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Assessment of Rural Dwellers Access to Primary Healthcare Services in Oyo State, Nigeria

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ABSTRACT

This study attempted to determine the rural dwellers access to primary healthcare services in Oyo State. A multistage sampling procedure was used to select 120 rural household heads data were collected using interview schedule which were analyzed using descriptive and inferential statistics (p=0.05). Results reveal that majority (92.5%) of the respondents were married, male (66.7%) and had diarrhoea (M=0.88), injuries (M=0.88) and headache (0.83) as ailments/health related challenges experienced. Community outreach (M=1.33), paediatric treatment (M=1.30) and family planning (M=1.29) were PHC services assesses most. Constraints to accessing PHC services were inadequate healthcare facilities (M=2.30), unfriendly behaviour of health care officers (M=1.89) and insufficient health care officers (M=1.75). At 0.05 level of significant relationship was established level of education (x2=1.020, p=0.001), constraints to accessing primary health care services (r=0.359; p=0.032) and access to primary healthcare services. Based on the foregoing it is recommended that there should be more deployment of health care officers and healthcare facilities to the rural areas. There is need for in-service training to ensure that healthcare officers adhere to the ethics of their profession.

INTRODUCTION

The Nigerian government is committed to quality and accessible public health services through provision of Primary Health Care (PHC) in rural areas as well as provision of preventive and curative services [1]. Quill [2] concluded in their report that when considering rural health, a few key terms must firstly be noted which are geographically and equality, they suggested that there should be an even distribution of services per head of population. Primary health care is an integral part of the Nigerian social and economic development, however, it is an individual and community first level of contact in the national health system, thus bringing health care to people where they live and work.

According to World Health Organization [3], Primary Health Care (PHC) is defined as essential health care based on practical, scientifically, sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. Similarly World Health Organization outlined the objectives of primary health care as: To make health services accessible and available to everyone wherever they live or work, to tackle the health problems causing the highest mortality and morbidity at a cost that the community can afford, to ensure that whatever technology used must be within the ability of the community to use effectively and maintain, to ensure that in implementing health program, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance. Ajilowo [4] perceived health accessibility as the ability of an individual or community to obtain health care services with ease.

The primary healthcare services in Nigeria and the health status of Nigerians are in a deplorable state, people in rural areas face some different health issues than people who live in towns and cities, however, and getting primary health care can be a problem when you live in a remote area because rural areas often have fewer doctors and nurses [5]. The serious complains on

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the access to primary healthcare services in rural areas include poor services rendered to people, problems of introduction of user fees for services provided, the unfriendly openings hours, poor skill of other staff and the absence of drugs [6]. Primary health care 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 [7]. Riddell [8] revealed the persistent and deep problems in accessing rural primary health care services which include cost of care, distance from health centers and transportation, discrimination and language. It is against this background that an assessment of rural dwellers access to primary health care services in Oyo state was embarked upon.

The study was guided by the following objectives:

- describe the personal characteristics of the respondents.
- identify the rural dwellers health challenges in the study area.
- identify rural dwellers constraints to primary healthcare services.
- determine the rural dwellers access to primary healthcare services.

METHODOLOGY

The study was carried out in Oyo state which covered approximately an area of 28,454 square kilometers. The climate is equatorial, notably with dry and wet seasons with relatively high humidity. The dry season lasts from November to March while the wet season starts from April and ends in October, average daily temperature ranges between 25°C (77°F) and 35°C (95.0°F), almost throughout the year. Multistage sampling procedure was used to select the respondent. This involved the stratification of Oyo State local government areas into rural and urban, the random sampling of 20% of 21 rural local government areas, the random sampling of 20% of the wards in each of the local government areas earlier sampled, the random sampling of 3 communities from the wards earlier sampled (24 communities) and the systematic sampling of 5 household heads giving a total sample size of 120. Variables investigated are: personal characteristics, ailment/health related challenges experienced, respondents stated if they have experienced it (yes) or not (no) from a list provided with scores of 1 and 0 assigned, PHC services assessed, response options always, occasionally and never with scores 2, 1 and 0 were assigned respectively and constraints to accessing PHC services, response options severe, mild and not a constraint with scores 2, 1 and 0 were assigned respectively.

RESULTS AND DISCUSSION

Personal Characteristics of the Respondents

The result of the analysis in **Table 1** shows that 50.0% of the respondents were between the age of 40-44 years which could be deduced that respondents are still in their productive years, this is in consonance with [9] that population within this age group are productive. Majority of the respondents were male (66.7%), married (92.5%), and the religion they practiced is Christianity (66.7%) which implied that Christianity is a popular religion. Also, 45.0% of them attained primary education which indicated that level of education will likely to have impact on rural dwellers access to primary healthcare services. On the respondents household size, 65.7% of them had household size between 4-6 and majority of them were mostly engaged in farming (62.5%).

