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Health Consumer's Perception on Increasing Primary Health Care Services Utilization and Quality Enhancement at the Primary Health Centers in Enugu, Enugu State, Nigeria

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Abstract

Background: Primary healthcare, which is supposed to be the bedrock of the country's health care policy, is currently catering for less than 20% of the potential patients.

Aim: This study assessed the knowledge and perception of women of child bearing age (15-49 years) about the health services offered at the PHC centers and the factors militating against the efficient and effective use of these services.

Methods: The design is a descriptive cross-sectional. A multistage sampling method was used in sample selection. Data instrument was a semi-structured questionnaire, pretested and interviewer administered. Data analysis was done using a statistical software package, Epi-info version 3.3. Confidence interval was at 95% and level of significant set at 5%.

Results: 300 women were studied. 17 (7.8%) of the 219 (73.0%) women aware of the existence of primary health care centres in their localities used the services offered monthly, 20 (9.2%) used it often while 126 (57.5%) used occasionally. Immunization 183 (61.0%), antenatal services 162 (54.0%) and treatment of minor ailments 157 (52.3%) were the most health services known by the women. On the average, 118 (39.3%) of the women agreed on the positive statements regarding the quality of health services, 48 (16.0%) disagree while 134 (44.7%) were uncertain. Poor staff attitude 139 (46.3%), incomprehensive health services 128 (42.7%), distance of the health center 111 (37.0%) and unavailability of doctors 107 (35.7%) were the militating factors. Improvement in the worker's salary 207 (67%), making health service completely free 195 (65%), ensuring regular supply of drugs and recruiting more doctors 192 (64%) each, retraining of health staff 188 (62.7%), erecting more health centers 187 (62.3%) and ensuring regular supply of electricity 184 (61.3%) were recommended.

Conclusion: Primary health care services were grossly under-utilized and the quality rated poor. Health service and personal factors were implicated.

Keywords: Health consumers; Primary health care; Health centers; Health services utilization

Introduction

The Joint World Health Organization and United Nations (WHO-UNICEF) International Conference in 1978 at Alma-Ata (USSR) having recognized the failure of the then conventional health care systems to provide equitable, accessible and affordable health care to the citizenry, especially in the developing countries called for a revolutionary approach to health care, declaring primary health care as the way to achieving WHO goal of Health for all by 2000 AD. The services provided under the primary health care system are described as "essential health care" made available and accessible to all people at the first level of care [1].

In the Nigeria, as is the case in many other countries in sub-Sahara Africa and South-East Asia, several serious attempts have been made at implementing primary health care especially in the areas of construction of basic health units (Comprehensive health centers, primary health centers health clinics, posts and mobile units) with the objectives of providing essential services, correcting geographical imbalances between rural, urban and regions and utilizing the lowest cadre of staff capable of accomplishing some basic tasks. Attempts were also made at implementing component primary health care programmes by the three tiers of the government though in the absence of clearly mapped-out policies, programme plans and objectives leading to poor service integration [2].

Despite these short comings, several achievements and progress where made in the early implementation stage as health indicators showed that most communicable and non-communicable diseases in Nigeria were put at a halt. Immunization programme jumped from less than 20 percent to 80 percent [3]. However, these achievements were not sustained due to utter neglect by the stakeholders and poor financial support in terms of specific budgetary allocation and release far below the recommended 15% of the total budget by the World Health Organization [3].

Over 20 years after the introduction and implementation of the primary health care in Nigeria, the country is yet to witness the much desired impact of promoting and protecting health, preventing diseases and reducing mortality, morbidity and disabilities associated

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with diseases and illnesses. The health system performance of the country was ranked 187th among the 191 member states by the WHO and lowest among the 146 countries that have failed to stem maternal and child mortality ratio in 2008 [3].

Maternal Mortality in Nigeria is one of the highest in the world[4]. In the first five years of the millennium, maternal mortality rose by 14 percent from 704 to 800 per 100,000 live births while under five mortality rate rose from 97 to 110 per 1000, an increase of 13 percent. The causes of these under-five mortalities regrettably are preventable and treatable diseases like diarrhoea and pneumonia while that of maternal mortalities such as haemorrhage, pre-eclampsia/eclampsia, sepsis and septic abortions can be predicted to a large extent and treated at the primary healthcare centers where emergency obstetric care capacities and functions are available [3-5].

