Social-Economic and Cultural Barriers and Primary Health Care Service Delivery in Rural Communities in Abuja, Nigeria

Dahida D. Philip (Ph.D) and Chima Paul (Ph.D.)
Department of Public Administration,
Faculty of Management Sciences,
University of Abuja, Nigeria.

Abstract:
The study investigates the extent to which socio-economic and cultural characteristics of the communities constitute barriers to the primary health care services delivery in the Federal Capital Territory, Abuja Nigeria. Descriptive cross-sectional field survey was utilized. Primary data were utilized and exploratory analysis was used. ANOVA and t-Test were used as tools of analysis to bring out statistical differences in the perception of the respondents regarding the subject matter understudy. The inhibiting factors to primary health service delivery and utilization related to socio-economic and cultural characteristics of the users of the services found among others in rural communities of Abuja were: users perceived it that treatment received locally from traditional sources are cheaper than the PHC services, prevailing insufficient means of transportation, lack of assertive or esteem spirit by the users of the services etc. In view of the findings, the study recommends inter-alia; location of health centres in catchment areas to all members of the communities to reduce cost of transportation, scaling up awareness campaign in the communities through the use of health helpers or aids appointed from the community to sensitize the communities on the usefulness of the PHC service over the traditional healing methods.

Introduction

Effective administration of health care is a priority to the development of any nation. Health administration, a branch of public administration (Basavanthappa, 2008) deals with matters related to promotion of health, preventive services, medical care, rehabilitation, the delivery of health services, the development of health manpower and medical education. Public health administration is the science and art of organising and coordinating government agencies with primary purpose of improving the physical, mental and social well-being of the people. The main purpose is the prevention of diseases, preservation and promotion of health which helps individuals to enrich the quality of life leading to his ethical, artistic, material, and spiritual development and also to provide economic and efficient total health services to the people.

Primary health care as a branch of public health care is a paradigm shift in health care provision to avoid the shortcomings of conventional medical approach (Paul, 2014). The identified shortcomings of the conventional approach was that it emphases more on come-and-get approach that was available only for those who could reach the service. Thus, majority who could not access it were left without care. This approach was criticised as being too narrowly technological and highly professionalized, a client approach, hence creating professional dependency. It was also too costly for poor countries, hence, resulting in inequitable distribution of health care.

Primary health care offered an alternative approach which differed from the conventional medical approach in terms of the following characteristics. First, primary health care implies much more than a concern for clinical treatment of the ill in a hospital based service. Rather, a comprehensive community-based service was the focus. Second, health was no longer limited to the absence of disease as viewed within a medical paradigm. Rather, in a PHC approach, "health is a fundamental human right and a worldwide social goal" (WHO, 1978). In this social paradigm of health, people were not viewed just as consumers of health care, but rather as able to provide it for themselves. Consequently, the phrase, "health by the people" was coined (Gish, 1982; and Rifkin, 1985). PHC as an approach emphasised the importance of self-reliance as an expression of human dignity and development. This proposal indicates that the professional-client (provider-client) relationship should be changed to an equal partnership between the providers and the users of the service so as to bring health care service closer to the people.

To ensure effective health care administration in such a way as to bring health closer to the people, FCT just like every other states of the Federation in Nigeria divided her health sector into three levels. These are Tertiary, Secondary and Primary levels. The tertiary care is provided at Teaching and Specialist Hospitals. The secondary health care is provided through the establishment of General Hospitals where all basic specialty services are made available. The primary health care is the first level of contact of individuals, families and communities. The provision of health care at PHC level is largely the responsibility of local governments with the support of state ministries of health and within the overall national health policy (Nigerian constitution, 1999). In FCT, it is provided by Area Councils. This is done through health centres and health posts. They are staffed with nurses, midwives, community health extension workers, health technicians and physicians (doctors). The services provided at primary health care include; prevention and treatment of communicable diseases, immunisation, maternal and child health services, family planning, public health education, environmental health and the collection

