ASSESSMENT OF UTILIZATION AND SATISFACTION WITH PRIMARY HEALTHCARE SERVICES AMONG WOMEN OF CHILDBEARING AGE IN PLATEAU STATE, NIGERIA

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JUNE, 2023

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A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY ZARIA, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER DEGREE IN HEALTH EDUCATION

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JUNE, 2023

DECLARATION

I declare that the work in the dissertation entitled, "**Assessment of utilization and satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria**" has been carried out in the Department of Human Kinetics and Health Education under the supervision of Dr. S. N. Akorede and Prof. V. Dashe,all sources of information have been appropriately acknowledged in the text and written in the list of references. No part of this thesis was previously presented for another Degree at any University.

_____ _____

FIDELIS, JelkyesYerse **Date**

CERTIFICATION

This dissertation entitled "**Assessment of utilization and satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria**" meets the regulations governing the award of M.Ed.degree in Health Education in Amadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This research is dedicated to my beloved parents and family.

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The researcher wishes to extend his profound gratitude to the Almighty God for His grace and mercy throughout this programme, may all praise, honour and adoration be ascribed to Him alone forever.

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ABSTRACT

Primary healthcare service in Nigeria isbeen distributed to the grassroots level in order to provide a door step access to healthcare services for individuals and families living within the rural areas of the country. Primary healthcare facilities and trained human resources are made available by the government for every local government area to serve as the first level of contact between the people and the healthcare system and to provide integrated healthcare services for health promotion in Nigeria. Utilisation of healthcare services and being satisfied with the services rendered will contribute greatly to addressing most of our existing health challenges. Hence, the purpose of this study was to assess utilization and satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria. To achieve this purpose a descriptive survey research design was adopted for the study. The population for this study consist of 321,506 of women of childbearing age in Plateau State. A sample of 420 women of childbearing age was used for the study. This was achieved through a multi-stage sampling procedure which comprised of stratified, simple random, systematic, purposive and proportionate sampling techniques. A researcher' developed questionnaire was used for data collection. Out of the 420 copies of the questionnaire distributed in the field 409 (97.4%) were retrieved and considered valid for analyses. Descriptive statistics of frequencies and percentages were used to describe the demographic characteristics of the respondents. Mean and standard deviations were used to answer the research questions. Inferential statistics of one-sample t-test was used to test formulated hypotheses1, on utilisation of primary healthcare units by women of childbearing (WCBA) age in Plateau State.2, on satisfaction with primary healthcare services among WCBA in plateau state and 3, on the types of primary healthcare services rendered to WCBA in Plateau State Primary Healthcare Units while Pearson Product Moment Correlation were used to test the formulated hypotheses 4, on the relationship between utilisation and satisfaction with PHC services among WCBA in Plateau State, Nigeria.The results of the study revealed that, utilization of healthcare services provided by Primary Health Care units for women of childbearing age in Plateau State, Nigeria is significant ($p = 0.000$). Satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria is significant ($p = 0.000$). Healthcare services provided by Primary Health Care centres for women of childbearing age in Plateau State, Nigeria are significant ($p = 0.000$). There is a significant relationship between utilization and satisfaction of primary healthcare services among women of childbearing age in Plateau State, Nigeria ($p = 0.000$). It was therefore concluded that women of childbearing age in Plateau state utilize health care services provided by Primary Health Care Centres. That women of child bearing age in Plateau State are satisfied with healthcare services rendered at the primary health centres. Based on the following conclusions, it was recommended thathealth educators should intensify their enlightenment/education campaigns on Maternal and child care so as to encourage women of child bearing age in the state to sustain the existing utilization of health care services provided by primary health care centres in the state, all the Hypotheses were tested at 0.05 level of significance.

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ABBREVIATIONS

HCP	Healthcare Providers
DPT	Diphtheria Pertussis Tetanus
PHCC	Primary Health Care Centre
HBM	Health Belief Model
HF	Health Facility
UNICEF	United Nations Children's Fund
WHO	World Health Organization
NPC	National Planning Commission
CBN	Central Bank of Nigeria
GDP	Gross Domestic Product
UNDP	United Nations Development Program
ANC	Antenatal Care
MDG	Millennium Development Goal
PNC	Post-natal Care
USAID	United State Aid
HIV	Human Immunodeficiency Virus
STIs	Sexually Transmitted Illnesses
LGA	Local Government Area
IMU	Index of Medical Under-service
WCBA	Women of Child Bearing Age
PHC	Primary Health Care
PPMCC	Pearson Product Moment Correlation Coefficient
MSS	Midwives Service Scheme
RI	Routine Immunisation

MNCHW	Maternal and New-born Child Health Week
AFRIN	Accountability Framework for Routine Immunisation in Nigeria
REW	Reaching Every Ward
WPV	Wild Polio Virus
NHMIS	National Health Management Information System
NPHCDA	National Primary Health Care Development Agency
BEOC	Basic Essential Obstetric Care
CEOC	Comprehensive Emergency Obstetric Care
NSHDP	National Strategic Health Development Plan
DHIS	District Health Information System
ICF	International Classification of Functioning

OPERATIONAL DEFINITION OF TERMS

For the purpose of this study the following are operationally defined terms:

Health Care Services: This are the services rendered in all the healthcare centres in Plateau state according to the provision of the healthcare act.

Primary Healthcare Service: This is referring to health services render at the grassroots level of every community that is the first level of contact between the patient and the healthcare system situated at the local government level of each state of Nigeria

Satisfaction: Refers to the measure of quality of care women of child bearing age receive when they visit primary healthcare centres in Plateau state, Nigeria.

Utilization: Is a process where by women of child bearing age in Plateau state make use of available healthcare services at the primary healthcare centres in the state.

Women of child bearing age: These are all women who are within the age of 15-49 years of age, used as participants in this study.

Utilisation of Primary Healthcare Service Among WCBA: This is the process of using the grassroots health services centres (PHC).in other to solve any health need by women of child bearing age in Plateau State.

Satisfaction with Primary Healthcare Service Among WCBA: Is a term which describes the amount of enjoyment and acceptance towards healthcare services received by women of childbearing age at the grassroots health facilities (PHC).

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Since from inception the world health organisation (WHO), Millennium Development Goal (MDG),Sustainable Development Goal (SDG) and others have been putting efforts and resources in attempt to ensure that health in Nigeria and Africa is maintain to expectations but despite all input, health challenges still remain common in our societies.

In developed countries, utilization of antenatal care facilities has become a routine. Prevalence of utilization is approximately 100 percent, bringing the maternal mortality rate to a- significantly lower level of 0.3 percent per 1000 live births. In developing countries, maternal mortality has been little affected by modern maternity due to poor utilization of these services.

Primary health care is defined as essential health care that is based on 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 that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Federal Republic of Nigeria Health Review, 2017). Primary healthcare can also act as the basis of the healthcare system by establishing fundamental policies, programme and priorities that respond to the population health needs. In Nigeria, a notion of primary health care is seen as a defined set of services, which are in accordance with local needs, and it is an entry point into the health care system. The services at that level alone are not sufficient to adequately cater for the more complex health needs of the populace. Thus health care systems should work in an integrated manner through the development of mechanisms that coordinate care across the entire spectrum of services, including referral systems (Obionu, 2017). Utilization could be the

main benefit of the primary healthcare scheme and perspective about the services accessed, is very important that many out patience seemed dissatisfied with the services accessed under primary healthcare services; with dissatisfaction from service areas like registration processes, poor utilization of the facilities, long waiting time, poor staff attitudes, and unavailability of prescribed drugs and others. It is on this basis the researcher intends to assess the utilization and satisfaction of Primary Healthcare Service among women of childbearing age in Plateau State, Nigeria. Most pregnant women who register for antenatal care in a health facility with a skilled birth attendant in Nigeria do not deliver in such facility, some end up delivering in mission houses, traditional or even at home, assisted in delivering by unskilled birth attendant, while a portion of those who deliver there do not utilise other maternal healthcare services available within the facility and in Nigeria 41% of women who register for antenatal care in facility with skilled birth attendant, did not deliver in a health facility, (Dahiru&Oche, 2019),

Public health system in Nigeria, has failed to deliver adequate level of services, especially to the disadvantage groups (Lecky, 2018). First, access to public healthcare is limited, due to financial barriers for the availability and accessibility of health facilities. Secondly, public health worker's morale is poor, as salaries in public health sector are low in Nigeria, especially at state levels. As result of poor healthcare delivery system, the utilization of public health services is actually decreasing in some areas (Oladipo, 2010). Recently mental and dental care as well as primary eye care have been included as other components of primary health care. The basic principles of the PHC system are essential health care, community participation, equity, appropriate technology and inter-sectoral collaboration (Federal Republic of Nigeria Health Review, 2017).

Client's satisfaction with healthcare services has in recent years, gained widespread recognition as a measure of quality of care. Since high quality healthcare outcome is dependent on

compliance which, in turn, is dependent on patient satisfaction, the latter has come to be seen as a legitimate healthcare goal and therefore of quality care. Hence care cannot be high quality unless the patient is satisfied. Increasing consumerism poses challenges for healthcare providers (HCPs), particularly for those in primary care. Quality improvement to meet patients' heightened demands for service excellence will require effective continuous measurement of patient perspectives. By systematically measuring patient satisfaction and perception of quality, medical practices can increase the effectiveness of primary care, improving patients' outcome and control cost (Akpala, 2018).

Access to healthcare service is consider as a link between the healthcare system and the population it serves, the volume of types of services whether or not the service can be reached, the clients perceptions of the relative worth of the service and acceptability of the services provided, all influence access and the utilization of services. healthcare facilities in Nigeria constitute a hierarchical system which is reflected in space by the geographical arrangements of service outlets in which a particular tend to have numerous primary healthcare facilities, less secondary and a very fewer tertiary health facilities if at all, (Okafor 2007). Ewunetu, Mekonnen and Anteneh (2019) revealed that Satisfaction involves the collection of factors such as the service provider's knowledge, medical and communications skill, personal attributes, accessibility, the convenience of location and the surrounding area, resource availability. While Mehate, and Paudel, (2017) identified physical environment of the delivery ward and quality of care. Maternal satisfaction is one of the most frequently reported outcome measures for quality of care, and it needs to be addressed to improve the quality and efficiency of health care before and during pregnancy, childbirth, and puerperal period, that is from birth to three weeks after birth, to provide quality maternal-friendly services. The satisfaction of Women of childbearing

age is very necessary since they are an important group in the population of a country and constitute 21% of the whole population of a country and are a determinant in the utilization of maternal health care services (Al-mandari, 2018). Therefore, good quality maternal healthcare, health facility delivery service, maternal and foetal good condition should increase women's satisfaction.

To improve maternal and child healthcare, child bearing women have to be satisfied with antenatal, delivery, postnatal and family planning services, hence the need to study the satisfaction level of childbearing women with quality of maternal healthcare services from the client's experience and perspective as it relates to some structural factors (physical facility, resources: human and material resources, process of care; healthcare delivery, midwives communication skills, staff conduct and practice. Findings from a qualitative study conducted by Al-Mailam (2019) on why women do not utilize primary health for pregnancy care, revealed the quality of care as one of the reasons and this includes provider's competence, negligent and unfriendly attitudes of PHC providers, physical environment and facilities, inadequate supply of drug,Lack of man power, long waiting time and inappropriate referrals. To many women who mentioned the quality of care as a barrier, they would rather give birth at home than go to a primary healthcare facility. These explain the reason why attention needs to be given to their satisfaction level on the quality of maternal healthcare services. Existing interventions to reduce maternal mortality in Nigeria have centred on health-seeking behaviour and access to services, with little focus on the social and cultural factors that influence maternal mortality (Kana, Doctor, Peleteiro, Lunnet& Barros, 2019).

1.2 Statement of the Problem

Healthcare service sector has been bedevilled with a lot of challenges from poor utilization to lack of hospital visits from the community members to mention a few.

From the researcher's experience, even though primary health care services are accessible, affordable and available in virtually every community and village in Nigeria, clients still travel long distances to reach secondary and tertiary health care institutions, contributing to pregnancy and childbirth-related complications, high maternal and neonatal mortality. This shows that the existence of maternal health services alone does not guarantee their use by women hence, the need for childbearing women to be satisfied with the quality of maternal healthcare services in Nigeria. This is evident in world health organization [WHO] (2020) report which stated that increase in maternal and new-born mortality and stillbirths are due to inadequacies in the quality of care provided in health facilities.

The researcher also observed that there is an increase in the number of maternal and child mortality, this could be as a result of the underutilization of healthcare services among women of child bearing age. Titus, Adebisola and Adeniji (2015), reported that under-utilization of healthcare services in the public sector remains a universal phenomenon. The World Bank (2010), reported that "the state of the Nigerian health system is dysfunctional and grossly under-funded with a per capita expenditure of US$ 9.44". As a result, Nigeria still has one of the worst health indices in the world and sadly accounts for 10 percent of the world's maternal deaths. Healthcare access and utilization remains an area of major interest to rural development, because they are vital elements of wellbeing and components of human capital (Aghion, Howitt,

&Murtin, 2010). In rural areas, where physical jobs tend to be more abundant, healthcare access and utilization stand to be more important.