Several reasons have been given for the poor performance of primary healthcare system in Nigeria, most of which centers on the supply side than the demand side. According to two former president of Nigeria Medical Association, Primary healthcare system has deteriorated to an unacceptable level due to inefficiency and corruption on the part of the people positioned to consolidate what the founding fathers like Ransome Kuti started, who rather spend time paying lip service to the system [3]. The available data showed that 70% of all ailments could be treated at the primary care levels and just 20% need to get to the secondary level while 5% to the tertiary level. But now, primary healthcare, which is supposed to be the bedrock of the country's health care policy, is currently catering for less than 20% of the potential patients [3]. Other reasons given for low performance of primary healthcare by experts includes grossly inadequate number of facilities (One PHC for 60,000 to 80,000 Nigerians), unavailability of drugs, inadequate health personnel, poor and dilapidated infrastructures and poor understanding of the place of primary health care delivery system by the Nigerian citizens [3].

In the recent past however, government of Nigeria has taken a bold and giants step to strengthen the primary healthcare by constructing over 500 model healthcare centers and equipping them with medical equipments and seed of drugs for drug revolving fund schemes, yet most of the facilities are nonfunctional and where functional are poorly utilized. The senate of Nigeria has also passed the National health bill aims to establish a framework for the regulation, development and management of the national health system and underpins primary healthcare as the entry point into the national health system [6].

It is no longer in doubt that despite the progress and achievements made so far in the implementation of the primary health care programme, the services provided are grossly under-utilized. Even in states like Enugu where some aspects of health services are free such as free maternal and child health services, most of the women do not utilize these services [7]. Other survey studies outside Nigeria also reported low maternal health services utilization at the PHC facilities [8-11]. Women and children are among the major stakeholders of health and the most vulnerable group in the society and bear the brunt of the consequences of the deteriorating health system. Women and their children also are the group in the society that most frequently use health services at any of the three levels of health care. Most of the health care services target women and their children and thus they are in a better position to assess and evaluate services provided at the PHC centers in the spirit of community involvement and ownership.

Thus, this study seeks to find out the knowledge of women of child bearing age (15-49 years) about the health services offered at the PHC centers, how frequent they use these health services and their views about the quality of the services received. The study also assesses the factors acting as deterrents to the effective and efficient use of the available health services and the proffered solutions. The findings of this study will assist the stakeholders of health in making an evidence based decisions and policy formulations that will enhance or improve health system performance as well as form a data base for future interventions on the part of the healthcare providers and the consumers.

Materials and Methods

Enugu state is made of 17 Local Government Areas (LGAs). Enugu urban, the study area is made of three LGAs visa viz: Enugu North, Enugu East and Enugu South. The study LGA, Enugu South has a population of 198,723 (94,461 male, 104,262 female) by 2006 National population census. The study design is a descriptive cross-sectional type, involving a calculated sample size of 300 women of child bearing age (15-49 years). A multistage sampling method was used in sample selection. Enugu South LGA was selected out of the three LGAs in Enugu Urban by simple random sampling technique. Out of the mine communities in Enugu South, Uwani and Maryland communities were selected using simple random sampling method. Uwani community had 50 streets while Maryland had 18 streets. This gives a ratio of approximately 3:1 streets. Nine and three streets were randomly selected from Uwani and Maryland respectively. Each street is estimated to have an average of 100 households, resulting to a total of 900 households in the selected Uwani streets and 300 household in the Maryland streets.

Out of the sample size of 300 women of childbearing age studied, 225 and 75 were proportionately allotted to Uwani and Maryland respectively. Using the primary healthcare (PHC) household numbering and a sampling interval of four (4) for each community, 225 and 75 women of childbearing age were selected by systematic sampling method from Uwani and Maryland respectively. The first woman in each household who met the inclusion criteria and gave orally informed consent was interviewed. Information elicited are the socio-demographic variables, awareness and frequency of use of health centers, knowledge of the available PHC services, quality of services, factors affecting health services utilization and proffered solutions. An interviewer administered questionnaire pretested in another LGAs was used. Data analysis was done using statistical package for social sciences (SPSS) version 11.0 and Epi-info version 3.3.2. Frequency distribution tables were used in data presentation and chi-square test of significance was applied were appropriate. Confidence interval was at 95% and level of significant set at 5% ($p<0.05$ considered significant).