of statistical data on health and health related events. Despite this vital arrangement, effective health care delivery and utilization in the Federal Capital Territory is thwarted by so many barriers. The likely barriers ranged from poor medical facilities, negative attitude of health personnel and lots more. These aforementioned factors normally occurred at the health facility level/ supply side of the service. The focus of most studies in this area has been on the aforementioned factors and the extent to which they affect the effective delivery and utilization of the primary health care facilities without taken into cognisance the likely factors affecting the primary health facilities from the community dimension. This study therefore is an investigation of the perculiar social-economic and cultural characteristics of the rural communities and the extent to which they are responsible for the negative health seeking behaviour of the users of the primary health services in the Federal Capital Territory, Abuja. This is not to say that study of this nature has not been carried out elsewhere before. But to the best of the writer's knowledge, study of this kind has not been done in FCT prior to this write up. This makes it unique and hence close the existing gap in knowledge as far as FCT is concerned.

Conceptual Review
Social-Economic:
Social-economics involves the relationship between social and economic factors within a society (Wikipedia, 2016). Socio-economic factors influence how a particular group, or socioeconomic class, act within society including their actions as consumers. For instance, different socioeconomic classes may have varying priorities regarding how they direct their funds. There may also be certain goods or services that are considered unavailable to certain classes based on their ability to afford them. This can include access to educational opportunities, the ability to meet certain nutritional guidelines and access to more advanced or complete medical care.

Research about socioeconomic status and health began to gain momentum in the mid-1980s (Gornic, 2002). Since 1985, there has been a substantial increase in the number of studies and conferences about the relationships between socioeconomic factors and health. These among others include the work of Adler and Ostrove (1999), the 1987 conference sponsored by the Kaiser Family Foundation (Gornic, 2002). In the conference, leading social scientists from the U.S. and Great Britain presented a number of papers that showed that the effect of socioeconomic factors was much broader than just poverty. In their view, many social-economic factors are related to health. In addition, they argued that there is a gradient effect between socioeconomic status and health: as socioeconomic status increased, health improved. The reverse become the case if the socioeconomic status decreases, health deteriorates. For Ostrove, there are multiple pathways by which SES determines health. Ostrove asserts that a comprehensive analysis must include macroeconomic contexts and social factors as well as more immediate social environments, individual psychological and behavioural factors, and biological predispositions and processes. He therefore stressed that on the average, the more advantaged individuals are in terms of socioeconomic status, the better their health.

While much has been learned from these studies, frequently lacking in most of these researches is a clear conceptualization of what constitute socio–economic factors. Though, different individuals have different dimensions regarding the components of socioeconomic factors, but a common agreement exists among all the perspectives. Choinière cited in Pampalon and Raymond (2000) for instance points to inequalities in

415

income, education, employment and family structure as major socio-economic factors depriving people utilizing health care services in both rural and urban settings. Similarly, Haddad and Fournier (1995) identified charges and fees. Kroeger (1983) noted indirect or opportunity cost of health services use, such as the cost of transport as factors affecting health service delivery.

Culture:

Closely related to the issue of socioeconomic variables are the cultural factors. Culture as a concept has multiplicity of definitions. But the most suitable one for this study is the overwhelmingly used definition which sees culture as the total way of life of people. This is in consonance with the definition of culture by Ferraro (1994) which sees culture as everything that people have, think, and do as members of a society. This everything could be material objects, ideas, attitudes, values and behavioural patterns.

Corroborating the above, The United States Department of Health and Human Services Office of Minority Health (2000) defines culture as "integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." In the same vein, Leininger (1985) defines culture as "the learned and shared beliefs, values, and life ways of a designated or particular group which are generally transmitted intergenerationally and influence one's thinking and action modes." In view of the importance of culture to health care delivery, U.S. Department of Health and Human Service Office (1999) asserted that culture and language have considerable impact on how patients access and respond to health care services. It went further therefore to recommend among others, that health care organizations and providers should:

i. Promote and support the attitudes, behaviours, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

ii. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, and training.

From the foregoing, it can be seen that different social-economic variables such as income, education, employment and family structure as well as transport cost and users charges coupled with cultural factors like behaviours, values and customs have been considered to influence acceptance and utilization or even rejection of health care services. It therefore, becomes imperative to investigate how these issues affect the delivery of health care services in Abuja, Nigeria.

