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Assessment Of Rural Womens' Access To Primary Health Care Services In South West Nigeria

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***Abstract:** This study assessed rural women's access to primary health care service (PHCs) in southwest, Nigeria. The study was conducted in rural communities of Ekiti and Oyo state in southwest Nigeria. A validated interview schedule was used to source information from one hundred and sixty rural women for the study. Descriptive statistics such as frequency counts, percentage means, and ranking were used to summarize the data. Pearson correlation and chi-square (X^2) were used to determine the relationships between selected socio-economic characteristics of respondents, constraints and accessibility to PHCs respectively. The study revealed that the mean age of rural women was 39.3years, 61.7% were married, and 83.3% had formal education. The major PHCs available in the study area was immunization. The major constraints to PHCs were inadequate health personnel, inadequate health facilities, non-availability of right type of service. There were positive significant relationships between educational ($r=0.082$, $p\leq0.05$) and marital statuses ($r=0.28$, $p\leq0.05$) of rural women and their accessibility to PHCs. Also there were significant associations between constraint such as inadequate health facilities ($x^2 30.0$, $p\leq0.05$)) inadequate health personnel ($x^2 18.9$, $p\leq0.05$), non-availability of the right type of service ($x^2=18.14$, $p\leq0.05$) and accessibility to PHCs. It was concluded that the pattern of PHCs availability dictated the pattern of PHCs accessibility, government at different levels and various stakeholders on PHCs should find a way of ameliorating constraints to PHCs in order to improve health conditions of rural dwellers generally.*

***Keywords:** Assessment, accessibility, primary health care services, rural women.*

I. INTRODUCTION

The basic requirement for an individual to live a socially and economically productive life is sound health. The world health organization reported that Africa loses one percent in economic growth annually to epidemic diseases (WHO, 2000). Poor health inflicts great hardships on households generally and worst still rural families, including debilitation, substantial monetary expenditures, loss of labor and sometimes death.

The primary health care services in Nigeria and the health statuses of Nigerians are in deplorable states. Access to healthcare services is a multidimensional process involving the quality of care, geographical accessibility, availability of the right type of care for those in need , financial accessibility and acceptability of service (Peters *et al.,* 2008).

There has been a growing recognition of the challenge of rural people's health issues and the need for it to be addressed (Hamid *et al*, 2005). There is a huge shortage of qualified practitioners in the rural areas. Accessing health care in rural

areas is confounded by problems such as insufficient health infrastructure, the presence of chronic diseases and disabilities, socio-economic and physical barriers (Ricketts, 2009).

There is no doubt that rural farmers have immense potentials which can be tapped to enhance the economic survival of the nation. The health conditions of rural farmers in Nigeria should therefore be of utmost concern to the government and other stakeholders. The on-farm and off- farm activities of rural farmers contribute to the economic growth of the nation and provide job for the teaming population and most essentially service as source of food for the people (Onumadu and Egeonu, 2012).

The essence of health care to grassroots is to make sure that the management of PHC services are more effective and closer to the people. However, in view of the level of health awareness, one begins to question the extent to which health care has been taken to the doorstep of the rural people. One of the hindrances to the development of health especially in Nigeria has to do with insufficient number of medical personnel as well as their uneven distribution. The third development plan (1975 to 1980) for Nigeria focused on the inequality in the distribution of medical facilities and manpower/personnel. Despite the desire by the government to ensure a more equitable distribution of resources, glaring disparities are still evident. The deterioration in government facilities, low salaries and poor working conditions had resulted in a mass exodus of health professionals (Iyun, 1988). There has been too much concentration of medical personnel at the urban to the neglect of the rural areas. Other significant problems in the management of PHC are poor transportation, inadequate immunization outreach, inadequate finance, over dependent of LGAs on federal, state and international agencies for supports because of the meager amounts being generated by LGA. All the above mentioned problems among others are militating against rural people's farm productivities. Killen, (2005) indicates that rural households have in Nigeria incurred heavy losses due to poor health through expensive health care fees and menace of fake drugs. Since rural women are integral part or rural families; therefore, based on the seemingly poor health statuses of rural families, the study proffered answer to the following research questions:

What are the socio-economic characteristics or the rural women in the study area?