Results

Three hundred questions administered were completely filled. The women of child bearing age interviewed ranged from 15–49 years with mean age 25.8 years. Most, 185(61.7%) were within the age range 20-29 years (Table 1), students 178(59.3%), married 201(67%) with predominantly tertiary level education 150(50%). Majority, 288(96%) were of Christian religion with Catholic, 159(53.0%) the predominant Christian denomination.

219 of the women (73.0%) were aware of the existence of health center within their locality. Only 17(7.8%) of the 219 uses the health center monthly while 20(9.2%) uses the health center services often. Immunization 183(61.0%), antenatal services 162(54.0%) and treatment of minor ailments 157(52.3%) were the most primary health center services known by the women of child bearing age. Knowledge

of other services such as family planning, health education/counseling and delivery services among the women were 139(46.3%), 136(45.3%) and 136(45.3%) respectively (Tables 2 and 3).

The positive statements on the quality of primary health center services were rated by the women and were scored as follows: strongly agree (4), agree (3), disagree (2), strongly disagree (1) and uncertain (0). In all the ten positive statements regarding the quality of services rendered at the PHC centers (Table 4), on the average 16.8% of the women strongly agreed, 22.7% agreed, 13.3% disagreed, 2.9% strongly disagree while 44.3% were uncertain or skeptical about the quality of services offered.

The most important factors identified by the women militating against efficient use of health center services in the decreasing order of importance were poor staff attitude 139(46.3%), incomprehensive health services 128(42.7%), distance of the health center 111(37.0%) and unavailability of doctors 107(35.7%). In order to improve the use of health services at the primary level, the women recommended the following in the decreasing order of importance: improvement of workers salary 207(67%), making health service completely free 195(65%), ensuring regular supply of drugs/vaccines and recruiting more doctors 192(64%) each, retraining/retraining of health staff 188(62.7%), erecting more health centers 187(62.3%) and ensuring regular supply of electricity/power 184(61.3%).

Age group (years)	Frequency	Percentage
15–19	44	14.7
20–24	113	37.7
25–29	72	24.0
30–34	36	12.0
35–39	18	6.0
40–44	9	3.0
45–49	8	2.7
Total	300	100

Table 1: Age distribution of the Respondents.

Characteristics	Frequency N=300	Percentage
Occupation:		
Student	178	59.3
Trader	48	16.0
Business woman	27	9.0
Civil servant	26	8.6
Applicants	12	4.0
Artisans	9	3.0
Marital Status:		
Married	201	67.0
Single	99	33.0
Religion:		
Roman Catholic	159	53.0
Pentecostal	75	25.0
Anglican	54	18.0
Traditional	11	3.7
Islam	1	0.3
Level of Education:		
Tertiary	150	50.0
Secondary	6	2.0
Primary	138	46.0
No formal education	6	2.0

Table 2: Socio-demographic characteristics of the Respondents.

Variable	Frequency N=300	Percentage
Awareness of health centre	219	73.0
Use of Health Centre:	N =219	
Occasionally (sometimes)	126	57.5
Never	44	20.0
Many times (often)	20	9.2
Frequently (monthly)	17	7.8
Uncertain	12	5.5
Uncertain	219	100
Total	300	100

Table 3: Awareness and use of local health centers by the Respondents.

Knowledge of PHC Services	Frequency N=219	Percentage
Immunization	183	83.6
Antenatal services	162	74.0
Treatment of minor ailments	157	71.9
Family planning	139	63.5
Health education/counseling	136	62.1
Delivery services	136	62.1
Pharmacy services	117	53.4
Laboratory services	97	44.3
In/out patients' services	80	36.5
Referral services	68	31.1
Community dental services	41	18.7
Community mental health	26	11.9

Table 4: Knowledge of PHC services offered in health centres by Respondents.

Discussion

Majority of the respondents studied were within adult age bracket 20-29 years, married and understandably students as the major secondary occupation of Enugu urban residents is education, considering the vast number of educational institutions in the metropolis offering opportunities for the residents, marriage and single alike further their education.

