGEMENT SCIENCES
DEPARTMENT OF SOCIOLOGY
INTERVIEW GUIDE FOR KEY INFORMANTS

Dear Sir/Madam,

I am a Postgraduate student in the Department of Sociology, Bayero University, Kano. I am conducting research on the topic: "A Study of Factors Influencing Utilization and Non-utilizatio of PHC services in Baure Local Government area of Katsina State. Kindly spare your time and respond to some questions which are strictly academic and. Your responses

Thank You.

Yours faithfully,

Junaidu Abdulkadir

Introduction

1. Where do people mostly go before PHC centers?
2. Does traditional medicine affect level of PHC services utilization in this area?
3. Do you think people's income affect their utilization of PHC services?
4. Do you think people in this area save money in case of illness?
5. Do you think the costs of the services being charged at the PHC centers are too much?
6. Do you think level of education influence perception of illness and level of PHC services utilization?
7. How do you think lower level of education affect people's PHC services utilization?
8. Do you think distance of reaching a PHC center influence people's utilization?