Empirical Review

Extant literature suggests that socio-economic and cultural characteristics of communities are factors triggering their negative health seeking behaviours or non-utilization of existing health centres. Al-Ghanim (2004) in his study indicated that the socio-economic and cultural factors that usually influence negatively primary health care service deliveryand utilization of rural people in Riyadh, Saudi Arabia include level of income, illiteracy and absence of health insurance. Ibrahim and Ibrahim (2012) also found that one of the accessibility problems of primary health care to rural people in Jigawa State, Nigeria, was that, distribution of primary health care centres and facilities were not homogeneous because of political policy. Consequently, their location does not offer equal access or uniform benefits to the rural people. They further revealed that, the few

settlements that have primary health centres and cottage hospitals located in them were poorly connected by roads. Ibrahim's findings is in tanden with the outcome of the study carried out by Onokerharaye (1999) on Access and Utilization of Modern Health Care Facilities in the Petroleum-producing Region of Nigeria: The Case of Bayelsa State. He found that:

Many people in the study area go to traditional health practitioners when their first action at self-medication fails to produce satisfactory results. This was discovered to be due to a number of factors associated with modern health centers including their inaccessibility, high cost of treatment, attitude of the health personnel and delay in receiving attention whenever they visit modern health care centres.

The finding of the above study also supports the results of the pitiable state of primary health care in FCT communities as reported in Daily Trust by Itodo and Yahaya (2012). The traditional ruler of Kwaiter-Tsoho in Kwali Area Councils, Abuja, Nigeria, Zakar Magaji, told the reporters that residents of his community face difficulties over lack of primary health centre at the village, except Kwaiter town. The monarch reiterated that most of the residents especially those that fell sick have to be conveyed on motor cycle to Kwali town on bad road to receive medical attentions. In Bwari area council, it was equally reported that residents of Zuma community complained that they are discouraged from using primary health facilities because they face the hardship of assessing health facilities in far away Bwari town. The same situation applied in Kuje, Abaji and Gwagwalada of the Federal Capital Territory, Nigeria according to the reporters.

Methodology of the Research

Descriptive cross-sectional field survey was utilized. Primary data were utilized and exploratory analysis was employed. This study was based on an empirical survey of six hundred and forty four (644) respondents carefully drawn from staff of the primary health care centres and members of the communities in the four area councils selected for the study. Six hundred and twenty (620) usable copies of the questionnaire were returned, yielding a response rate of 97 percent. This is significantly adequate for a survey analysis. Community health extension workers were selected purposively from health facility level and chairmen or secretaries of health development committees were also purposively selected from the communities in the four Area Councils or the Local Governments selected out of the six Area councils that make up the Federal Capital Territory, Abuja. The choice of the health extension workers is that their duties are directly related to the community. The chairmen or secretaries of health development committees residing in the communities were chosen because; they were popularly selected by communities to represent them in health matters. It is also assumed that they are involved in decisions leading to the health care service delivery; and they are better informed about health care related issues. The instrument for the study containing ten items modelled on Likert scale of five point rating was developed from the literature reviewed. Items in the questionnaire focused on Socio-economic and cultural characteristics of the communities and delivery of primary health care services.

Data collected for this study were analyzed using Statistical Package for the Social Sciences (SPSS) to provide descriptive and inferential analyses. In order to bring out the statistical differences in the hypothesis, Analysis of Variance (ANOVA) was employed. One factor ANOVA was used in this study. This is because it is capable of testing differences among at least three groups and above. Since the study is testing the

417

differences in opinions of the four Area Councils on issues under investigation, ANOVA was considered more useful. T-test was further employed to compare the opinion of the health facility workers with that of the members of the communities. This becomes useful since the views of the two groups are being compared. The premise for the validity and consistency of this study was the calculation of the P-value. The p-value is the probability that a sample drawn from a population is tested given that the assumptions proposed by the study are true. A p-value of .05% indicates that there would only be a 5% chance of drawing the sample being tested if the research proposition was actually true. In other words, it demonstrates a 95% confidence level meaning that the study has 95% of assurance that the research questions were significant to provide responses appropriate to the research objectives. A p-value of 0.05 was used to evaluate the stated hypothesis, and a value below .05 is said to be significant (Tusting etal, 2005)

Result of the Research
This section reports the statistical analysis of the research questions and the hypothesis used in the study.
Research Question: How do the responses of the health facility workers and communities across the four Area Councils vary regarding socio-economic and cultural variables of the communities as barriers to the service delivery of primary health services by rural communities in FCT?