The researcher observed that there is an increase in the number of vaccine preventable diseases.Previously and occasionally there used to be an outbreak of measles, cholera, scabies and malaria in my community of assignment (Ganawuri),in a process of home visit for community diagnosis on immunisation compliance and other health prevalence, the researcher noticed a lot of immunisation defaulters card and card less cases, in such situation it will be difficult to prove whether such child has ever been immunised or not, more of such child is dangerous to the community in terms of health promotion and prevention this could also occur as a result of not being satisfied or not utilising primary healthcare units by women of child bearing.Feldstein, Mariat, Gacic-Dobo, Diallo, Conklin, & Wallace, (2017) stated that Nigeria is the country which has the largest number of under one-year population in Africa,also pointed out that about 20% of the world's children under 1 year of age who live in Nigeria had incomplete Diphtheria PertussisTetanus (DPT) vaccination in 2017. This could be as a result of several factors. Olorunsaiye and Degge, (2016) and Adedokun, Uthman, Adekanmbi and Wiysonge (2017) reported that maternal education, lack of antenatal care attendance and place of delivery, religion and place of residence have been reported to be associated with lack of childhood vaccination in Nigeria.Immunisation coverage are generally low in rural areas compared to the urban areas (Adedokun, et al. 2017), the study by Dudu and Onokerhoraye (2018) reported lower rates of immunisation coverage in slums than in formal urban areas. The rapid urbanisation in Nigeria may become a further barrier to childhood immunisation uptake, growth results in overstretching of the health facilities, leading to decreased health service quality and reduced access to health and immunisation (Dudu&Onokerhoraye, 2018).

The researcher also observed that women of child bearing age are mostly not satisfied with the healthcare service delivery at the Primary Health Care (PHCC). Most of the women the researcher interacted with showed their displeasure in the manner and way the healthcare workers shout at them or scold them when they go for hospital delivery and other healthcare services. Their bitterness could be an indication of lack of satisfaction. More so in an open conversation with some women of childbearing age pertaining health services issues the researcher also experienced similar challenges from their response that, at most, the charges for drugs use to be high despite that only 50% of medications will be available they will still have to purchase others from the pharmacy patients.It is therefore on this background that the researcher was moved and chose to conduct this study to assess utilization and satisfaction with healthcare services among women of childbearing age in Plateau State, Nigeria.

1.3 Purpose of the Study

The main purpose of the study was to assess the utilization and satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria. The specific purposes are, to assess the;

1. Utilization of healthcare services provided by primary health care units for women of childbearing age in Plateau State, Nigeria.
2. Satisfaction with healthcare services provided by primary health care units for women of childbearing age in Plateau State, Nigeria.
3. Services provided by primary health care units for women of childbearing age where available in plateau state, Nigeria.
4. Relationship between utilization and satisfaction with healthcare services provided by primary health care units for women of childbearing age in Plateau State, Nigeria.

1.4 Research Questions

Based on the specific purposes of the study, the following research questions werestructured for the purpose of this study:

1 Do women of child bearing age in Plateau State utilize the health care services provided by primary healthcare centres?

2 Do women of childbearing age in Plateau State satisfy with healthcare services provided by primary health care centres for women of childbearing age?

3 What are the healthcare services providedin primary health are (PHCs) Units for women of child bearing age in Plateau state, Nigeria?

4 What is the relationship between utilization and satisfaction of healthcare services provided by primary health care centres for women of childbearing age in Plateau State, Nigeria?

1.5 Research Hypotheses

On the basis of the research questions, the following hypotheses were formulated for the purpose of this study;

1. Utilisation of primary healthcare services by women of childbearing age in Plateau State, Nigeria. Is not significant
2. There is no significant satisfaction with primary healthcare services bywomen of childbearing age in Plateau State, Nigeria.
3. The healthcare services provided at the Primary Health Care Units for women of childbearing age in Plateau State, are not significant.

4. There is no significant relationship between utilization and satisfaction of healthcare services provided by primary healthcare amongwomen of childbearing age in Plateau State, Nigeria.

1.6Basic Assumptions

On the basis of available research evidence, it is assumed that.

1. The utilization of primary healthcare services of the women of childbearing age in Plateau State, Nigeria is poor.
2. The satisfaction with primary healthcare services of the women of childbearing age in Plateau State, Nigeria is insignificant.
3. The primary healthcare services being utilized by women of childbearing age in Plateau state, Nigeria is inadequate.
4. The relationship between utilization and satisfaction with primary healthcare services among women of childbearing age in plateau State, Nigeria is not proper.

1.7Significance of the Study

The results of this study will be beneficial to women of child bearing age, primary healthcare development agency, health educators and researchers:

The findings of this study when published would be of benefit to all women of child bearing age. It will provide them with information regarding healthcare services at the primary health care available for women of child bearing age, therefore this would help to make them aware of the services and as well encourage utilization among the women, also will be of benefit to WCBA in the sense that there response on the questionnaire for utilisation and satisfaction with PHC services will be measured and the result will speak indirectly to the authority about their

experiences and the challenges which they are facing during the period of seeking for antenatal healthcare services at the PHCCs in Plateau State, if it require any amendment.

The findings of this study will also be of benefit to primary healthcare development agency in the state by providing them with the state of utilization and satisfaction by women of child bearing age with regards to healthcare services provided at the PHCCs in the state. This would help them to make plans to establish more strategies that will encourage WCBA to utilise the PHCC for antenatal and child delivery also to organise workshops and symposiums that would help to improve service delivery at the PHCCs in the state so as to further sustain, encourage and improve utilization among women of child bearing age in the state. Furthermore, the study will also encourage, Non-Governmental Organisation (NGO) to put in more assistance in support of WCBA at the PHC level in the State.

The findings of this study would benefit health educators, it would provide them with information regarding utilization and satisfaction of health care services among women of child bearing age in the state. This would help them to organise awareness and sensitization campaigns so as to enlighten the women of child bearing age as well as the general public on the need for health seeking at the primary healthcare.

The findings of this study will also be of benefit to researchers. It would provide them with literatures to help those interested in carrying out further studies on utilization and satisfaction of healthcare services among women of child bearing age.

1.8Delimitations of the Study

This study was delimited to “Assessments of utilization and satisfaction with primary healthcare service among woman of childbearing age in Plateau State, Nigeria”. The study was specifically delimited to;

Utilizationof primary healthcare services among women of childbearing age in Plateau state, Nigeria.

Satisfaction with primary healthcare services among women of childbearing age in Plateau state, Nigeria.

Women of childbearing age (15-39 years) in Plateau State attending healthcare facility.

Three senatorial zones, 3 LGAs and 6 wards in Plateau State, Nigeria, were used as the study areas.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0Introduction

This study focused on Assessment of Utilization and Satisfaction of Primary Healthcare Service among women of childbearing age in Plateau State, Nigeria. Relevant and professional literature evidences are reviewed and presented under the following sub-titles:

2.0 Introduction

2.1 Conceptual Framework

2.2 Concept of Primary Health Care

2.3 Primary Healthcare System in Nigeria

2.3.1 Components Primary Health-Care Service Delivery

2.3.2 Types of Primary Health Care Services Been Utilised by Women of Childbearing Age

2.3.3 Barrier to Primary Health Care Service Delivery in Nigeria

2.4 Development of HealthCare Service in the 21st Century

2.5 Provider Base Factor

2.6 Empirical Studies on utilization and satisfaction of healthcare services Among Women of Child Bearing Age (WCBA)

2.7 Utilisation of Primary Health Care Service amongWCBA

2.7.1 Age Determination of Primary Healthcare Utilisation

2.7.2 Barriers to Utilisation and Satisfaction of PHC Services

2.8 Satisfaction with Health Care Delivery System among WCBA 2.9 Theoretical Framework

2.10 Summary

2.1 Conceptual Framework

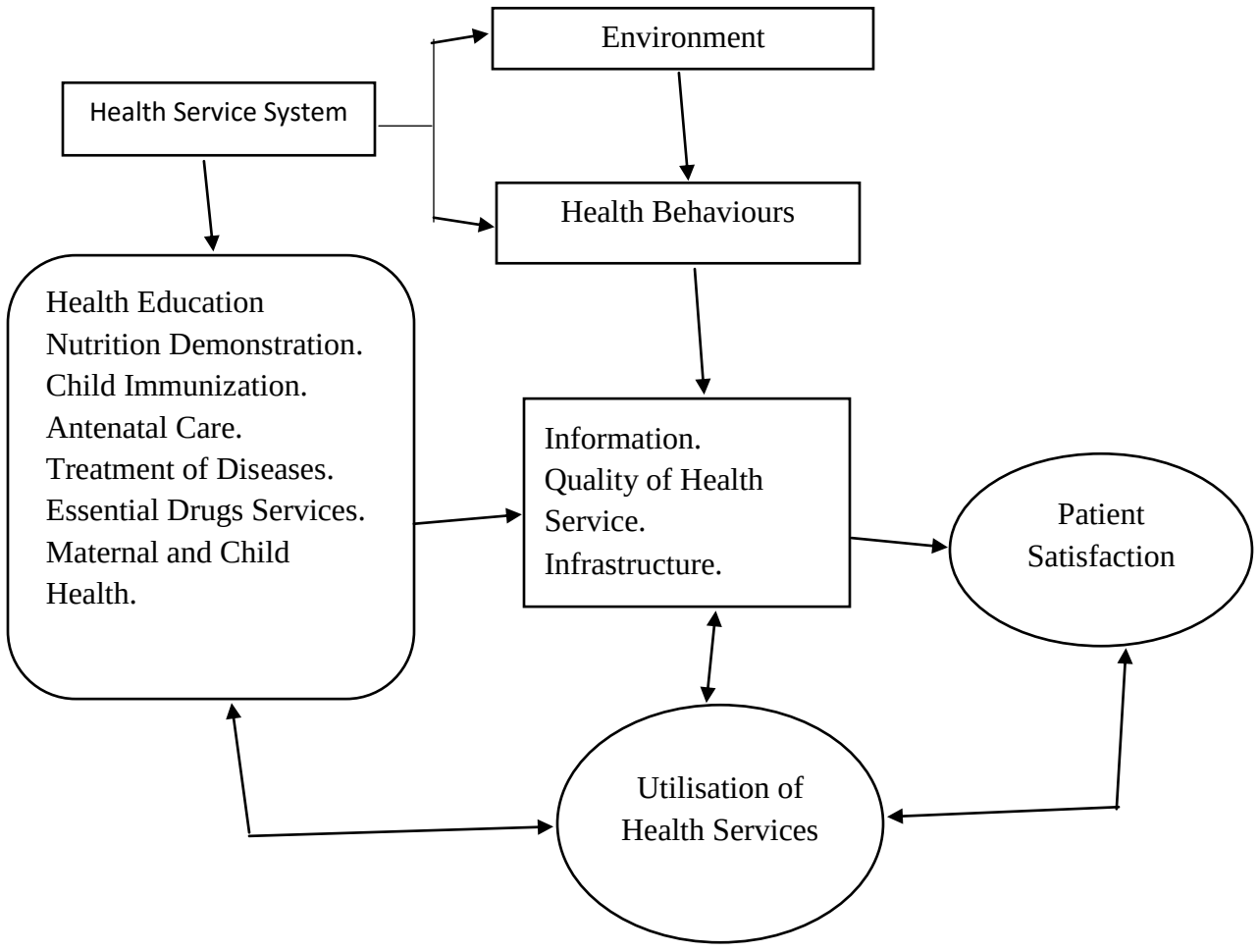


Fig 1. Conceptual framework for Primary Healthcare Services Utilisation and Satisfaction

In other attain the goal of sustainable health for all as expected by the world health organisation, reducing global morbidity and mortality, which was part of the observed challenges that lead the researcher to assessing the utilisation and satisfaction with primary health care services among women of child bearing age in plateau state, primary health care has been used as a grass root approach equipped with various services to the cater for the health needs of the most communities. One of the major target group are WCBA, in our communities these facilities are spread with the available resources to provide healthcare services, the above conceptual framework constitutes variables which illustrates the researcher's idea for primary healthcare service utilisation and satisfaction by women of childbearing age in Plateau State.

With the existence of primary healthcare units in most environments the health behaviour of women varies according to individuals and their socio-cultural beliefs and practice toward seeking for healthcare services, primary healthcare centres provide the following healthcare services; Health Education, Promotion of Safe Food Supply and Proper Nutrition, Maternal and Child Healthcare including Family Planning, Immunisation Against Major Infectious Diseases, Provision of Essential Drugs, Adequate Supply of Drinking Water and Basic Sanitation, all these services are obtainable at each PHCC, with a positive change in behaviour among WCBA toward seeking for healthcare service through proper awareness and information,quality of health service, and adequate infrastructure coupled the services render at the PHC units for WCBA, Utilisation will increase in connection with Satisfaction among women of childbearing age in Plateau State, Nigeria respectively.

2.2 Concept of Primary Healthcare

The concept of primary health care was formulated and adopted by 134 countries that met at the Alma-Ata Conference in Russia on the 12th day of September, 1978, under the auspices of

World Health Organization (WHO) and the United Nations Children Fund (UNICEF) (Statistics, 2018) It is that system of health care that is closest to the communities and that is meant to serve those in the most vulnerable group whose needs for health are paramount and critical. Thus, all activities performed at this point are supposed to be first-line, aimed at bringing health care as close as possible to where people live and work and contributes the first elements of a continuing health care process.

Primary Health Care (PHC) arose as a result of the clear realization of the numerous mismatches in the health care system vizthe colossal mismatch between the innumerable health needs of people and the scarce resources meant to address these needs. There is also a mismatch between health needs and inter-sectoral health expenditures. While 80% or more of our problems are preventable our spending on health are in the opposite direction, another mismatch is between population distribution and health services distribution; (the so called inverse pyramid of health care), these series of problems and dislocations have led to the alienation of the people and made the beneficiaries of the system passive and docile. There is therefore the need for a people oriented system that will be able to address all the above challenges; it is believed that Primary Health Care can do that (Akpala, 2018).