Ailments/Health Related Cases Experience

Figures in **Table 2** reveal that Diarrhea, Injuries and Headache (M=0.88) were the ailments/health related cases experienced most by the respondents. The plausible reason for this may be as a result of their untidy environment and the nature of occupation (farming) that they are engaged in. It is worthy to note that Cancer, Diabetes and Asthma (M=0.0, 02 and 0.03 respectively) were the ailments/health related cases experienced least by the respondents. From these findings it is sufficient to say that these diseases do not occupy a common place in the rural areas when compared with the urban areas, where they are highly pronounced.

Access to Primary Healthcare Services

Available statistics in **Table 3** reveal that high access was recorded for community outreach (M=1.33), pediatric treatment (M=1.30) and family planning (M=1.29) services. Conversely low access was recorded for treatment of injuries (M=1.16), immunization (M=1.22), antenatal and child delivery (M=1.23) services. The observed trend of the services accessed establishes the renewed effort of the health sector towards community sensitization on ensuring a safe and clean environment and maternal and child health which is been driven by family planning.

Respondents Level of Access to Primary Healthcare Services

Table 4 reveals that majority (69.2%) had low access to primary healthcare services; the observed low access to primary healthcare services could be attributed to the challenges faced in accessing these services. It is suffice to say that there is still a huge gap to be filled as regards primary health care service delivery in the study area.

Respondent's Constraints to Accessing Primary Healthcare Services

Table 5 reveal that inadequate healthcare facilities (M=2.03), unfriendly behavior of healthcare officers (M=1.89) and

Table 1. Distribution of respondents according to their personal characteristics n=120.

Age (years)	Frequency	Percentage	Mean
20-24	2	1.7	-
25-29	6	5.0	57.17
30-34	10	8.3	-
35-39	14	11.7	-
40-44	60	50.0	-
>44	28	23.3	-
Sex	**Frequency**	**Percentage**	**Mean**
Male	80	66.7	-
Female	40	33.3	-
Marital status	**Frequency**	**Percentage**	**Mean**
Married	111	92.5	-
Single	5	4.2	-
Divorced	1	0.8	-
Widowed	3	2.5	-
Religion	**Frequency**	**Percentage**	**Mean**
Islam	39	32.5	-
Christianity	80	66.7	-
Traditional	1	0.8	-
Level of Education	**Frequency**	**Percentage**	**Mean**
No formal education	19	15.8	-
Primary education	54	45.0	-
Secondary education	38	31.7	-
Tertiary education	9	7.5	-
Household size	**Frequency**	**Percentage**	**Mean**
1-3	14	11.7	5.25
4-6	81	67.5	-
7-9	24	20.0	-
Above 9	1	0.8	-
Major Occupation	**Frequency**	**Percentage**	**Mean**
Teaching	13	10.8	-
Trading	20	16.7	-
Farming	75	62.5	-
Artisan	12	10.0	-

Source: Field Survey, 2015.

Table 2. Distribution of respondents according to Ailments/Health related cases.

experienced Health challenges	Yes (%)	No (%)	Mean
Malaria	93(77.5)	27(22.5)	0.78
Complication in family planning	12(10.0)	108(90.0)	0.10
Cholera	50(41.7)	70(58.3)	0.42
Diarrhea	105(87.5)	15(12.5)	0.88
Tuberculosis	40(33.3)	80(66.7)	0.33
Injuries	106(88.3)	14(11.7)	0.88
High blood pressure	6(5.0)	114(95.0)	0.05
Headache	100(88.3)	20(16.7)	0.83
Cough	73(60.8)	47(39.2)	0.61
Catarrh	73(60.8)	47(39.2)	0.61
Asthma	5(4.2)	115(95.8)	0.03
Eye defects	10(8.3)	110(95.8)	0.08
Cancer	0	120(100)	0
Diabetes	2(1.7)	118(98.3)	0.02
Arthritis	18(15.0)	102(85.0)	0.15
Stomach upsets	96(80.0)	24(20.0)	0.80

Source: Field Survey, 2015.

insufficient health care officers (M=1.75) were the constraints to accessing primary healthcare services, this finding is in an agreement with [10] that inadequate doctors and nurses are impediments to accessing healthcare. However it is worthy to note that poor treatment (M=0.11) and absence of doctors and nurses (M=0.15) were not constraints to accessing primary health care services. It is noted that respondents get adequately treated when they patronize these centers owing to the availability of health personnel, however the dearth of social infrastructure could be responsible for the insufficient personnel.