Socio-Economic and Cultural Variables as Barriers to the Utilization of PHC Services:
Table1: *Mean Scores/Rank for Socio-Economic, Cultural*
Variables and delivery of PHC Services.

Item No.	Statements	Bwari Area Council	Gwagwalada Area Council	Kuje Area Council	Kwali Area Council	$\overline{X}$	Rank
1	High cost of transportation to health centres	2.93	3.08	3.02	2.98	3.00	5
2	Lack of assertive or high-esteem spirit.	3.07	2.99	2.96	3.06	3.02	3
3	Insufficient means of transportation	3.04	3.02	2.93	3.25	3.06	2
4	Lack of awareness of health services	3.03	3.06	2.97	2.89	2.99	8
5	Perception of stigma associated with some sickness.	3.06	2.99	2.88	2.96	2.97	9
6	Local treatments are cheaper than PHC services.	3.11	3.12	3.22	3.10	3.14	1
7	Preference for self-medication, herbal and spiritual means.	3.16	2.92	2.94	2.74	2.94	10
8	Unacceptability of modern health care processes.	3.08	2.98	3.11	2.87	3.01	4
9	Unaffordability of user charges	3.05	2.85	2.97	3.11	3.00	6
10	Failure to consult communities on places to locate PHC centres	2.90	3.08	2.88	3.12	3.00	7
	Significant Index (60.24%)	Sectional mean				3.01	

*Source***: SPSS Computation**.

From table 1 above, it can be seen that the sectional mean is 3.01, with significant index of 60.24%. This means that the overall response of the section agrees that the socio-economic and cultural variables of the communities were barriers to the delivery of primary health services by rural communities in FCT. Since the significant index was above 50%, it was invariably concluded that socio-economic and cultural variables of the communities were factors affecting the delivery and utilization of primary health services in rural communities of the FCT. A closer view of the result shows that the cost of PHC services compared with local treatment (unorthodox) alternatives was higher. This evidence was demonstrated with item 6 which attracted a mean score of 3.14. There was evidence also that lack of means of transportation scares members of the rural communities from utilizing the primary health services. This was demonstrated with item 3 which attracted a mean score of 3.06. A further evidence indicated lack of assertiveness or low-esteem as a factor that scares users of primary health services. This was also demonstrated with item 2 which attracted a mean score of 3.02. Other related factors such as unacceptability of modern health care processes by the communities, high cost of transportation to health centres, unaffordability of users' charges, failure to consult communities regarding where to locate primary health care centres combined to worsen the problem of socio-economic and cultural characteristics of the communities.

Hypothesis:
H_0: *There is no significant difference in the respondents' perceptions across the four Area Councils regarding socio-economic variables of the communities as barriers to the delivery of primary health services in rural communities of FCT.*

Table2: *ANOVA Test for Socio-Economic and Cultural Variables of the Communities as Barrier to the delivery of PHC Services.*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	.016[a]	3	.005	.474	.702
Intercept	362.840	1	362.840	31290.666	.000
Area Councils	.016	3	.005	.474	.702
Error	.417	36	.012		
Total	363.274	40			
Corrected Total	.434	39			

Source: **SPSS Computation.**

From the ANOVA in table 2 above, the mean responses from all the four area councils of the FCT were compared with a univariate analysis of variance resulting to a significant probability value of 0.702 which is greater than the 0.05% level of significance. This implies a "no significant" mean response from the four area councils. The conclusion therefore, was that the views of the entire respondents sampled from the four area councils were similar. Hence, the null hypothesis stated earlier that "there is no significant difference in the responses of the health facility workers and members of the communities across the four Area Councils regarding socio-economic and cultural variables of the communities as barriers to the delivery of primary health services in rural communities of

FCT" was accepted. To ascertain the authenticity of the result from the ANOVA analysis, t-test was applied in table 3 below.