The World Health Organization defined primary health care 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 (Lucas, 2017). The World Health Organization (WHO) went ahead to itemize the aims and objectives of the Primary Health Care system as follows: (Lucas, 2017).

1) To make health services accessible and available to everyone wherever they live or work.
2) To tackle the health problem causing the highest mortality and morbidity at a cost that the community can afford.
3) To ensure that whatever technology is used must be within the ability of the community and use effectively and maintained.
4) 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.

a good primary health care service must be essentially aimed at promoting health, curing and preventing disease as well as rehabilitating people to ensure that they live full normal lives after illness or disability. In the 1999 Constitution of the Federal Republic of Nigeria and the National Health Bill (2018), which was a document meant to provide a framework for the regulation, development and management of a national health system through setting standards for rendering health services in the federation. In the Constitution of the federal government, health is in the concurrent legislative list and by implication; the three tiers of government are vested with the responsibilities of promoting health at various levels of care. According to these documents, the federal, state and local government shall support in a coordinated manner. The three tier stepwise system of health care viz: Primary Health Care to be coordinated by the localGovernment; Secondary Health Care by the state government and Tertiary Health Care by the federal government.

Therefore, Primary Health Care at the grass root shall serve as the focal as well as the entry point for all health care activities. The National Health Bill also made a provision for the establishment

of the National Primary Health Care development fund; which shall be financed from the consolidated revenue account, via not less than 2% of the fund, 50% of the funds shall be used for the provisions of basic minimum package of health care services to all citizens in the Primary Health Care through the National Health Insurance Scheme; while 25% of the funds are for the provision of materials and transport facilities in the Primary Health Care, while 10% of the funds shall be used for the development of human resource (Adeyemo, 2005)

The delivery of this package shall be coordinated by the National Primary Health Care Development Agency in close collaboration with the various state and local government health care departments. The National Primary Health Care Development Agency (NPHCDA) was established by Decree 29 of 1992, set up with the primary aim of ensuring sustainability of the Primary Health Care system in Nigeria (Senate Federal Republic of Nigeria (2018).

As a parastatal under the Federal Ministry of Health, to give support to the health policy through motivating of Primary Health Care plans and implementation, as well as provision of technical support to Primary Health Case implementation. For ease of administration, it operates based on the geo-political nature of our political system. It aims to mobilize support nationally and internationally for program implementation, administer or commission studies on Primary Health Care issues; if properly utilized, National Primary Health Care Development Agency(NPHCDA) was designed in such a way that it could serve as a capacity building organization. Moreover, they were measurable and had clear targets. In the next few years, some agencies added; food supplementation, female literacy, and family planning (FFF) to the acronym; Growth monitoring, Oral rehydration, Breast feeding and Immunisation.(GOBI), creating GOBI-FFF (Yan, 2019).

According to Evans, Hall and Warford(2019) it created the right balance between scarcity and choice, the notion of comprehensive primary health care, as the holistic original idea of primary

health care began to be called, considered selective primary health care to be complementary to the Alma-Ata Declaration, while others thought it contradicted the declaration and view it as a narrow techno centric approach that diverted attention away from basic health and socio economic development without addressing the social causes of disease, and resembled vertical programs.In addition, critics said that growth monitoring was difficult since it required the use of charts by illiterate mothers (recording data was not an easy operation, weighing scales were frequently deficient, and charts were subject to misinterpretation) (Evans, et al, 2019).

Antenatal Care: The word 'antenatal' relates to any event or condition that occurs or exists in the embryo or the mother during the period between conception and delivery of the infant. Antenatal care, therefore, is the care of a pregnant woman and her foetus by health care staff from conception to the onset of labour (WHO, 2016). In addition to providing antenatal care, health professionals in the primary health care perform face-to face education for all pregnant women on issues such as pregnancy, delivery, and the postpartum period, and also recommend a schedule for the next visits. Pregnant women can select their own health professionals for receiving prenatal care and the education they need (Trotman, Chhatre, Darolia, Tefera, Damle, & Gomez-Lobo, 2015). The effectiveness of antenatal care is not only the aim but also improving maternal satisfaction with health care services (Tunçalp, Pena- Rosas, Lawrie, Bucagu, Oladapo, Portela, &MetinGülmezoglu, 2017). The knowledge about users' views is still very limited, especially in the developing countries. The number of pregnant women in the developing countries receiving antenatal care during pregnancy has increased significantly since 1990 about 20 % (Gebremeskel, Dibaba, &Admassu, 2015).

The purpose of ANC is to improve pregnancy outcomes for both the mother and the foetus. The aim of the first ANC visit is for health staff to establish rapport with the client and to collect

information to evaluate the client's health status and preparedness for motherhood. Antenatal care from a trained provider is important to monitor the pregnancy and treat complications in pregnancy. According to the Nigeria Demographic and Health Survey (NDHS) (2016) results, 94 percent of women who gave birth in the five years preceding the survey received antenatal care (ANC) from a health professional at least once. Urban women are slightly more likely to receive ANC at least once than rural women (97 percent compared with 93 percent) (UBOS and Macro Org. 2017). Furthermore, opportunities for preventive health services, such as prophylactic treatment of malaria and immunization against neonatal tetanus (Preston, &Guillot, 2000) are also provided through antenatal care (ANC). Antenatal care also makes it possible to screen for sexually transmitted diseases such as HIV infection, which is known to have taken its toll in much of the developing world. Counselling and education of pregnant women about their own health and that of their children is also an opportunity that can be incorporated into ANC.

The WHO (2018) recommends a minimum of four ANC visits for every pregnant woman. A greater number of visits, though not beneficial for low risk pregnancies, are recommended for women with higher risks of obstetric complications. However, the capability of ANC in improving Maternal Health (MH) outcomes is greatly reduced in the absence of a viable health and referral system where women can receive emergency obstetric care when needed.

Skilled Birth Attendance: Skilled attendance is a term which encompasses the presence of professionals (midwives, doctors, nurses, etc) during delivery and also an enabling environment where the equipment, drugs and other supplies required for effective and efficient management of obstetric complications are available (Alayon, 2017). Skilled Birth Attendants (SBA) are trained to recognize the signs of complications early enough to intervene and manage the situation or make quick referrals to higher levels of care. Available evidence suggests that the

presence of SBAs during delivery dramatically reduces maternal mortality (Mpembeni, 2017). This is illustrated by historical evidence from industrialized countries where maternal mortality was reduced by half following the introduction of professional midwifery care at birth, in the early 20th century. Improved access to hospitals after the Second World War further reduced maternal death rates, subsequently resulting in the impressive low levels currently recorded (WHO, 2018).

Contemporary empirical research also supports the presence of skill birth attendants as a tool to improving maternal health. For example, in the 1950s and 1960s, studies show that maternal mortality ratios were reduced by half in Sri Lanka, Malaysia and Thailand within a 10-year period by increasing the number of midwives attending to births. Similarly, by doubling the proportion of births assisted by skilled professionals, Egypt reduced its maternal mortality ratio by 50% between 1983 and 2000 (WHO, 2018). Skilled attendance during delivery can only be provided in the presence of functioning health systems which include adequately trained and motivated workers, well equipped facilities, transportation and rapid referral systems. These are non-existent in the health systems of developing countries, which are grossly under-funded. It is, therefore, no surprise that women in these countries have limited access to SBAs and even less access to emergency obstetric care (Kruk, 2017). The presence of SBAs at all births is regarded as, probably, the single most critical intervention for reducing pregnancy-related deaths and disabilities (Alayon, 2017; Mpembeni, 2017). For this reason, the proportion of births attended by a skilled health professional is currently being used as one of the indicators for monitoring progress in the achievement of MDG 5.

Postnatal Care (PNC): The postnatal period is the time from immediately after birth up to 40 days. It is important for mothers to receive care at this time as it has been recorded that more

than 60% of maternal deaths take place during the postnatal period (Gill 2017). The death of a mother further exposes her new-born child to high risks of morbidity and mortality. Thus, receiving PNC can make the difference between life and death for both mother and child. In developing countries, the most common causes of maternal deaths during the postpartum period are haemorrhage, infections and hypertensive disorders (Gill, 2017). Technically, all of these conditions are treatable. Through examination of the mother after childbirth, PNC can identify these conditions and any other life-threatening or debilitating conditions that may require urgent medical attention.

Several other important services and information can be provided during PNC. These include family planning services where information about child spacing and techniques to avoid unwanted pregnancies can be given. Other services and information, such as maternal and child nutrition, immunization, hygiene and sanitation, prevention of infections including HIV and other STIs (USAID, 2019); can all be provided during PNC. However, though the importance of these services are well known and are sometimes available in clinics, it is reported that less than 30% of women in developing countries access or receive care or medical follow-up in the period immediately following childbirth (Population Council, 2010).

2.3 Primary Health Care System in Nigeria

In Nigeria, primary healthcare was adopted in the National Health Policy of 1988 (FMOH, 2004) as the cornerstone of the Nigerian health system as part of efforts to improve equity in access and utilization of basic health services. Since then, primary health care in Nigeria has evolved through various stages of development. In 2005, primary health care facilities were found to make up over 85% of health care facilities in Nigeria (FMOH, 2010)

there were three major attempts at evolving and sustaining a community and people oriented health system in Nigeria. The first attempt occurred between 1975 and 1980. The fulcrum of this period was the introduction of the Basic Health Services Scheme (BHSS) (Smith, 2018) The Basic Health Services Scheme came into being in 1975 as an integral part of Nigeria's Third National Development Plan (1975 – 79) and was structured along "basic health units" which consisted of 20 health clinics spread across each LGA, which were backed-up by four (4) primary health care centres and supported by mobile clinics serving an approximate population of 150,000 each. The drawback of this attempt was the non-involvement of local communities who were the beneficiaries of the services. This led to the inability to sustain the Scheme at the close of the third national development plan period, (Dungy, 1979: Adeyomo, 2005)

A second attempt which was led by late Professor OlukoyeRansome-Kuti occurred between 1986 and 1992 This period was characterized by the development of model primary health care in fifty-two (52) pilot local government areas all of which were implementing all eight components of primary health care. A key result of this dispensation was the attainment of 80% immunization coverage for fully immunized under-five children. Meticulous application of the principle of active community participation and focus on issues relating to health systems strengthening (HSS) was largely responsible for the success recorded, (Kuti et al, 1991).

The National Primary Healthcare Development Agency (NPHCDA) was established in 1992 and heralded the third attempt to make basic healthcare accessible to the grassroots. During this period, which spanned through 2001, the Ward Health System (WHS) which utilizes the electoral ward (with a representative councillor) as the basic operational unit for primary health care delivery was instituted. This was in response to the devolution of Primary Healthcare to the Local Governments by the then military government. The Ward Minimum Health Care Package

(WMHCP) which outlines a set of cost effective health interventions with significant impact on morbidity and mortality was also developed. The package took into cognizance the nation's burden of disease, current trends in disease prevalence and priority diseases of national importance. The Ward Minimum Health Care Package was developed within context of the Ward Health System and aligned with the millennium development goal (MDG) targets of Nigeria. To drive this new policy over 500 hundred model health centres were established across the nation by the federal government (NPHCDA, 2012).

These centres served as a fulcrum for the establishment of the Ward Health System and the community mobilization as Ward Development Committees, which is constituted of selected community representatives, were established around the model primary health care centers. While it was logical that Primary Healthcare, which is community oriented, be established around the tier of government perceived to be closest to the people, the sudden devolution of primary health care to the local government areas may have had negative implications on sustainability of quality as that level of governance is also known to have the weakest technical capacity. Again the Federal Government's intervention by building model health centres for the local government areas, though well-conceived, was paradoxical to the newly initiated principle of devolution of healthcare. While this intervention may have been sustainable under the unitary military dictatorship, its sustainability was challenged by the advent of democracy in 1999, (Huber,2020).

Although the National Primary Healthcare Development Agency (NPHCDA) had some modest achievement in its early years, it was not until the advent of democratic governance that it earnestly began to formulate, establish and implement policies that would secure its place as the steward of primary health care in Nigeria. Particularly noteworthy amongst these are reactivation

of routine immunization, polio eradication initiative, midwives service scheme (MSS), primary healthcare reviews, integrated primary healthcare governance, strengthening of the National Health Management Information System (NHMIS), and the bi-annual Maternal New-born and Child Health Weeks (MNCHW), (WHO, 2019).

i. Reactivation of Routine Immunization (RI)

is being effected through the development of required policies and tools provision of bundled vaccines and cold chain equipment and active participation in the entire immunization process. The fusion of the National Program on Immunization (NPI) with National Primary Healthcare Development Agency (NPHCDA) in 2007 marked a major stride in the delivery of integrated PHC services in Nigeria. Nigeria has recently developed a National Routine Immunization Strategic Plan (2013-2015) which highlights the Reaching Every Ward with RI services (REW); Accountability Framework for RI in Nigeria (AFRIN) and Back to the Basics: Health System Strengthening, as its pivot strategies. In keeping with the determination of the nation to interrupt the transmission of the wild polio virus (WPV) by December, 2014, the NPHCDA stepped up its polio eradication drive with the establishment of the Polio Emergency Operation Centres; strengthening of the national and sub-national immunization plus days in addition to community sensitizations and various stakeholder meetings as strategies to overcome socio-cultural and other barriers to achieving this target.

ii. The Midwives Service Scheme (MSS)

is a national initiative designed to improve the quality of (and access to) maternal and child health services with the overall goal of morbidity and mortality reduction, The MSS utilizes a cluster model of hub and spoke arrangement in which four (4) selected primary health care

facilities with capacity to provide Basic Essential Obstetric Care (BEOC) are clustered around a General Hospital with the capacity to provide Comprehensive Emergency Obstetric Care (CEOC) and which serves as a referral facility (NPHCDA, 2013a). The scheme currently covers 250 clusters comprising of 1000 primary health care facilities and 250 General Hospitals in Nigeria. Quarterly Primary Healthcare Planning and Reviews (PHC Reviews) were introduced in 2010 to monitor the progress in implementation of PHC component of the National Strategic Health Development Plan (NSHDP). The reviews currently utilize the Diagnose-Intervene Verify-Adjust (DIVA) model. This methodology provides real-time evidence to inform policy decisions at all levels of decision making across six (6) determinants of PHC outcomes. These include availability of commodities, human resources and geographical accessibility representing the supply side determinants while on the demand side, initial utilization, continuity and quality coverage are examined during the reviews. A key constraint in sustainability of this intervention is the poor buy-in of the various state governments. Although all the thirty-six (36) plus the federal capital territory have been trained on this methodology, the NPHCDA reports that as at 2013, only Lagos, Kaduna and Nasarawa states have initiated some level of institutionalization of the process. Attempts at addressing the series of management challenges confronting primary health care in Nigeria have led to the renewed interest in the establishment of a unified state level structure that should have the responsibility of coordinating the management of primary health care systems/services (NPHCDA, 2013b).