What are the primary health care service services which are available in the study area?

Do rural women have access to primary health care services in the study area? and

What are the constraints militating against respondents' accessibility to PHC services in the study area.

OBJECTIVE OF THE STUDY

The major objective of the study is to assess the rural women's accessibility to primary health care services in South West, Nigeria.

The specific objectives are to:

- ✓ describe the socio-economic characteristics of rural women in the study area;
- ✓ identify the available primary health care services in the study area;
- ✓ examine primary of health care services which are accessible to rural women in the study area; and
- ✓ identify the constraints militating against rural women's accessibility to PHCs.

HYPOTHESIS

Ho_1: There is no significant relationship between socio-economic characteristics of rural women and their accessibility to PHCs.

Ho_2: there is no significant relationship between the constraints militating against rural women and their accessibility to PHCs.

II. METHODOLOGY

The study was carried out in Southwest Nigeria. Southwest is one of the six geopolitical zones in the country comprises of Oyo, Ogun, Lagos, Osun, Ekiti and Ondo states. The major ethnic group in the zone is the Yorubas. Data were collected through the use of a structure interview schedule. A multi-stage sampling procedure was employed to select one hundred and eighty rural women for the study. The first stage involved a random selection of one-third of the total number of states in southwest which were Ekiti, Osun states. The second stage involved the proportionate selection of three Local Government Areas (LGAs) from sixteen LGAs in Ekiti state and six LGAs from thirty LGAs in Osun state. Thus, a total of nine LGAs were selected from the study. The third stage involved a random selection of two communities from each of the LGAs sampled for the study. The final stage, involved a random selection of ten rural women from each community, making a total of one hundred and eighty (180) rural women for the study. Descriptive statistics such as frequency counts, percentage, and means were used to summarize respondents' socio-economic variables, extent of availability and accessibility of primary health care services (PHCs) and constraints to PHCs. Pearson product moment correlation and chi-square analyses were employed to test the hypotheses set for the study.

III. RESULT AND DISCUSSION

The results presented in table 1 show the distribution of respondents' based on their socio-economic characteristic. It was found that rural women in the study area were young and in their active working age with a mean of 39.3 years. This corroborates the finding of Dias *et al* (2009) who submitted that age is expected to be positively related to utilization of health facilities. He argued that rural households' heads in their active and economic age seek health care from government hospitals with a few of them utilizing self-care and traditional care. Majority of the respondents (61.7%) were married, singled (21.6%) divorced (11.1%) and widowed (5.6%) and household size of the respondents was fairly large with a mean of 7 members. Majority (56.7) engaged in

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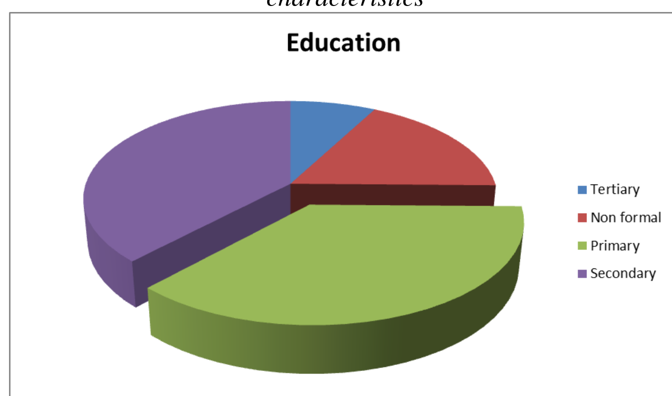
farming and farming related activities like farm products processing, marketing of farm produce. It was found that all these activities were carried out by rural women to assist their spouses. Other occupation rural women engaged in were trading (12.8%) artisans (25.0%) and daily paid works (5.6%). The results in fig. 1 reveals that majority (83.3%) could read and write while only 16.7 percent of the respondent did not received formal education. It was found that education has been a vital social factor assisting rural women in seeking health treatments and cares from any available Government's and non-Government's health institution. Most of the respondents in the study area were educated and this would have informed their healthcare choices.