Table3: *Paired Sampled T-Test for Socio-Economic and Cultural Characteristics of the Communities and Delivery of PHC Services.*

	Paired Differences					Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	T	Df	
Health workers-Community member	.00300	.66163	.20923	.014	9	.989

Source: **SPSS Computation.**

From the t-Test in table 3 above, it can be observed that the p-value is 0.989 which is greater than the level of significance 0.05%. This is an indication that there was "no significant difference" between the opinion of community members and the health facility workers regarding socio-economic and cultural characteristics of the communities as barriers to delivery of primary health services by the rural communities of FCT. This analysis supports the finding from the ANOVA result that there was no significant difference in the opinions of rural communities and health facility workers across the four groups regarding socio-economic and cultural characteristics of the communities as barriers to the delivery of primary health care services in rural communities of FCT.

Discussion of Results
The result of the analysis under this heading showed that respondents from the four area councils have similar views that the socio-economic and cultural variables of the communities were factors affecting the effective delivery of primary health services in the FCT.

The major issues inhibiting the delivery of primary health services from the socio-economic and cultural perspective were the perceived low cost of local treatment compared with PHC services which were high. What must have exercerbated the cost among others was the lack of means of transportation to the health facilities by members of the communities. Where transportation means like motor bike, popularly called "Okada" in Nigeria was found, the cost may be too exorbitant due to the nature of the rural roads. The long distance travelled before locating a health centre might have been occasioned by unequal distribution of health facilities.

The services were also considered too costly because of the high level of poverty in the rural part of the country. One of the major social costs which ranked third in the other of analysis was the big issue of lack of assertiveness and low esteem. A sight of the health facility workers normally generates inferiority complex in the life of the rural dwellers. This alone scares them the more from utilizing what actually belongs to them. This life style compels them to consider modern health care practices like family planning, immunization as unacceptable standard of behaviour. The high level of illiteracy among the rural dwellers prompted this attitude. These entire incidences compelled the users of the services to resort to the services of the traditional healers. The above were in line with the findings of Al-Ghanim(2004), Ibrahim and Ibrahim(2012), Onokerharaye (1999) and Itodo and yahaha(2012) as cited above.

Conclusion and Recommendations
The study pertinently concludes that the mounting challenges to the delivery of primary health services in Nigeria should not be ignored or wished away. This is because, the negative consequences of not stepping up the primary health care delivery in Nigeria would have extended negative multiplier effects on the other levels of health care delivery in Nigeria. By implication, the health sector services would further deteriorate, morbidity and mortality rate would increase and national development would decrease.

For effective primary health service delivery therefore, the socio-economic and cultural characteristics of the community should not be underrated. What is needed to be done in this case is to enhance community participation in order to improve health service delivery. For instance, agitations from the users of the services that the cost of PHC was too high in comparative term with the traditional means and also too far away from them; can be avoided when the communities are consulted as regards where to locate a primary health centre. With their own inputs devoid of any politics, the health centres would be located at catchment areas to all the communities. When this is done, the cost of transportation may be reduced to a level that is affordable to the communities.

The study also recommends that in the meantime, the Conditional Cash Scheme (CCS), which is a current intervention by the Office of the Special Assistant to the Presidency on MDG (OSSAP-MDG) should be scaled-up in the FCT. The scheme specifically stated that if a community member has visited primary health care centre for some consecutive period of times, he/she should attract some cash grant from the government. It is a motivational strategy to encourage positive health seeking behaviour.

Again, community members should be involved in the fixing of users charges. Through this, the community interests would be well articulated and they would be adequately informed by their representatives regarding the processes followed before the charges were fixed. This could be partly done through a process called drug revolving fund.

As for lack of awareness of the benefits of health services, fear of stigmas associated with some kind of diseases, cultural preference for self-medication and other alternatives, the drastic action needed is to get some people recruited as volunteers carrying various names as community health promoters, helpers or aids as the case might be. These categories of the people will carry out awareness campaign within the communities in order to reduce some level of ignorance and doubts with reference to primary health services in the community. A household of about 15-20 could be placed under the care of each health

helpers. The helpers would monitor closely the health of these people and report to the health centres respectively. Through these people, some barbaric cultures inhibiting communites from utilizing health services might be wiped off. The choice of the members of the communities and perhaps alongside professional health staff is that, the entire members of the communities would have that sense of belonging seeing a fellow member of the community participating. This will make them to pay adequate attentions to the groups carrying out the awareness campaign or periodic health education in the communities.