Hence the need to integrate primary healthcare governance within the concept of 'PHC Under One Roof'. The PHC Under One Roof Initiative aims to strengthen the primary healthcare system through the implementation of the Principle of "Three Ones"- One Plan, One Management and One Monitoring and Evaluation System- for Primary Health Care. In response

to the challenge of poor health data management, the Federal Ministry of Health (FMOH) took leadership in the harmonization of routine data collection tools in 2013. The harmonized National Health Management Information System (NHMIS) tools and revised HMIS policy were developed and adopted by the 56th National Council on Health in 2013. The implication is the institution of the web-based District Health Information Software (DHIS 2.0) as the national platform for all health related data in Nigeria (FMOH, 2013).

Nationwide capacity building on this system and policy is ongoing with support from development partners and nongovernmental organizations. Although data reporting rates have increased since the commencement of this system, the quality of routine health data in Nigeria still leaves much to be desired, this is further compounded by the poor private sector compliance and buy-in into the NHMIS. The bi-annual Maternal New-born and Child Health Weeks (MNCHW) was launched by the Federal Ministry of Health in 2009 to provide the much needed platform for the delivery of cost-effective interventions aimed at reducing the existing high morbidity and mortality rates in children. During the week, primary healthcare services are offered in health facilities, from house to house, and at community stations. The services offered include immunizations, anthropometry, distribution of food supplements, distribution of mosquito nets and health education (NPHCDA, 2011; Ordinoha, 2013).

iii. Implementing Primary Health Care in Nigeria

The great idea of grass-root health care delivery as encapsulated in the principles of primary health care requires the strong commitment of all stakeholders to make it work. Stakeholders are those persons or groups that have vested interest in the delivery of primary healthcare services and in healthcare decisions (AHRQ, 2014). The key primary health care stake holders include the

people, the government, and the healthcare workers. The people need to own primary health care through adequate community mobilization. Community mobilization is the process of arousing the interest of the people and encouraging them to participate actively in finding solutions to their problems (Olise, 2012). When the communities are involved in the planning, implementation and evaluation of primary healthcare services, they will not perceive them as being dumped on them. Community mobilization is a veritable tool for engendering support for primary health care, especially in the rural areas where over 66% of the Nigerian population live and the worst health indices are found (NPC and ICF Macro, 2009; FMOH, 2010).

Aspects of community mobilization include community entry, community dialogue, and operation of development and health committees. Government at all levels must express, in practical terms, political commitment through funding, capacity building and system support. They must put money where their mouth is and translate the great ideas behind primary healthcare into great programs and great services. Primary health care services are not third-class services meant for third-class citizens. Therefore, adequate provision must be made in national, state and local budgets for quality healthcare delivery using the primary healthcare system. The role of government is critical in promoting access to essential and quality health services (FMOH, 2010).

This can be channelled through the building and maintenance of infrastructure, training and retraining of the workforce, and provision of materials and equipment for effective health care. Health care workers involved in primary healthcare delivery in Nigeria include doctors, nurses/midwives, community health workers, laboratory scientists/technicians, and health assistants among others (AHWO, 2008). To make primary health care work, workers need to contribute their quota to improving quality service delivery and achieving clients' satisfaction.

This they can do through innovative utilization of available resources, encouraging patient participation in their care, and promoting healthcare worker patient communication (Babatunde, Aiyenigba, Awoyemi, Akande, Musa, Saludeen, Babatunde, &Atoyebi, 2013). The disposition of healthcare workers is very important in enhancing public perception on utilization and satisfaction of primary health care services. Commitment to duty, empathy, and a listening ear are desirable traits in primary health care workers that can enhance service delivery (Godlee, 2019).

2.3.1 Components of Primary Health Care Services

The components of Primary Health Care include at least the following: According to UNICEF (2010) they are;

i. Education concerning prevailing health problems and the methods of preventing and controlling them.
ii. Promotion of food supply and proper nutrition.
iii. Adequate supply of safe water and basic sanitation.
iv. Maternal and child health care including family planning.
v. Immunization against major infectious diseases.
vi. Prevention and control of locally endemic diseases.
vii. Appropriate treatment of common diseases and injuries.
viii. Provision of essential drugs.
ix. Community mental health care.
x. Dental Health.

Mental health and dental health are recent additions to the PHC component, but due to shortage of resources in Nigeria, the two are not made presently available (Agba, 2010).

The principles of PHC have been highlighted in subsequent discussions, but it is vital to appreciate that PHC is more than just the delivery of medical services. PHC always attempts to address people's health through an integrated approach, utilizing other sectors such as agriculture, education, housing, social and medical services. Bearing in mind that majority of disease affecting the populace in Africa is preventable. Individually, education on the prevailing health problems involves the conscious dissemination of curative and preventive information to the people, with the explicit.

The purpose of making health care accessible to all through community and self-help processes. Provision of adequate water and sanitation involves the overall environmental improvement involving water supply, sanitation as well as hygiene and general community involvement in1environmental management. This is manifested in programs like water and sanitation program (WATSAN). The WASH Program and the key household responsibilities global commitment towards guinea worm eradication, maternal and child health, including family planning is perhaps the vastest of all the Primary Health Care components. Inadequate or improved provision of maternal and child health services are major contributing factors to the worsening maternal and infant mortality and morbidity in Nigeria (Campbell, 2017).

Vital indices of child and maternal health vary according to states and regions in Nigeria, with a mean TFR of 5.7%.6 It means an average Nigerian woman will bear about 5-7 children in her life time. Family planning refers to a conscious effort by a couple to limit or space the number of children. It has been defined as the sum total of all services offered to couples to educate them about family life and to encourage them to achieve their desired wishes with regard to preventing unwanted pregnancies, securing designed pregnancies, spacing of pregnancies and limiting the size of family in the interest of family health and socio-economic status (WHO, 2010).

The maternal mortality rate in Nigeria is currently 800/100,000 live births, Infant mortality 87/1000 as mortality of 150/1000 (Federal Ministry of Health, 1996). the average contraceptive prevalence rate in Nigeria is 15.0% and 14.4% ante natal coverage, and only 4.7% of women have ever delivered in a hospital.5 60% of all babies born were also born after an interval of less than 24 months.34 Immunization is today the most powerful cost-effective means of preventing all or most of the deadly child diseases, and the conscious efforts by the WHO, UNICEF, and other stakeholders to immunize all eligible children led to the emergence of the expanded program of immunization, whose aim is to achieve (Oladipo, 2010).

i. i.80% immunization coverage of the target population by the year 1990 and a midterm goal of 60% by 1987.
ii. To reduce by 1990 at least 50%, the incidence of the target disease, i.e. TB. Diphtheria, pertussis, tetanus, poliomyelitis and measles through immunization and other preventive measures.
iii. To establish an efficient system of surveillance and program monitoring activities to ensure reliable systematic vaccine procurement strategies.
iv. To foster inter-sectoral cooperation and community involvement and participation in these activities at all levels and thus, to enhance the ability of the program to sustain itself.

The importance of this program led to the emergence of the National Program of Immunization as a parastatal under the Ministry of Health by Decree No. 12 of August, 1997. It has the following specific objectives:

I. To achieve polio eradication by the year 2005.
II. To eliminate maternal and neo-natal tetanus by the year 2005.

III. To reduce measles morbidity by 90% and mortality by 95%.

Among other objectives, it has the target of conducting the cold-chain rehabilitation plan by 2007 and ensures knowledge and skill developments are pursued (WHO, 1999). Whether or not these targets are met is subject to debate. But some literatures point to the fact that the overall national immunization coverage is 29% and in some states, it is as low as 1%. Promotion of food supply and proper nutrition to check or to correct prevailing nutritional problems in Nigeria, the percentage of U-5 who are malnourished has been taken to be 36%. 36 while another more reliable figure is 54% (WHO, 2003). Provision of essential drugs and supplies, the national drug list was drawn in 1985 and consists of about 420 items. The local government primary health care uses only 40 items at the community level, with a maximum participation of not more than 3 drugs allowed (Federal Ministry of Health, 2019).

2.3.2 The Type of Primary Healthcare Services being utilized by Women of Childbearing Age in Plateau State.

The types of primary healthcare services of PHC vary in various countries and communities. However, the basic concept of PHC is the same. According to the Alma-Ata Conference, the components of primary health care are:

i. Health Education: Good health is fundamentally and intrinsically important to live a worthwhile human life. Health education communicates with the facts that help to promote the ways of healthy living and to solve basic health problems. There are no standard health education program which are applicable everywhere; they must be developed locally with the communities concerned so that health technologies proposed will be appropriate, applicable, and compatible with their socio-cultural situation and their resources.

The implementation of PHC is primarily through services carried out at the primary health and home visits. These services are specifically related to the components of PHC previously discussed. The great idea of grassroots health care delivery as encapsulated in the principles of primary health care requires the strong commitment of all stakeholders to make it work. Stakeholders are those persons or groups that have vested interest in the delivery of primary health care services and in health care decisions (AHRQ, 2018). The key primary health care stakeholders include the people, the government and the health care workers.

As it is in other parts of the world, Nigeria has her own peculiarities characterizing the health care system. These peculiarities are related to her cultural, religious and socio-political diversities. Thus, strategies to implement primary health care must be evolved to meet the challenges associated with these diversities. These strategies include community mobilization and advocacy, service integration, health research, capacity building, and international and nongovernmental collaborations. Community mobilization is the process of arousing the interest of the people and encouraging them to participate actively in finding solutions to their problems (Olise, 2017). It is the gateway to providing effective health care services to individuals, families and groups within the community concerned. Community mobilization engenders community participation and community ownership and ultimately guarantees sustainability of health program (Magawa, 2019). In addition, it enhances resource mobilization, cost minimization and appropriate utilization of health services.

ii. Promotion of safe food Supply and Proper Nutrition: A balanced diet is highly necessary to live a healthy life. Sufficient supply of food and management of proper nutrition is necessary to get a balanced diet. Various health related problems emerge along with malnutrition.

Therefore, proper supply of food and management of nutrition is one of the important aspects of PHC.

iii. Maternal and Child Health, including Family Planning: Priority has been given to the service, training and research aspects of maternal and child health, including family planning. These activities are being supported by WHO in collaboration with other United Nations agencies such as UNFPA and UNICEF as well as multilateral and bilateral organizations.

iv. Immunization against Major Infectious Diseases: Immunization is a widely accepted level of protection against a large number of communicable diseases. People of developing countries, due to lack of proper knowledge of health, poor economic status and sophisticated curative health services, are not in a position to afford the expenses of treatment. Therefore, immunization is the only major preventive measure against such communicable diseases.

v. Provision of Essential Drugs: In the area of essential drugs, economic strategies have become an important component which merits serious consideration and inclusion in national drug policies. The member countries of WHO are strengthening primary health care in the context of The Goal of Health for All. One of the eight elements of primary health care, as identified at Alma-Ata is the provision of essential drugs. vii. Availability and Distribution of Medicine: One of the major intentions of the primary health care is to distribute and make the most common medicines available to the areas so as to control primary illness.

vi. **Adequate supply of safe drinking water and basic sanitation**: There is a close relationship between supply of water and sanitation. If there is no supply of water, the sanitation condition will automatically be affected. Water related diseases are most common causes of illness and death among the poor of developing countries. According to the World Health Organization,

1.6million deaths of children per year can be attributed to unsafe water, poor sanitation, and lack of hygiene

2.3.3 Barriers to Primary Health-Care Service Delivery

The waiting times are one of the outstanding obstacles in decision making for the choice of a particular health care service (National Academies of Sciences, Engineering, and Medicine, 2018) if waiting time will affect the job performance of patients, he would rather opt for self-treatment. This implies that the time spent waiting for medical treatment is associated with the level of utilization and that the probability of choosing any health facility considering the time spent waiting for treatment will ultimately determine whether or not seek for medical attention in such health centre. However, there are several plausible reasons for choosing another health centre of health services as a determining factor. For instance, the quality of time spent on waiting for treatment is usually no encouraging. Adelaja (2013). So long as the patient cannot wait for such long hours in obtaining medical attention, he may eventually opt for self-treatment. According to Iloh, Ofoedu, Njoku, Odu, Ifedigbo and Iwuamanam (2012), the trust index coefficient at public hospitals is the most significant is the marginal benefit that a patient gets from waiting time to obtain the interaction health facility. Individuals might prefer to wait for treatment from a health provider they trust. There is no direct opportunity cost for a seriously sick person because the person cannot work, except for persons accompanying the patient. Once a person is sick, the next decision to make is to look for treatment, in which case, each treatment has its cost. For low income groups, waiting time in a public facility, where user fees are low, can be taken as a boost to the net income (income after paying the user fees). This situation implies that the marginal net benefit from waiting time will be higher at a health facility with a low cost of treatment, such as a public clinic. This waiting for treatment at a facility is

synonymous with using time as a resource to pay for quality services where fees are low (Iloh, et al, 2012).