Variable	Frequency	Percentage
Age		
30	12	6.7
30-40	101	56.1
41-50	40	22.2
51-60	20	11.1
60	07	3.9
Marital status		
Single	39	21.6
Married	111	61.7
Divorced	20	11.1
Widowed	10	5.6
Household size		
1-3	23	12.7
4-6	65	36.1
7-9	55	30.6
10-12	20	11.1
13	17	9.4
Primary occupation		
Farming	102	56.7
Trading	23	12.8
Artisan	45	25.0
Others	10	5.6

Source: field survey, 2019, percentages in parentheses

Table 1: Distribution of respondents by socio-economic characteristics



Source: field survey, 2019, percentages in parentheses

Figure 1: Distribution of respondents by education status

The results in Table 2 reveals that the major Primary Health Care services (PHCs) available in the study area. Immunization programme which has components such as personal hygiene, family planning, adequate diet, oral –polio vaccine for children, circumcision for male children, environmental health among others topped the list and ranked first. This was followed by Ante-natal care with the mean of 2.28. This care was made available to rural pregnant women. The post-natal care came 3rd with the mean of 2.16. This service has a major component called neo- natal which include Maternal and child health care services, exclusive breast feeding. Treatment of communicable and non- communicable diseases came fourth with mean ($\bar{X}$) of 2.08. Several communicable diseases are cough, HIV, AID, Tuberculosis etc. There are also non- communicable diseases such as dysentery, fever etc. The last major PHC in health which ranked 5th, was dental clinic service with a mean score of 1.88. This was probably so due to the category of people whom this service was available to. This was evident in that 85 percent of the respondents were 50 years and below. These were likely children and adults who probably had less of dental problems.

Primary health care services	Always available	Available	Not available	Mean	Ranking
Immunization	69 (38.3)	111(61.7)	-(0.0)	2.38	1st
Ante-natal care	50(27.8)	130(72.2)	-(0.0)	2.28	2nd
Post- natal care	42(23.3)	125(69.4)	13(7.2)	2.16	3rd
Treatment of communicable and non-communicable diseases	38(21.1)	119(66.1)	23(12.8)	2.08	4th
Dental clinic service	35(19.4)	89(49.4)	56(31.1)	1.88	5th

Source: field survey, 2019, percentages in parentheses

Table 2: Distribution of respondents based on availability of primary health care services

The results in table 3 present how accessible these PHCs were to the rural people, immunization which comprise of services such as, treatment of measles and yellow fever among others with a mean score of 2.83 ranked first. Ante-natal care with mean score of 2.25 came second. Non- communicable diseases seen in the health centers were very few. This could be due to lack of trained professionals and facilities in the health center. Most of the communicable diseases are often referred, for instance most or the severe illnesses and complicated pregnancies are often referred to higher and well equipped government hospitals which could be referred to as secondary health care. However, treatment of communicable and non -communicable disease with a mean score of 2.06 ranked 4th. Dental clinic service with a mean score of 1.47 was ranked 5th. The study found that the pattern of accessibility or PHCs followed the pattern or PHCs availability.

Primary health care services	Always accessible	Sometimes accessible	Not accessible	Mean	Ranking
✓ Immunization	151(83.9)	29(16.1)	-(0.0)	2.83	1st
✓ Ante-natural care	45(25.0)	135(75.0)	-(0.0)	2.25	2nd
✓ Post-natural care	40(22.2)	125(69.4)	15(8.3)	2.14	3rd
✓ Treatment of communicable and non-communicable disease	35(19.4)	121(13.3)	24(13.3)	2.06	4th
✓ Dental clinic service	19(10.6)	46(25.6)	115(63.9)	1.47	5th

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Source: field survey 2019. Percentages in parentheses

Table 3: Distribution of respondents based on the accessibility primary health care services

The results in table 4 show percentage distribution of rural women based on the constraints they were facing in accessing primary health care services (PHCs). Inadequate health facilities where PHC centers were filtering units for those who require specialized services at the higher levels of care, specialized medical services like radiotherapy, orthopedics procedure and surgeries were completely absent was the major constraint of 35.0 percent of the respondents. About 33.3 percent of the respondents claimed that non-availability of the right type of service constraint. Poor/inadequate health personnel characterized by the presence of health workers who were untrained and the trained ones who lack the modern concept of PHC practices was the submission of 31.1 percent of the respondents. Also, lack of community linkage where most of the services rendered lack community linkage which resulted to community members not being aware of some available services as claimed by 28.3 percent of the respondents. Others were high cost of primary health care materials (22.8%) and poor infrastructure (17.8%).