Women's lack of awareness can range from lack of understanding of what PHC services are, to lack of knowledge of the location of a healthcare delivery site [12]. In this survey, not all the women of the reproductive age group studied were aware of the existence of health centre within their locality. Ordinarily, it would be expected that all the women should be aware of the availability of health center in their area. Although appreciable percent of the women (73%) were aware, yet this negates the spirit of bringing healthcare to the door step of the people. This incomplete awareness among the women may have contributed also to the irregular or varied use of the health center services. Less than ten percent of the women assess primary healthcare services regularly or frequently while the rest only uses health center services sometimes or occasionally. Again, this is not in consonant with the philosophy of making primary healthcare the first level of contact of individual, especially the women, the family and the community with the national health system [2]. Women carry a considerable burden as bearers of children and careers of families including family health while still suffering from poorer schooling and low status, the fact which among others lead to the conception of primary healthcare [2].

The 20% of the women who never used health center services in this study may be among the 27% who were not aware of the existence of health center in their localities. This inference is supported by a study on the factors influencing utilization of postnatal services in Mulago and Mengo hospitals in Kampala, Uganda where it was found that women who did not attend postnatal services either did not known the

location of the health centers or were not aware of the services rendered in those hospitals [12].

Knowledge is an important factor in the utilization of PHC services. In this study, awareness of the presence of PHC centers were high just as the knowledge of the services offered by the health centers were also high. The high awareness and knowledge may have positively influenced the use of the health services in this study as about 80% of those who were aware of the existence of health centers in their localities also utilize the services though in a varying degrees. The variation in use may be that the people have not yet fully understand the place of primary healthcare delivery system in health care or the infrequent use may be a result of several factors identified by the women in this study such as poor staff attitude, incomprehensive health services, location or distance of the center from the people and non-availability of medical officers or doctors (Tables 5 and 6). Similar findings of the positive effects of client's and women's knowledge to the utilization of health services had been demonstrated by other researchers [12]. In one of the studies, Agrawal et al. found out that of the 26.2% of the mothers who knew about postnatal services. 25% utilized the services [9].

Generally, the rating of the quality of services offered in the PHC centers by the women of child bearing age was poor as majority were uncertain or skeptical about the quality of services offered in these health centers. However, among the women that were certain about the nature of the quality of services offered, more were satisfied compared to those who were not satisfied with a statistically significant difference (p=0.000). The average percent of those who expressed some form of satisfaction was less than 40% while those dissatisfied were less than 20%. Among the factors identified as contributory to the poor satisfaction in addition to the ones earlier stated include lack of confidence in the staff, lack of drugs, incompetent staff and high cost of services in the decreasing order of importance. The poor satisfaction in this study is in contrast to findings in other studies outside the shore of Nigeria probably because these factors borders on attitude, poverty and ignorance. However, similar findings and observations were made in the survey studies done within the country.

In their focused group study in the USA, Anderson et al. reported that most of the women were satisfied with the humaneness, competence, convenience (short waiting time) and facilities in the health care delivery system [13]. Singh et al. reported that respondents in Trinidad and Tobago appear to be generally satisfied with the services of health centres and showed that respondents were satisfied with comfort of the health centres (Table 7), the distance, medical care and short wasting time [14]. Singh et al. additionally reported that patients were dissatisfied with incompetence, attitude, management, as well as staffing and funding of health centres [14]. These findings to some extent conform to the findings in this study. The dissatisfaction due to poor environment observed in this study also agrees with Anderson et al. finding in the area of environmental cleanliness as according to them, the environment could function to communicate to the patients the level of confidence with which they could entrust their lives to the health care system [13].

There is a relationship between the quality of services rendered in Health Centres, the level of satisfaction of the patients, and the barriers to utilization. Uzochukwu et al. reports that long waiting queues, providers' behaviour and lack of doctors militate against the utilization of maternal and child health services [15]. In addition to the factors reported in the study by Uzochukwu et al. incomprehensive services, distance of health centre to the users, lack of confidence in the staff, absence of drugs, incompetent staff and high cost of services in decreasing order were also found in this study. According to report from Safe Motherhood, poor quality of care is the most common reason why women do not seek care or do so late. Timyan et al. also agree with the poor quality of services offered by Health Centres and concluded that healthcare that is not considered appropriate will not be used [12].