1. Source of Health Care

Information: Information that a patient has about a health facility and the services it offers has a significant impact on choice of a health care (Nwabu, 2015). Sufficient information about the quality of healthcare service dictates weather to visit a health care health provider for medical attention. It appears that private health facilities benefit more from the information that individual possess about the quality of health care being offered in the study area. This finding is in line with that of Thompson (2003), who found out that lack of adequate health information was associated with variations in health care utilization at various health facilities, and especially between rural and urban areas. The information patients possess on health services influence health care seeking behaviour. Health care for individuals in Nigerian society needs to be interpreted with caution due to the likelihood of selection bias. However, information available about health services is a key determinant of health care demand among individuals in contemporary society in both developed and developing nations of the world.

Gender Issue: Gender is significant in choosing health facilities, being male or female decreases the likelihood of visiting public facilities for self-treatment. It is also the case that females are more likely to visit public health facilities than their male counterparts. Females are more sensitive to their health status more than male. This has implication that males are likely to seek for medical care from the private hospital with good health facilities. The females are more likely to seek for professional health care compared to their male counterparts. Nwabu (2015) opined that women are more likely to consult all types of providers of modern care for self-treatment. Women might be less endowed with resources to seek medical care at private facilities.

According to Sahn (2003), male tended to visit public health facilities with lower frequencies compared to women.

2. Size of the Household

The effect of the size of household on the choice of health care is positive and largely significant having a large family increases the probability of visiting both public and private health facilities compared to self-treatment. The intuition behind this comes from Bamindele (2014), who argued that the greater the number of working members there are in a household, the more likely individuals will turn away from self-medication. While we would have expected persons from larger households to be less likely to seek care, because of competition for resources in the household, the choice of health care may also be complex. Sahn (2003), and Bamidele (2014), found household size to be positively related to probability of seeking health care from the formal health care system. Household size positively affects the demand for health care in the public facilities. Another plausible reason is that in a large household there is less attention to members of the household in terms of their nutritional needs and this makes them prone to illness, increasing probability of using medical care.

3. Education

As expected, education has a positive and statistically significant coefficient. This result supports the prediction that educated individuals are more likely to seek out professional healthcare for self-treatment. The parameter estimates are positive and significant in all health facilities. These results are consistent with many results in the literature. Interesting, and inconformity with Sahn (2003), the rate of increase in demand is great for public health facilities than in the private health facilities. Cisse (2006) found education to positively affect demand for health care. Similarly, Hutchision (2014), found more educated women to have higher likelihood of seeking

health care than less educated ones. This is also in line with the general notion that the pattern of reporting morbidity and contacting a health professional tends to increase the level of education. The implication that educated people could have distinguished real quality of health care by observing the qualifications of the health providers. A public health facility is guaranteed of quality and trained health personnel are not readily known. There is a perception that a year of schooling reduces the probability of seeking health care from a public health facility for self-treatment (Hutshision, 2014).

4. Age The effect of age on the demand for health care is significant and positive across all the health facilities indicating that the probability of using professional health care service in relation to self-treatment increases with age. For instance, other variable such as education, social learning, and income are likely to increase with age. For example, the years of schooling and age are much related. Moreover, having stayed in the same area of a long time is likely to improve the information possessed about the social amenities, including health facilities. There is a conventional belief that as people get older, they seek treatment from traditional medical practitioners. The fact that a household headed by older people has a chance higher chances of seeking professional health care rather than self-medication. This to a large extent implies that the head of the household still controls economic resources as well as the choice of health care.

5. Occupation: Occupation of the household head did not have a significant impact on the choice of health facility, this implies that a person in a formal employment, preferred private clinics to self-treatment. This is consistent with the widely held assumption that those who are formally employed would prefer professional health care to self-treatment, especially since they are enrolled in a mandatory health insurance scheme that pays for formal health care (Onyenweze, 2016).

2.4 Development of HealthCare Service in the 21st Century

Numerous public health initiatives have promoted the development of health care since the American era. In fact, Frenk (2010), advocated 'a "healthful situation" that promoted physical exercise as one of the primary subject in the offices were developing during the office activities. However, prior to the mid-1800s, efforts to introduce health care program into the office were isolated. It was not until 1840 Rhode Island passed the first legislation to make health care mandatory for public officers and other states soon adopted this concept of comprehensive health care services.

This background led to public health program receiving major attention as a means to promote public health care and prevent disease. In 1970's, most government in developed countries started implementing' health care delivery program in most public offices. One of the earliest health care programs was in Asia which was established at Kalatura Ceylon in 1926; the main focus of the establishment was the care of public servants control of communicable diseases' and health education. These services were not without the support of the Rock feller foundation. According to Agbeko (2005), in 1975 precisely, there was a great nutritional and health status of individuals in Nigerian society which clearly map out some action plans in solving and managing the health problem of people. However, health care is aimed at covering community health problem, health education strategies, socio-religious aspect of health, mother and child health first aid, nutritional and identification and treatment of communicable and highly prevalent diseases.

In Africa, for instance failure of health care services to meet up with the health status of people is a major problem; the quantity and quality of the health personnel in relation to the existing health care situation in most offices is very poor. Most African countries have not been able to provide

adequate health care in the environment and assistance in varying degrees in solving problems such as: food, housing, recreation, and personal problems. A successful health care program is considered in a three dimensional perspectives viz: health service, health instruction, and relationship in the community setting these three dimensional ways were opined by Lucas (2017), Adegbite (1990). Against this background however, it has become very essential to consider the Health Care Services as a very important tool in promoting the health of the individuals and to achieve this target, it is the major responsibility of the health agencies within the community and in an office environment to promote the health status of individual this assertion was made by Musgrove, Zeramdini and Carrin, (2002). The process of providing working experiences which favourably influence understanding, attitudes and conducts with regards, to individual and community health is regarded as Health care system as opined by Stone (2011).

The World Health Organization WHO (2004), views Health Care of individuals as that part of health program which consists of planned attempts to change individual's groups and community behaviours with the aim of helping to achieve curative, preventive rehabilitative and promotion of health. Health Care for individuals should provide a systematic program for the development of desirable habits, attitudes, concepts, and knowledge of individual and community health; Health care provide a variety of learning experiences ranging from discussion, problem solving activities, direct first-hand experiences.

Stone (2011), remarked that "Most of the morbidity and mortality in our community are due to communicable diseases, most of which can be prevented or readily treated such as malaria, dysentery, pneumonia, tetanus, tuberculosis, cholera and others" and with the active involvement of health personnel in a well-planned health care services, which will eventually lead to

improvement in personal hygiene among civil servant and subsequent reduction in related morbidities, Journal of Community Medicine (2007). According to Park (2000), most of our environments are plagued with infections and parasitic diseases due to poor health habits, poor sanitation system which usually are course of morbidity and mortality in many developing countries most of the individuals are usually affected with environmentally related disease such as malaria, typhoid, diarrhoea and dysentery are constant threat to life as opined by Lucas and Glues, 1990). Portable drinking water supply and poor environmental sanitation in the environment are the reasons why diseases associated with un-hygiene disposal of faces and refuse due to lack of good health education program in the society are very common in environment. The most important incidence of disease as a result of poor environment includes diarrhoea and intestinal worm infections which account for over 10% of the total disease in most of our environment (WHO, 2005). More importantly, inadequate supply of portable water increases the risk of schistosomiasis, guinea worm and skin infections Park, (2000). The environmentally related diseases can be controlled and prevented through good health behaviour in seeking medical attention and improved environmental sanitation in the society. Ugbonnaya (2013) remarked proper and well planned health care promotion/heath education program is usually aimed at increasing the individual's ability to withstand any stress in any environment especially through good nutrition and health education program.

An improved health standard of civil servants should not base entirely on curative services but also acquiring scientific facts hence. Turner (2008), opined that in any health scheme, there should be provision of social and basic knowledge of science in hygiene, which would enable people to live in harmony with their environments, this could be accomplished through health education. In other words, with series of health care services, individuals will learn the good

habit of keeping their environment clean and tidy and also observed some good health rules of preventive medicine.

2.5 Provider Based Factors

The health care provider has significant contribution toward individual health care seeking behaviour of individual in Nigeria society. Provision of health care facility to individuals is based on the availability of health facility and also on its location to the beneficiary Bobadilla, Cowley, Musgrove and Saxenian, (1994), Posted that individual patronize healthcare according to their names or location to the beneficiary. Prompt delivery of health care services determines to a large extent the frequency of seeking for such health care services. Health provider in this regard is a significant determinant of health, accessibility to health services enhance the propensity or the opportunity of seeking for frequent health assistance. From all indications, the location and the environment of health care centre shows a very significant impact on the choice of treatment. Location of health centre increase the likelihood of choosing such health centre for medical attention health care provider play a significant role in promoting, sustaining and maintenance of individual's health status in the study.

Trust of health care provider is a significant determinant of the demand for health care in most of Nigerian societies. Trust of the health care provider increase the likelihood of choosing a particular health care provider. The implication of this is that the more trust and cordial relationship that exist between health care providers establish with their patients, the higher the probability of a visit to that provider in the event of illness. Trust in this context means a relationship between the health provider and the health seeker.

Apart from a business relationship resting on credit, trust also depends on the patient's health outcome after visiting a health provider. The campaign against the use of over-the-counter drugs

without the prescription of a physician is likely to erode trust in self-treatment and shift demand in the formal health care system. Though public facilities usually deliver quality health care at a slow pace, there is a strong perception in Nigerian society that it is the government clinics that should lead in extending modern health care to the public (Brannen, McDonnell, Boche, &Fosnaugh, 2008).

2.6 Empirical Studies on utilization and satisfaction of primary healthcare services among WCBA

A number of related research studies in the areas of utilization and satisfaction with primary health healthcare service among women of childbearing age were identify in the section.

ML, Malonga, Dramaix-Wilmet, &Donnen (2012) conducted a similar study that assessed determinants of maternal health services utilization in urban settings of the Democratic Republic of Congo–a case study of Lubumbashi City. This was a transversal study of women residing in Lubumbashi who had delivered between January and December 2009. In total, 1762 women were sampled from households using indicator cluster surveys in all health zones. Antenatal consultations (ANC), delivery assisted by qualified healthcare personnel (and delivery in a healthcare facility) as well as postnatal consultations (PNC) were dependent variables of study. The factors determining non-use of maternal healthcare services were researched via logistic regression with a 5% materiality threshold. Result of the study revealed that the use of maternal healthcare services was variable; 92.6% of women had attended ANC at least once, 93.8% of women had delivered at a healthcare facility, 97.2% had delivered in the presence of qualified healthcare personnel, while the rate of caesarean section was 4.5%. Only 34.6% postnatal women had attended PNC by 42 days after delivery. During these ANC visits, only 60.6% received at least one dose of vaccine, while 38.1% received Mebendazole, 35.6% iron, 32.7% at

least one dose of SulfadoxinePyrimethamine, 29.2% folic acid, 15.5% screening for HIV and 12.8% an insecticide treated net. In comparison to women that had had two or three deliveries before, prim parous and grand multiparous women were twice as likely not to use ANC during their pregnancy. Women who had unplanned pregnancies were also more likely not to use ANC or PNC than those who had planned pregnancies alone or with their partner. The women who had not used ANC were also more likely not to use PNC. The women who had had a trouble-free delivery were more likely not to use PNC than those who had complications when delivering. In conclusion, it was reported that in Lubumbashi, a significant proportion of women continue not to make use of healthcare services during pregnancy, as well as during and after childbirth. Women giving birth for the first time, those who have already given birth many times, and women with an unwanted pregnancy, made less use of ANC. Moreover, women who had not gone for ANC rarely came back for postnatal consultations, even if they had given birth at a healthcare facility. Similarly, those who gave birth without complications, less frequently made use of postnatal consultations. As with ANCs, women with unwanted pregnancies rarely went for postnatal visits. The study recommended that in addition to measures aimed at reinforcing women's autonomy, efforts are also needed to reinforce and improve the information given to women of childbearing age, as well as communication between the healthcare system and the community, and participation from the community, since this will contribute to raising awareness of safe motherhood and the use of such services, including family planning.

Yohannes, Tarekegn and Paulos (2013) conducted a similar study that assessed mothers' utilization of antenatal care and their satisfaction with delivery services in selected public health facilities of Wolaita Zone, Southern Ethiopia.A facility based cross-sectional survey with exit interview was conducted in Wolaita Zone. 363 postpartum mothers were enrolled in the study.