Test of Hypotheses

Significant relationship exists between respondents level of education (x^2=1.020, p=0.001), constraints to accessing primary healthcare (r=0.359; p=0.032) and access to primary healthcare services. It is implied that the more educated the respondents are the more they receive access to primary health care services, it is expected that with their level of education they will better appreciate the service rendered by these centers compared to other health outlets or resulting to self-medication as shown in **Table 6** [11]. It is worthy to note that irrespective of the constraints faced to accessing primary health care service respondents still

Table 3. Distribution of respondents according to their access to primary healthcare services.

Services	Always	Occasionally	Never score	Weighted	Mean	Rank
Family planning	48(40.0)	59(49.2)	13(10.8)	155	1.29	3rd
Antenatal services	38(31.7)	72(60.0)	10(8.3)	148	1.23	8th
Community outreach	47(39.2)	65(54.2)	8(6.7)	159	1.33	1st
Treatment of Injuries	26(21.7)	87(72.5)	7(5.8)	139	1.16	11th
Postnatal services	39(32.5)	71(59.2)	10(8.3)	149	1.24	7th
Pediatric Treatment	41(34.2)	74(61.7)	5(4.2)	156	1.30	2nd
Obstetrics and Gynecology	39(32.5)	72(60.0)	9(7.5)	150	1.25	6th
Child delivery Services	40(33.3)	68(56.7)	12(10.0)	148	1.23	8th
Immunization	27(22.5)	92(76.7)	1(0.8)	146	1.22	10th
HIV testing & counseling	36(30.0)	79(65.8)	5(4.2)	151	1.26	4th
Treatment of Sexually transmitted Infections	37(31.6)	77(64.2)	5(4.2)	151	1.26	4th

Source: Field Survey, 2015.

Table 4. Distribution of respondents according to their level of access to Primary healthcare services.

Scores	Frequency	Percentage	Minimum	Maximum	Mean
High	37	30.8	5.62	11.73	9.23
Low	83	69.2	-	-	-

Source: Field Survey, 2015.

Table 5. Distribution of respondents according to their constraints to accessing primary healthcare services.

Services	Severe constraint	Mild constraint	Not a constraint	Weighted scores	Mean	Rank
Long distance to health care centers	70(58.3)	30(25.0)	20(16.7)	170	1.42	6th
Long waiting hours before treatment	75(62.5)	36(30.0)	9(7.5)	186	1.55	5th
High cost of drugs and consultation	97(80.8)	15(12.5)	8(6.7)	209	1.74	4th
Unfriendly behavior of healthcare officers	107(89.2)	7(5.8)	3(2.5)	221	1.89	2nd
Inadequate facilities at health centers	119(99.2)	6(5.0)	3(2.5)	244	2.03	1st
Insufficient health care officers	97(80.8)	16(13.3)	7(5.8)	210	1.75	3rd
Short consulting Hours	60(50.0)	40(33.3)	20(16.7)	160	1.30	7th
Poor treatment	4(3.3)	6(5.0)	110(91.7)	14	0.11	9th
Absence of doctors and nurses	3(2.5)	12(10.0)	105(87.5)	18	0.15	8th

Source: Field Survey, 2015.

Table 6. Relationship between socio-economic characteristics, constraints to accessing primary health care and access to primary healthcare services.

Variables	df	χ2	r-value	p-value	Decision
Age	-	-	0.867	0.092	Not significant
Sex	1	2.733	-	0.090	Not significant
Marital status	1	1.088	-	0.080	Not significant
Level of education	4	1.020	-	0.001	significant
Religion	2	4.060	-	0.090	Not significant
Household size	-	-	0.860	0.309	Not significant
Occupation	3	4.074	-	0.340	Not significant
Constraints	-	-	0.359	0.032	significant

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accessed it, suffice to say that because there are no alternatives respondents accessed these services despite the constraints they faced.

CONCLUSION

The study established that the majority of the respondents are in their productive age, are male, married, have below secondary education. Diarrhea, Injuries and Headache were the ailments/health related cases experienced, community outreach, pediatric treatment and family planning were primary health care services accessed. Inadequate healthcare facilities, unfriendly behavior of health care officers, insufficient health care officers were constraints to accessing primary health care services. Respondents still had access to primary health care services irrespective of they faced. It is advised that there should be more deployment of health care officers and healthcare facilities. There is need for in-service training to ensure that healthcare officers adhere to the ethics of their profession.

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