Distance to Health Centres ranked third among the factors that militate against the use of PHC services in this study. Several other authors similarly reported the barrier posed by the location of health centers from the end users [12]. Clarke reported that women do not access antenatal care because of the distance from their homes to the clinics and inadequate transportation among others [12]. This is also consistent with the findings of Mivaniki et al. in Kenya that mothers who were living in a distance of less than 5 kilometers from the health facilities utilized the services better than those who lived a distance 5

Variable	Satisfied			Dissatisfied			Uncertain	Total
	Frequency (%) N=300			Frequency (%) N=300			Frequency (%)	
	SA	A	Total	DA	SDA	Total		
Services are adequate	54(18.0)	73(24.3)	127(423)	36(12.0)	8(2.7)	44(14.7)	129(43.0)	300
Services are comprehensive	37(12.3)	74(24.3)	111(37.0)	41(13.7)	9(3.0)	50(16.7)	139(46.3)	300
Members of staff are competent	45(15.0)	60(20.0)	105(35.0)	47(15.7)	7(2.3)	54(18.0)	141(47.0)	300
Members of staff are friendly	53 (17.7)	72(24.0)	125(41.7)	44(14.6)	6(2.0)	50(16.6)	125(41.7)	300
Aseptic procedures arc used	46(15.3)	46(15.3)	92(30.6)	40(13.3)	7(2.4)	47(15.7)	161(53.7)	300
No re-use of syringes	68(22.7)	54(18.0)	122(40.7)	20(6.7)	13(4.3)	33(11.0)	145(48.3)	300
Drugs are available	54(18.0)	68(22.7)	122(40.7)	43(14.3)	8(2.7)	51(17.0)	127(42.3)	300
Short waiting time	37(12.3)	63(21.0)	100(33.3)	63(21.0)	16(5.3)	79(26.3)	121(40.3)	300
Environment is clean	57(19.0)	81(27.0)	138(46.0)	39(13.0)	10(3.3)	49(16.3)	113(37.7)	300
Affordable services	52(17.3)	87(29.0)	139(46.3)	23(7.7)	11(3.7)	34(11.4)	127(42.3)	300
TOTAL	**503(16.8)**	**678(22.7)**		**396(13.3)**	**83(2.9)**		**1328(44.3)**	

Chi-square (χ^2) of overall 'satisfied' against 'not satisfied'
χ^2=27.40, df=9, P=0.000*
*Highly statistically significant.
Legend:
SA=Strongly Agree
A =Agree
DA=Disagree
SDA=strongly disagree

Table 5: Respondent's rating of the quality of services offered by the health centres and their level of satisfaction.

Factor	Frequency N=300	Percentage
Poor staff attitude	139	46.3
Incomprehensive health services	128	42.7
Distance to health centre	111	37.0
No doctors available	107	35.7
Lack of confidence in the staff	96	32.0
No drugs	90	30.0
Incompetent staff	86	28.7
High cost of services	83	27.0

Table 6: Factors militating against the use of health services by respondents.

Solutions	Frequency N=300	Percentage
Improve worker's salary	207	67.0
Make health services free	195	65.0
Regular supply of vaccines/drugs	192	64.0
Employ more doctors	192	64.0
Train/re-train staff	188	62.7
Build more health centers	187	62.3
Regular power supply	184	61.3
Good roads	161	53.7
Provide security	153	51.0
Improve referral services	97	32.3

Table 7: Solutions proffered by respondents on how to Improve PHC service utilization and ensure quality.

kilometer away and beyond [12]. Gulliford et al. also found out that distance from a service is inversely associated with its utilization [12]. Timyan et al. contend that distance limits women's willingness and ability to seek health care, particularly when appropriate transportation is scarce, communication difficult, and terrain and climate harsh [12].

Cost of services ranked lowest in this study as a militating factor to use of PHC services. However, the mothers in this study also ranked free service as number two in the solutions preferred that will enhance service utilization. The inference would be that cost of service though is important but not as important as the quality of service provided. This is in line with the findings in the study conducted by Uzochukwu et al. on the community satisfaction with maternal and child health services where majority of the respondents were willing to pay for health services if drugs are available with overall improvement in quality [15]. Similarly, Griffith working in the UK, reported that socio-economic status was not a barrier to service use if women perceived the benefits of the service to overweigh the costs. However it has been assumed that the women in the UK can ultimately afford the services [12].

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