Client satisfaction was measured using a survey instrument adopted from the Donabedian quality assessment framework. Multivariate and binary logistic regression was applied to identify the relative effect of each explanatory variable on the outcome (satisfaction). Result of the study revealed that the proportion of mothers who had at least a visit to ANC Check-up was 85.7%. The overall level of satisfaction with delivery care was 82.9%. Middle aged (20-34) postpartum mothers were more (AOR =2.55(95% CI: 1.11,5.90) likely to be satisfied when compared to their 35-49 counter age groups where the later might have no/wrong experience with the delivery service. Mothers with some level of high school education (9-12) were at higher chance (AOR= 4.46 (95% CI: 1.63, 12.18) to be satisfied with the service in comparison with higher level of education as it might show higher demand of the more educated group or there may be underestimation of safe delivery. Women who stayed on labour pain for less than a sunset were in their above three times higher likelihood on their level of satisfaction when compared to their longer on labour counter mothers (AOR= 3.31(95%CI: 1.53, 7.17). In conclusion, it was reported that self-reported utilization of ANC service and satisfaction with delivery care given to them is promising. ANC can help for better utilization of institutional delivery. Care providers should plan for more institutional delivery by extending their acceptance in the already visiting ones. Mothers who happened to visit health facility for delivery attendance can be good promoters for institutional delivery as peer mothers to advocate the service.

Gudu and Addo (2017) conducted a similar study that assessed factors associated with utilization of skilled service delivery among women in rural Northern Ghana. The study was a cross-sectional study, data was collected from a sample of 400 women between the ages of 15 and 49 years who had given birth a year prior to the study. We used frequencies and percentages for descriptive analysis and chi-square (χ^2) test for relationship between independents factors and

utilization of skilled delivery services. Result of the study revealed that of the 400 women included in the analysis, 93.3% of them delivered in a health facility. Almost all of the mothers (97.3%) attended or received antenatal care at their last pregnancy with 75.0% of them having four or more ANC visits. The proportion of women who received ANC and utilized skilled delivery services was high (91.5%). Mother's educational attainment, ANC attendance, frequency of ANC visits, satisfaction with ANC services and possession of valid NHIS card significantly associated with utilisation of skilled delivery services. In conclusion, for a predominantly rural district, the percentage of women who deliver within health facilities where skilled assistance is available is very encouraging and a significant stride towards reducing Ghana's overall MMR. Having four or more ANC visits and improving on the quality of care provided has a great potential of improving uptake of skilled delivery services.

Lindsay, de Oliveira, Wallington, Greaney, Machado, Pagliuca and Arruda, (2016) conducted a similar study that assessed access and utilization of healthcare services in Massachusetts, United States. Five focus groups were conducted from April to May in 2015 using a purposeful sampling of Brazilian-born immigrant women living in Massachusetts, United State. The result of the study revealed that thirty-five women participated in this study. Although participants expressed their overall satisfaction with the US healthcare system, they noted several barriers to care, including sociocultural differences in delivery of care and communication barriers, including inconsistent quality of interpreting services. In conclusion, this study provides new information on the experiences and challenges faced by Brazilian immigrant women in accessing and utilizing healthcare services in the US and points out opportunities for improving services and the overall health of this immigrant population. Addressing noted sociocultural differences

and communication barriers including inconsistent quality of hospital's interpreting services might enhance Brazilian-born immigrants' experiences with the healthcare system.

Tadesse, Bayou and Nebeb (2017) conducted a similar study that assessed mothers' satisfaction with institutional delivery service in public health facilities of Omo Nada District, Jimma Zone. The study assessed satisfaction with institutional delivery service and factors affecting their satisfaction, among mothers who gave birth in public health centres of Omo Nada district, south west Ethiopia. A facility based cross-sectional study was conducted on 391mothers who gave birth in selected public health centres of Omo Nada district, south west of Addis Ababa. The total sample was allocated to four health centres, based on expected pregnancy in their catchment area. Sample mothers were selected using systematic random sampling, list of mothers registered on delivery registration books of each health centre were used as a sampling frame. Pre-tested structured questionnaire was used, 5 data collectors with diploma were recruited. Collected data were entered in to EPIDATA 3.0, and exported to SPSS version 16. Bivariate and multivariate logistic regression analyses were conducted. The overall satisfaction with institutional delivery service was 255(65.2%). Major satisfaction was recorded with supportiveness of the provider and cleanliness of delivery room. According to multivariate logistic regression analysis result, mothers who had ANC follow up had two fold increased satisfaction, [AOR= 2.05, 95% CI 1.33, 4.75]. Those who planned their pregnancy were 2.85 times more likely satisfied than those did not, [AOR=2.85 with 95%CI 1.56, 5.21]. This study showed ANC attendance, utilization of maternity waiting home (MWH) service, planned status of the pregnancy, distance and cleanliness of the toilet during delivery service were significant predicators of mothers' satisfaction with the service. Utilization of MWH and ANC attendance during pregnancy

significantly increases mothers' satisfaction with institutional delivery service. On the other hand, mothers with unplanned pregnancy showed decreased satisfaction.

Mekonnen, Yalew and Anteneh (2015) conducted a similar study which assessed women's satisfaction with childbirth care in FelegeHiwot Referral Hospital, Bahir Dar city, Northwest Ethiopia. The study is a Hospital based cross-sectional study which was conducted on women delivering their baby in April to May 2014. Systematic sampling procedure was used to select 594 eligible women, and face to face interview technique was used to collect the data. The data were coded, entered into EPI-INFO (3.5.1) and analysed using SPSS version 20 software package. The findings of this study revealed that the proportion of women satisfied with childbirth care service was 74.9 %. Mothers whose age less than 20, and 20–34 years were less likely to satisfy with the care during child birth compared to mothers whose age was above 35 years (AOR = 0.17, 95 % CI 0.04–0.68, and AOR = 0.13.95 % CI 0.13–0.85). Besides, women who did not attend ANC were more than 3 times likely to satisfy with care compared to women attended ANC (AOR = 3.75, 95 % CI 1.12–12.59). Moreover, who gave birth for the first time, and two to five times were more than 4 times likely to satisfy compared to women who gave birth for more than 5 times (AOR = 4.68, 95 % CI 1.75–12.54, and AOR = 4.38, 95 % CI 1.91–12.22). In conclusion, only 75 % of women gave birth satisfied with the care they received. Moreover, age of women, antenatal care follow-up and the number of deliveries were important predictors of level of satisfaction. Therefore, the hospital administration and health professionals need to offer patient oriented service to increase level of satisfaction, as it is one of the measures of quality care.

Zhou, Zhou, Yang, Ji, Ghose and Tang (2020) conducted a similar study which assessed sociodemographic characteristics associated with the utilization of maternal health services in Cambodia. Two rounds of Demographic and Health Surveys (DHS 2000 and DHS 2014) were used in the study. Sample population consisted 11,961 women aged between 15 and 49 years. The outcome measures were: Timing of first antenatal care (ANC) attendance, adequacy of ANC attendance, place of delivery and postnatal check-up. WHO guidelines were used to set the cut-off/define these measures. Data were analysed in Stata version 14 using descriptive and multivariate regression analyses. The findings of the study indicated that the overall prevalence of making the first ANC visit in the first trimester was 64.19% [95%CI = 62.22, 66.11], and that of having at least four ANC visits was 43.80% [95%CI = 41.89, 45.73]. Prevalence of health facility delivery was 48.76% [46.62, 50.90] and that of postnatal check-up was 71.14% [95%CI = 69.21, 73.01]. Between 2000 and 2014, the percentage of timely and adequate use of ANC increased by respectively 61.8 and 65.3%, while that of health facility delivery and postnatal care increased by respectively 74.5 and 43.9%. Important demographic, socioeconomic and geographic disparities were observed in the utilization of ANC, health facility delivery and postnatal care services. Urban residency, having better educational status, white collar job, access to electronic media showed positive association, whereas higher parity (having > 2 children) and unwanted pregnancy showed negative association with the use of maternal healthcare services. Having at least four ANC visits was associated with significantly increased higher odds of using health facility delivery and postnatal care. It was concluded that there has been a remarkable increase in the prevalence of women who are using the maternal healthcare services since 2000. The current findings provide important insights regarding the socio-

demographic factors associated with the utilization of maternal health services in Cambodia that could contribute to evidence-based health policy making and designing intervention programs.

Paudel, Mehata, Paudel, Dariang, Aryal, Poudel and Barnett (2015) conducted a similar study that assessed women's satisfaction of maternity care in Nepal and its correlation with intended future utilization. The study aimed to measure women's satisfaction with maternity care and its correlation with intended future utilisation. Data came from a nationally representative facility-based survey conducted across 13 districts in Nepal and included client exit interviews with 447 women who had either recently delivered or had experienced complications. An eight-item quality of care instrument was used to measure client satisfaction. Multivariate probit model was used to assess the attribution of different elements of client satisfaction with intended future utilization of services. Respondents were most likely to suggest maintaining clean/hygienic health facilities (42%), increased bed provision (26%), free services (24%), more helpful behaviour by health workers (18%), and better privacy (9%). Satisfaction with the information received showed a strong correlation with the politeness of staff, involvement in decision making, and overall satisfaction with the care received. Satisfaction with waiting time (p = 0.035), information received (p = 0.02), and overall care in the maternity care (<0.001) showed strong associations with willingness to return to facility. The findings suggest improving physical environment and interpersonal communication skills of service providers and reducing waiting time for improving client satisfaction and intention to return to the health facility.

Osiya, Daprim, and Lucky, (2017) Conducted a similar study which compared the level of patients' satisfaction with general practice care delivered at physicians-manned General Outpatient clinics at tertiary and primary health in Rivers State. The study employed a comparative cross-sectional design using the Patient Satisfaction Questionnaire (PSQ-18). A

total of 1290 regular patients were recruited by systematic random sampling. Non-parametric analyses such as median satisfaction scores, Chi-square, Kruskal-Wallis and Mann-Whitney U test were conducted using SPSS version 20 statistical software. A p-value <0.05 was considered statistically significant. Result of the study revealed that patients who received care at the comprehensive health Centre were significantly more satisfied in domains such as patient-doctor communication (p<0.001), interpersonal manner (p<0.001), accessibility and convenience (p<0.001), technical quality (p=0.006), financial aspects of care (p<0.001) and general satisfaction (p<0.001) than their counterparts at the tertiary Centre. There was no statistically significant difference with time spent during consultations in both (p=0.583). Other predictors of satisfaction were younger age, male gender, married, higher education, and those of the Moslem religious faith. In conclusion it was recommended that patients who sought general practice care from the health Centre were more satisfied that those who did at the tertiary Centre. We recommend increased sensitization on patients' utilization of primary health care systems as first contact, continuing, comprehensive and efficient personal and non-personal healthcare needs.

Al Nahedh, Nosa (1995), conducted a study on factors affecting the Choice of Maternal and Child Health Services in Rural Area of Saudi Arabia using content analyses reported that place of residence has been an important factor in the utilizations of the service. He posits that urban population makes greater use of the service than those in the rural area, he further noted that distance from the healthcare centre, education of the participants as well as their age are the strongest determinant of the utilization among participants in developing countries. He concluded that there would always be disparity in the utilization of the health services, in this study, emphasis was laid on the maternal and child health service.

Manzoor, Wei, Hussain, Asif and Shah (2019) conducted a similar study which seeks to measure the health care services, like a laboratory and diagnostic care, preventive healthcare and prenatal care, to patient satisfaction in the public health sectors of Pakistan. A descriptive survey research design was used for this study. The target population was patients from the out-patient department (OPD) of three public hospitals from Pakistan. By using the convenient sampling technique, 290 sample participants were selected from the target population. The reliability scales were tallied by using Cronbach's Alpha. The findings of the study are gleaned by using regression to explore patient satisfaction with the health care services, and whether or not the physician's behaviour moderates the link of patient satisfaction and healthcare services. SPSS Hayes process was used for the moderation effect of the physician's behaviour. The results of the study revealed that health care services, such as laboratory and diagnostic care, preventive healthcare, and prenatal care, have a significant and positive effect on patient satisfaction. Specifically, the study suggests that the physician's behaviour significantly moderates the effect of health care services on the satisfaction of patients. The overall opinions about the satisfaction level of patients for the availability of health services in the hospitals were good. The degree of satisfaction was satisfactory with respect to laboratory and diagnostic care, preventive healthcare, and prenatal care services. Based on the outcomes, the study confirms that the proposed hypotheses are statistically significant. Furthermore, the directions for future research of the study are offered.

Sule, Ijadunola, Onayade, Fatusi, Soetan, and Connel, (2008) conducted a similar study which assessed service/organisational factors and clients' perceptions that influenced utilisation of Primary Health Care (PHC) facilities in a rural community in Nigeria. The study was a cross-sectional household survey in the community as well as key-informant interviews of opinion

leaders and health care providers and participant observations of health facilities and utilisation pattern was used to collect data. Result of the study revealed that forty-four percent of respondents to the survey who were ill in the preceding six months visited a PHC facility for treatment, while others relied on self-medication/self-treatment. Education was positively associated with utilisation of PHC services ($P<0.05$). Maternal and child health (45.4%), prompt attention (23.0%), and appropriate outpatient (20.5%) services attracted respondents to use PHC services. Poor education about when to seek care, poverty, perceived high cost of PHC services, lack of drugs and basic laboratory services, and a regular physician on site at the facility were identified as barriers to utilisation. In conclusion it was concluded that community perceptions of poor quality and inadequacy of available services was responsible for low use of PHC services.

Ofili and Ofovwe (2005) conducted a similar study with the aims to determine patients' assessment of services rendered at a University Teaching Hospital. The study was a cross-sectional study carried out between July 2002 and September 2002 at the University of Benin Teaching Hospital**,** Benin – City, Edo – State, Nigeria. All patients (255) on admission were included in the study. Result of the study revealed that the average waiting time of patients was 2 hours 53 minutes (173 minutes) and the range was 2 minutes to 2 days. Two hundred and ten (84%) of the patients were satisfied with time spent with the doctor (consultation time). Services at the pharmacy were satisfactory to 140 (56.0%) patients while 73.2% were satisfied with services rendered at the laboratories. Eight –five percent and 76.8% of patients were satisfied with the X – ray and catering departments respectively. However, patients' rating of the level of sanitation was poor (46%). In conclusion it was reported that areas of need identified include, waiting time prior to consultation, sanitation of the hospital and pharmacy department. Although

patients expressed a high level of satisfaction with the laboratories, X – ray and catering departments, there is a need to work towards achieving total satisfaction with all facilities.