Constraints	Frequency	Percentage
Poor/inadequate health personnel	56	31.1
Inadequate health facilities	63	35.0
Poor infrastructure	32	17.8
Lack of community linkage	51	28.3
High cost of primary health care materials	41	22.8
Non availability or the right type of service	60	33.3

Source: field survey, 2019. Multiple responses were given

Table 4: Distribution of respondents based on constrains militating against accessibility to primary health care services

Result of correlation analysis in table 5 show that there are positive significant relationship between educational status (r=0.82, p=0.05) marital status (r=0.28, p=0.05) and accessibility to primary health care services. This implies that educational and marital statuses of rural women had great impact on the accessibility of primary health care services. It indicated that the more educated the rural women are, the more accessible they are to primary health care services. This means that they might probably be more aware of services under primary health care programme, hence, accessibility, having education at least to be able to read and write would inform their health care choices to some extent. Also, the relationship with marital status indicates married women accessed more primary health care service than those who were yet to get married. This probably might be because married women need to take care of themselves particularly during pregnancy and even the cares of their children employing primary health care service. However, age (r= -0.37, p= 0.05), income (r= -0.033, p= 0.05) were inversely related to the accessibility of primary health care services. This implies that as the ages of the respondent increase, their accessibility to PHCS decrease, meaning that older women might have less needs to use PHCS than younger rural women, also, on income, the richer the rural women, the lesser their interest in primary health care services but more of comprehensive sophisticated secondary and tertiary health care services.

Variables	Correlation co-efficient	p-value	Decision
Age	-0.37	0.04	S
Educational status	-0.82	0.02	S
Marital status	-0.28	0.00	S
Income	-0.033	0.008	S

Source: field survey 2019. S=significant at 0.05 level

Table 5: Result of correlation analysis showing relationship between social economic characteristic of the respondents and their accessibility to PHCS

Table 6 shows that poor or inadequate health personnel ($X^2 = 18.9$, $P \leq 0.05$), inadequate health facilities ($X^2 = 30.0$, $P \leq 0.05$), and Non availability of the right type of services ($X^2 = 18.4$, $P \leq 0.05$) were significantly related to rural women accessibility to primary health care services. The implications of these findings are that presence of adequate health personnel will influence high accessibility of PHCs and vice-versa. Also presence of adequate health facilities would aid accessibility of PHCs so also availability of the right type of services. Poor infrastructure($X^2 = 12.02$, $P \leq 0.05$), and lack of community linkage ($X^2 = 17.34$, $P \leq 0.05$), were not significant constraints to PHCs accessibility.

Constraints	X^2	df	p-value	Decision
Poor/inadequate health personnel	18.9**	11	0.03	S
Inadequate health facilities	30.0**	6	0.02	S
Poor infrastructure	12.02	6	0.06	NS
Lack of community linkage	17.34	3	0.16	NS
Non availability or the right type of service	18.14*	8	0.00	S

*Source: field survey, 2019. * ** Significant at $p \leq 0.01$, $p \leq 0.05$*

Table 6: Results of the association between the constraints experienced by rural women and their accessibility to PHCs

IV. CONCLUSION AND RECOMMENDATION

Inadequate and poor quality health personnel and poor health facilities have been shown to prevent accessibility of primary health care services. The study has shown that rural women benefited highly in immunization programmes while other components of PHCs services such as treatment of communicable and non-communicable dental clinic services were not regularly available. It was concluded that the pattern of PHCs availability in the study area grossly accounts for health facilities differentials between rural dwellers and urban dwellers. It is therefore recommended that the government and the various stakeholders in primary health care system should

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give necessary attention to the constraints of inaccessibility of rural women to primary health care services in the study area.

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