To crown it all, communities should be involved in health planning, control and management as captured in some of the issues raised above. If the above related community participation strategies are put into consideration, primary health care service delivery would improve positively.

References

Adler, N. and Ostrove. J. (1999), Socioeconomic Status and Health: what we know and don't know. Pp. 3–15. In Socioeconomic Status and Health in Industrialized Nations: Annals of the New York Academy of Sciences. Vol. 896. New York: New York Academy of Sciences.

Al-Ghanim, S. A. (2004), *"Factors Influencing the Utilisation of Public and Private Primary Health Care Services in Riyadh City."* Journal of King Abdulaziz University Medical Science JKAU: Econ. and Adm., Vol. 19, No. 1**,** pp. 3-27.

Basavanthapa, B. T. (2008), *Community Health Nursing*, New Delhi: Japee Brothers Medical Publishing (P) Ltd.

Chima Paul (2014), Community Particpation and Primary Health Service Delivery in the Federal Capital Territory, FCT, Abuja, being Doctoral thesis Submitted to Postgraduate School, University of Abuja in Partial fulfilment for the award of Ph.D in Public Administration.

Gish, O. (1982), *"Selective Primary Health Care. Old Wine in New Bottles"*. journal of Social Science and Medicine, vol.16. Issue 10. pp1049-54 Available at [http"//www.ncbi.nlm.nih.gov/.

Haddad S, and Fournier P. (1995), Quality, Cost and Utilization of Health Services in Developing Countries. A Longitudinal Study in Zaire. Soc Sci Med. 40:743–53.

Ibrahim M. J. and Ibrahim A. A.(2012), *"The Accessibility Problems of Primary Health Care to Rural People in Jigawa State"*, Nigeria. Global Advanced Research Journal of Social Science (GARJSS) Vol. 1(4) pp. 72-76, September, 2012 Available online http://garj.org/garjss/index.htm.

Itodo D. S and Yahaya H. (2012), The Pitiable State Of Primary Health Care in FCT Communities. Daily Trust, Wednesday August, 15, 2012. Vol. 1 No.49.

Kroeger A. (1983), Anthropological and Socio-Medical Health Care Research in Developing Countries. Soc Sci Med.17:147–61.

Leininger MM. (1985), Transcultural Care Diversity and Universality: a Theory of Nursing. Nursing Health Care. 6:208–12.

Marian E. Gornick (2002), Measuring the Effects of Socio Economic Status on Health Care. Washington (DC): National Academies Press (USA)

Onokerhoraye A. G. (1999), *"Access and Utilization of Modern Health Care Facilities in the Petroleum-Producing Region of Nigeria: The Case of Bayelsa State."* Research Paper

No. 162, Takemi Program in International Health, Harvard School of Public Health, 665 Huntington Avenue Boston, MA 02115N(617) 432-0686.

Rifkin, S. B. (1985), *Health, Planning and Community Participation: Case Study in South East Asia*. London: Croom Helm.

Tusting, D. H., Ligthelm, A. A., Martins, J. H. and Van Wyk, H.J. (2005). *Marketing Research in Practice,* Pretoria: UNISA Press.

U.S. Department of Health and Human Services Office of Minority Health (2000), Assuring Cultural Competence in Health Care: Recommendations for National Standards and Outcomes-Focused Research Agenda. Washington, DC: U.S. Government Printing Office.

WHO (1978), "*Declaration of Alma-Ata International Conference on Primary Health care",* Available at http:www.who. int/hpt/ NPA/does/declaration almata.pdf (Accessed January 10th 2012).

Wikipedia (2016), Socio-Economic Staus. Available@https://en.wikipedia.org/wiki
Ferraro G. (1994), The Cultural Dimension of International Business. Englewood Cliff, NJ: Prentice Hall.