Kebede, Belachew, Selbana and Gizaw (2020) conducted a similar study on maternal satisfaction with antenatal care and associated factors among pregnant women in Hosanna town, Ethiopia. Revealed that, generally around three-fourths of the respondents were satisfied with the service that they received, most of the clients were satisfied with privacy, approaches of care from the care provider, interpersonal and technical aspects, facility-related factors, and cleanness of the centre. Relatively low satisfaction was reported on the communication and information domain. Age, education status, distance from the facility, respect of privacy, cleanness of the facility, and provider respectfulness were the significant predictors of the satisfaction level. The authors of this study kindly request any additional support from governmental and nongovernmental organizations at the national and international levels including family doctor's practice to improve maternal care quality more specifically antenatal care services.

Ahmed, Tomson, Petzold and Kabir (2005) conducted a similar study on socioeconomic status overrides age and gender in determining utilization and health seeking behaviour in rural Bangladesh, The focus is to study the health seeking behaviour of the elderly members (aged 60 years) of households in rural Bangladesh, his study reveal that there is no major differences in health seeking behaviour between elderly people and younger adults on average about 35% (405/1169) of those who reported having been ill during the previous 15 days in both age groups chose self-care /self-treatment, for both age group the most commonly consulted type of provider was a paraprofessional such as a village doctor, a medical assistant or a community health worker. A household's poverty status emerged as a major determinant of health seeking behaviour.

2.7 Utilization of Primary Healthcare Services among Women of Childbearing Age

The procedure for implementation of Primary Health Care services include baseline survey, situation analysis, preparation of detailed geographical maps, settlement demarcation, registration of households, formation of district and village health communities with the aim of mobilizing the community; training including retraining of existing health workers and volunteers. Upgrading of existing health facilities to perform the function of comprehensive health care and finally, a detailed monitoring and evaluation of clinic, community and local government of various activities of primary health care services (National Economic Empowerment and Development and Deployment Agency, 2010).

The structure of the local government primary health care department is composed of the Primary Health Care coordinator as the head, departmental heads of Monitoring and Evaluation, Disease Control Essential Drugs, Health Education and Maternal Child Health exist with each department being headed by a coordinator under the Primary Health Care Department coordinator. The recently created Water and Sanitation Department also does some part of the Primary Health Care jobs and has the following under its department; water quality and control, all with the coordinators under the PHC coordinator. The various health facilities in the village are named by various cadres of health personnel, with PHC implementation committees at the local government area which has the local government as chairman. Local government PHC coordinators as the secretary with members drawn from the LGA Health Department, Traditional Rulers Institutions, clergymen as well as other influential members of the society. The aim of any Primary Health Care system is to provide the whole population with essential health care that is universally accessible and available. This however, is independent on numerous factors which affect the overall utilization of these services. Utilization here being a measure of the

provision of health care services and is expressed as a proportion of people in need of a service who actually received it in a given period of time (Alihonow&Inoussa, 2014).

Enhancing the Utilization of Healthcare Services:

Enhancing the utilization of healthcare services has two Faceswhich are;

a. Increasing initiation of patient to treatment and
b. Ensuring their subsequent retention

Initiation refers to the choice of health care services made by the patient seeking treatment for the first time, while retention refers to follow-up visit to the same health care services in order to seek treatment for the same period of illness.40 an example is the proportion of children at risks who are immunized. Proportion of pregnant women who received antenatal care or have their deliveries supervised by trained birth attendants, and others. The Index of Medical Under-service (IMU) is a scale of 0 to 100, where 0 represents completely underserved and 100 represents best served areas. A least underserved, any region or area with a score of less than 62.0 is undeserved (Akenzua, Akpovi, &Ogbeide, 1981).

The trio of acceptability, availability as well as accessibility have an overall effect on the utilization of PHC services, availability is viewed in public health as the ratio of the population as a function of the health assigned to it, e.g. population per health centre, number of doctors per patient, ratio of women who delivered under care of trained traditional birth attendants, and others (Akenzua, et al, 1981). Accessibility on the other hand implies the kind of care that is geographically, financially, culturally, and functionally within each reach of the whole population/community.

The accessibility can be geographical, which means that distance, the travel time, the location of the health centre, the kind of people employed as staffs are acceptable to the people. Technically,

accessibility can be defined as the number of people of a given population that can be expected to use specific facilities and personnel assigned to it (Akenzua, Akpovi, &Ogbeide, 1981).

Financial or economic accessibility is the ability of the individual or community to be able to cover the financial health care is via, out of pocket payment, presently out pocket payment constitutes (75%) of the payment system (43%). If a service is available, but neither the individual nor the community can afford it, then it is not accessible. Dislocations along the referral chain could also serve as a potential barrier to the utilization of services, even though there is paucity of information on linkages between levels of care in Nigeria. For instances in 2004, 92.9% of cases seen at University of Ilorin Teaching Hospital (a tertiary referral facility) within a four-week period were without referrals (Alihonow&Inoussa, 2014). Patients referred from primary health and comprehensive health were 5.2% and 2.3% of the cases respectively with the bulk from private clinics (34.3%) and the General Out-Patient Department of the hospital (41.9%) (Alihonow&Inoussa, 2014).

Social and cultural accessibility refers to the process of providing health care in keeping in keeping with the social, cultural and religious peculiarities of the community, while functional accessibility refers to the right kind of care if available on a day-to-day basis to those who need it, whenever they need it and that it is provided by the right people at the right location.

2.7.1 Age Determinant of Health Care Utilization

The acceptability of health service is to the degree to which it is culturally appropriate for the target patient base. Utilization health services operate from a position of cultural sensitivity and respect, and allow the clients' cultural practices to be maintained. Cultural acceptability is an important determinant of indigenous people's use of needed health services (Scrimgeour&Scrirngeour, 2008).

A study from the biology and medical research Confirms findings in other studies that higher parity women are less likely to attend antenatal care **(**Glei 2013; Lambo, et'al 2003). Women aged 20-24 were shown to receive antenatal care more than older groups although this difference was not statistically significant. This could be due to the fact that there are no major differences between women aged 14-17 and 20-24. Women with 1 to 3 children receive antenatal care more than those with high parity 4-7 children. This advantage could be due to the support married women receive from husbands, and the health delivery system that tends to favor younger married women than older married women (Simkhada, 2008). Our findings reveal that 44. 2% of the young women use skilled professional assistance at hospital during delivery as against 32, 1% of older women. This finding supports those of several studies which confirmed that younger women beginning child bearing tend to fear home deliveries as they consider themselves a high risk group- As a result, such young women seek professional assistance from skilled professionals in hospitals (Filippi, 2009; Roost, 2004), Considering the higher risks young women face during pregnancy and childbirth, the results of this study cannot be interpreted to mean that young women are better users of skilled professional assistance (Williams, 1995), it is estimated that maternal deaths during birth are 2-4 times higher among young women, and babies born to them have a higher risk of death during the neonatal period due to low birth weight, compared to older women (Alenoghena, Yerumoh, &Momoh,, 2019; Adamu&Salihu, 2002).

2.7.2 Barriers to the Utilization and satisfaction of PHC Services

Nigeria is one of the few countries in the developing world and has systematically decentralized the delivery of basic services in the country including health, to locally elected governments, states, and community based organizations, as a result of this, the entire health system is not

insulated from the myriad of problem affecting the nation, that is why simple or increase in allocating greater public resources to basic health services is not enough to ensure that quality services are made available to the vast majority of poor citizens in the country (Thaddeus, 2016). Even though, the states and local government are assigned primary responsibility for the delivery of basic primary health care service, they are not equipped with adequate resources in terms of revenue to fulfil their expenditure obligations. There is therefore the need for increased funding as well as better fiscal responsibility on the part of the administration and other stakeholder involved in the health sector. It is believed if the spending by local government is properly coordinated and monitored. It will effectively translate into better basic health and infrastructure at the grass root (USAID, 2018).

There is also a need for clear and explicit demarcation of roles and responsibilities in the management of health care in Nigeria, the roles and responsibilities of the three tiers of government need to be clearly explained and interpreted within the concept of the constitution. Numerous attempts by the government in the form of national health policies, nation health bill, various health sector reform initiatives have all attempted to do this, but they could not see the light of the day. Lack of community participation and ownership of health care at the grass root is also a barrier to the utilization of health. In a study, it was found that there is a comparatively little or no community engagement in setting and monitoring prices and charges for drugs as was envisioned in the Bamako initiative and also the community plays a negligible role in disciplining staff, which is also overwhelmingly indicated as the responsibility of local government development committees (USAID, 2018).

Neglect of staff welfare leads to staff demoralization and bad attitude with concomitant reduction in productivity and utilization of health services. There is also a global shortage in virtually all

primary health nationwide (Alihnow, 2014). This translates into diminished utilization and inefficiency. Poor staff community relationship is also a barrier to the utilization of health services nationwide. The characteristics of facilities and services provided perhaps constitute one of the major barriers to utilization in primary health care services (Alihnow, 2014). Usually, facilities that are well equipped proximate to a much higher density of population and referral centre, better provided with public amenities such as water and electricity are more likely to be utilized than otherwise (Folashade, 2016).

The presence of alternative sources of care also serves as an impediment to publicly provided primary health care. In areas where there is availability of alternative sources of care like private clinics, secondary or tertiary health clinics, traditional medical practice, etc. The utilization of primary health services is usually low, and in areas with relative shortages of alternative sources of care, pressure is usually high on the hospital and the staff (Folashade, 2016). The shortages of essential drugs and basic equipment's are generally characteristics of virtually all health facilities nationwide. In a study, it was found that majority of health facilities nationwide. In a study, it was found that majority of health lack basic equipment's, 95% did not have microscopes, 59% did not have sterile gloves, 98% did not have a malaria smear and 95% lack a urine test strip. 46 This deficiency in critical infrastructures tend to undermine service delivery and hence, utilization of PHC.

Socio-cultural and religious factors are one of the greatest determinants of health care utilization. Primary health care facilities should therefore be provided in line with the social, religious, cultural, and other peculiarities of the people. Other factors that determine health care utilization include economic factors like per capita income, cost of health care and method of payment.51 Socio-economic statuses, health literacy, level literacy, educational level, ownership of

livelihood assets irrespective of wealth, and health seeking behaviour. All these factors and practices go a long way in determining how health is utilized at the primary level. The barriers to the use of primary health care are therefore multiple, multi-dimensional and complex and will need a thorough understanding and appreciation of the local peculiarities of the people before they could be properly understood (NPC, 2004).

2.8 Satisfaction with Health Care Delivery System in Nigeria

The quality of health care provided for individuals in Nigerian society has a significant impact on demand for health care. According to Bobadilla, Cowley, Musgrove and Saxenian, (1994), the level of patronage in private health centre is quite high implying that seeking for quality health care in private hospital increases the likelihood individuals to choose private health for medical treatment. Private health facilities are profit motivated so that there is a focus on improving quality service to attract patients. The result could be indicating that the quality of health care is higher at private clinics than government health. The finding is in agreement with the studies conducted by Sahn (2003) in Tanzania, Mwabu, (2014) in Kenya, and Ellis (2013) who also found out that medical quality, assessed in terms of both health staff qualifications and by the availability of drugs increases the probability of a visit to both private clinics and public hospitals. The fact that health service information is strong in determining the demand for health care at private health facilities and this implies that information about quality of health care in Nigerian society determines to a large extent the choice of seeking for medical attention by individuals in the society.

2.9 Theoretical Framework

Health Belief Model (HBM)

The Health Belief Model (HBM) is associated with the prediction of individual health behaviour towards decision-making process of choosing health care services. The Health Belief Model Theory is primarily a behaviour change model, in this study, the HMB model is applied to explain the health care-seeking behaviour of choosing a particular health services among adults. The theory which was propounded by Adeyemo (2005), is considered applicable to this study based on the fact that many scholars used the model theory as a whole without separating out its various components of health system. In this study however, different components of the model are applied separately to examine individuals own risk assessment, decision-making processes, and continuity of medication use. Risk perception of individual were examined by assessing the individuals' perceived susceptibility and perceived severity of the disease condition. Decision making processes were assessed though exploring the specific health-seeking behaviours including medication use continuity. The following sub-sections elaborate the components of the

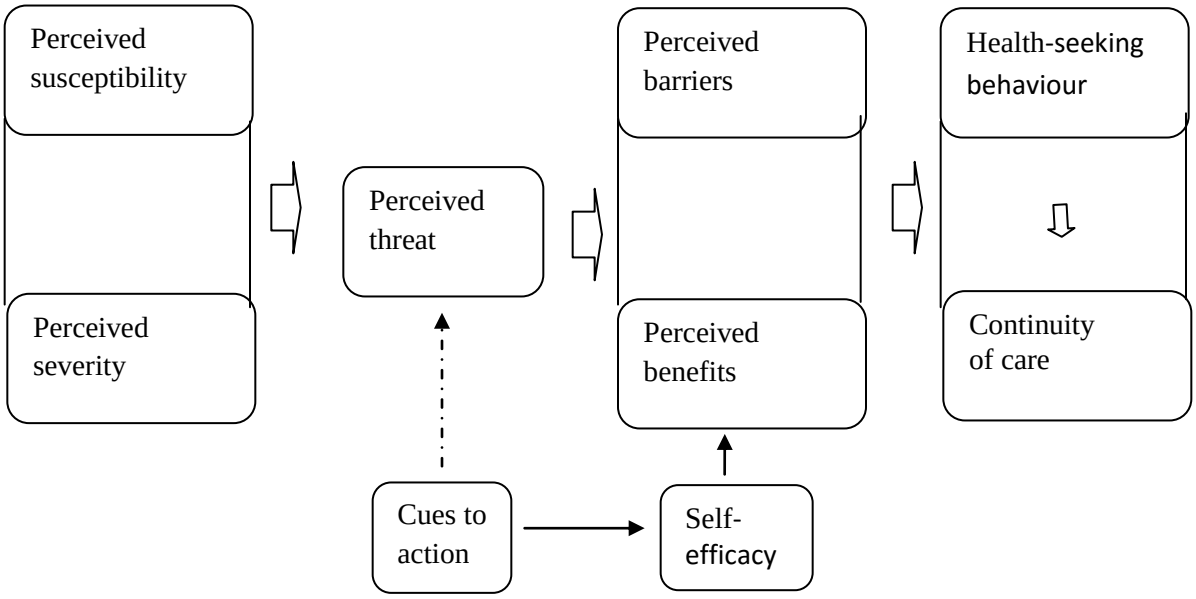


Fig 2.1: The Health Belief Model (HBM) components and linkages

The theoretical framework of this study according to Oniyansi (2011), is built on a psychological theory of "health behaviour and quality of life" propounded by Hanks and Eckland (1976). This theory is an extension of the theory of reasoned and action in the society. The theory states that personal attitude, subjective norms in the society as well as perceived behavioural control, are indices that shape an individual's intensions, desires and behaviour to accept or reject particular health care services. In other words, accepting or seeking health care services a planned behaviour aimed at attaining personal goals. The theory emphasized that it is a deliberate action or behaviour of individual that reasoned towards monitoring the behaviour of a particular set of individual for the purpose of achieving some specific goal. Similarly, the theory of planed behaviour specifies the nature of relationships that exist between beliefs and attitude towards accepting particular health care services. According to those models, people's attitudes towards behaviour are determined by the level of health awareness. Specifically, the evaluation of the available health care services contributed greatly to the level of acceptance in direct proportion to the person possibility that the available health care services will be acceptable or not (Nwabu 2015).

It has often argued that health status and individual quality of life are closely inter connected since the human body is designed to move along with his desire to seek or reject a particular health care services that will promote the health condition of an individual in order to function optimally and avoid illness in the society. The study of Hartmann, (2014), has revealed also that individual's family background, socio-economic, education and sedentary life style is a risk factor for the development of many chronic illnesses that needs medical treatment. Furthermore, living an active life according to Trudeau and Shepard (2013), brings about many other social and psychological benefits and there is a direct link between physical activity of individuals and

planned health behaviour that leads to life expectancy. In other words, physically active population work force seeks for health services tend to live longer than inactive ones. People who become more physically active in the society perform better both in physical and mental point of view and enjoy a better quality of life. In a related development, Harry (2016), submitted that the human body, as a consequence of regular physical activity, undergoes morphological and functional changes, which can prevent or delay the appearance of certain illness and improve the capacity from physical effort. There is sufficient evidence to show that those who live a physically active life can gain a number of health benefits including the following:

i. A reduced risk of cardiovascular disease
ii. Prevention and prompt attention to ill health
iii. Adequate provision of health services
iv. Development on the treatment of arterial hypertension, and improved control of arterial pressure especially in individuals who suffer from high blood pressure.
v. Decreased absenteeism (sick leave) from work.
vi. Lower stress levels and associated with improved sleep quality after official hours.
vii. Good cardio-pulmonary function.
viii. Improved self-image and self-esteem and increased enthusiasm and optimism.
ix. In every old adult, a lower risk of falling and prevention or delaying of chronic associated with ageing.
x. Maintenance and improvement in muscular strength and endurance, resulting in an increase in functional capacity to carry out daily activities.

xi. Maintenance of cognitive functions and lowered risk of depression and dementia.

xii. Maintenance of motor functions including strength and balance.

xiii. Improved digestion and regulation of the intestinal rhythm.

xiv. Improvement in mineralization of bones in young ages, contributing to the prevention of osteoporosis in older ages.

xv. A lowered risk of certain cancers, such as breast, prostate and colon cancer.

These health benefits motivated a planned health behavioural pattern to achieve these health values in the society. Theorists like Green and Honlihan (2012), believed that the promotion of individual health status through the acceptance of the available health care services is now firmly entrenched on the public health policy agenda in both developed and developing nations of the world. The health and well-being of citizens in the entire society form part of popular discourse, which evidenced by repeated reference to "obesity" and "high blood pressure" which is an epidemic diseases ravaging the lives of people. This scenario is widely published in the mass media and also indicated by the establishment of new health policies that refocuses on previous government and other stakeholders' efforts to address these issues. For instance, in some developed countries of the world such as United States, Germany, France, Japan, South

Korea etc. a new central government Ministry responsible for the promotion of health has been established to work in collaboration with the department for communities and Local Government, Department for Education and Department for health services. There is a relationship that exist between all these ministerial and agencies in the world. The health of citizens in the country, the propositions of the theory of "health behaviour and individual quality of life" therefore form the basis which the present study is built upon.

2.10 Summary

The literature is review with the following sub-headings;Introduction to the chapter, Conceptual Framework, The Concept of Primary Health Care, Concept of Health, Concept of Health Care Services in Nigeria, the Concept of Antenatal Care, Theoretical Framework, Utilisation and Satisfaction of Primary Health Care Delivery System in Nigeria, Barriers to Primary Health Care Service Delivery, Utilization of Primary Health Care (PHC) Services among WCBA in Plateau State, Age Determinant of Health Care Utilization, Barriers to the Utilization and Satisfaction of PHC Services, the types of Primary Health Care Services being utilised by WCBA in Plateau State, Determinants of Health-seeking Behaviour, Provider Based Factors, Components of Primary Health Care Service, Development of HealthCare Service in the 21st Century, Empirical Studies, Summary. The importance of maternal and child healthcare as well as other health needs among all women of childbearing age and other individuals in our communities seeking for healthcare services todayin Africa, Nigeria and Plateau State cannot be overemphasized it is therefore important that pregnant women, nursing mothers and other people within the society accept and utilized health care services provided by the World Health Organisation (WHO) through the wide spread or coverageof Primary Health Care system and establishment, as these will serve as a route to supporting the obtainment of the goal captioned “health for all” viewed by the WHO.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The purpose of this study was to assessutilization and satisfaction withprimary healthcare services among women of childbearing age in Plateau State, Nigeria. To achieve the above stated purpose, research design, population of the study, sample and sampling techniques, research instrument, validity of research instrument, procedures for data collection and data analysis were presented and described in this chapter.

3.2 Research Design

The research design adopted for the purpose of this study was descriptive survey. According toMbahi (2001) This design was chosen because the study is not an experimental study but a survey type. Therefore, the research design wasconsidered most suitable for the study.

3.3 Population of the Study

The population for the study comprised of 321,506women of childbearing age (15 – 39years) in Plateau State, Nigeria. According to theNational Population Commission and National Bureau of Statistics (2016)theprojected population of women in Plateau State is 1,607,533 out of which 321,506arewomen of childbearing age living in Plateau State. According to World Health Organization (2020) the projection for women of child bearing age from a given population is

20% of that population. Therefore, the projected population of women of child bearing age is321,506.

3.4 Sample and Sampling Techniques

The sample size for this study was 420. To determine the sample size, the researcher employed the Table paradigm for determine sample size as proposed by research advisors (2006). Research advisors proposed that for a population of 321.506 and above, 384participants areconsidered adequate.In order to cover for possible attrition which might occur in the field the researcher employed the 10% paradigm as proposed by Ferguson, (1970), therefore, the sample size was increased by 10% of 382 which makes it 420. To arrive at this sample, the researcher employed a multi-stage sampling techniques as follows:

Stage I – Stratified sampling technique: the researcher stratified Plateau state into the three (3) already existing senatorial district, 3 which are Plateau South, Plateau Central, and Plateau North.

Stage II – Simple random sampling technique: simple random sampling techniquewas used to select three local government areas (LGAs), out of the existing seventeen (17) LGAs in Plateau State which was further divided into three senatorial zones namely Plateau South with six (6) LGAs, Central with five (5) LGAs and North with six (6) LGAs,Hence atotal of seventeen (17) LGAs in Plateau State.One from each of the senatorial districts was selected for the study through the following procedure;theresearcheremployed the dip hand method to select the LGAs. First the researcher wrote the names of the LGAs in each senatorial districts on pieces of paper, folded them and dropped in a container. The researcher shook the container and instructed his research assistant to dip his hand and pick a piece of paper one at a time. The name of the LGA

on the piece of paper was then written down and the same procedure was used for each senatorial district until three LGAs were selected for the study.

Simple random sampling techniqueswas used to select two (2) ward from each of the (3)selected Local Government Areas (LGAs).Shendam Local Government (LG) has eleven (11) wards, and two was selected. Mangu LG has sixteen (16) wards and two was selected while Jos South has twelve (12) wards two was also selected respectively to arrive at six (6) wards selectedfor the study out of the sum of thirty-nine (39) wards of the three (3) LGAs selected for the study. The researcher used simple random techniques as described initially.

Stage III – Systematic random sampling technique: the researcher with his two research assistants systematically selected the households depending on the differences between the sample size calculated for each ward multiplied by two (2) since the researcher used households bearing the even numbers after house numbering in each of the wards selected for the study. For instance, if the sample size was ten(10) for a selected ward, twenty(20) houses was numbered because the even numbers determines the household to be use, therefore to arrive at ten(10) households twenty houses were numbered. Starting from the ward head's householdthe researcher and his assistants numbered the houses. Those households that fell under the even numbers (2, 4, 6, 8...) were selected until the total number of 10 households needed for the study in each selected ward were obtained.

Stage IV - Purposive sampling technique: The researcher purposively selected women of child-bearing age (15-39 years) who have at least one child to serve as the respondents for the study at each household selected for the study. At a household, where there are more than one woman of child bearing age, the researcher and his assistants picked the eldest among them all to serve as the respondent.

Stage V – Proportionate sampling technique: Proportionate sampling techniquewas used to determine the sample size of the respondents at each ward. Proportionate sampling wasemployed because of the differences that existed in the number of women of child bearing age at each ward per selected LGA. To arrive at the number of sample size, the researcher divided the population of the women of child bearing age at each ward over the total population from the selected wards and multiplied it by the sample size (420). Proportionate sampling formula is illustrated as follows:

Proportion = $\frac{n}{N}$ x 420

Where n= population of women of child bearing age in a ward

N= total number of women of child bearing age from all wards

Table 1: Sample size base on proportionate calculation perward

S/N	Senatorial Distric	LGA`s	Population	Selected LGAs Ward	Population	Sample Size
1.	Plateau South	Shendam	268,700	Shendam Central (A).	12,400	72
				Yelwa	12,512	72
2.	Plateau Central	Mangu	393,700	Mangu 1	13,762	79
				Gindiri 1	10,840	63
3.	Plateau North	Jos South	407,900	Bukuru	12,675	73
				Gyel (B).	10,655	61
		3	**1,070,300 WCBA 20% = 321,506**	**6**	**72,844**	**420**

National Population Commission (NPC) and National Bureau of Statistics, (2016)

3.5 Instrument

The Instrument that was used for data collection was a close ended researcher developed questionnaire comprising of four (4) sections (A-D). Section A,consisted of six (6) items on socio-demographic characteristics of the respondents. Section Bconsisted of eight (8) statements on the utilization of primary healthcare services among women of child bearing age in Plateau State, Nigeria. Section Ccontained eight(8) statements on the satisfaction of primary healthcare services among women of child bearing age in Plateau State, Nigeria. Section D comprised of 8 items on the primary healthcare services available in Plateau State, Nigeria. Thus, a total of thirty (30) statements constituted the research instrument whichwasused for data collection. The items on the research instrument were scored using a 4 – point modifiedLikert scale rating as shown below:

Strongly Agreed	(SA)	4 points
Agreed	(A)	3 points
Disagreed	(D)	2 points
Strongly Disagreed	(SD)	1 point

Therefore, any mean score of response 2.5 and above was considered positive or accepted; while any mean score of response which is less than 2.5 is considered negative or not accepted.

3.6 Validity of the Instrument

To ascertain the face and content validity of the research instrument, copies of the questionnaire werevetted by four (4) experts in the Department of Human Kinetics and Health Education, Ahmadu Bello University, Zaria. The corrections, observations and suggestions made by these professionals were harmonised with supervisor and implemented by the researcher and a clean draft of the questionnaire was produced for data collection.

3.7Procedure for Data Collection

First, the researcher collectedan introductory letter from the Department of Human Kinetics and Health Education,Ahmadu Bello University Zaria and issued it to the ward heads of the selected communities for approval to administer same in their ward, Secondly, the researcher briefed two (2) research assistants on the content of the questionnaire and how to administer them to the respondents. The research assistants were healthcare workers who were knowledgeable in collection of data and have prior knowledge of healthcare services at the PHC. The two research assistantshelpedto interpret the items in the questionnaire to the respondents in the language they understand for the purpose of clarity. At the households, the women of child bearing age who were to be selected to serve as respondents for the study must be one who has at least one child, where there were multiple women of child bearing age at a household the eldest of them all was purposively selected to serve as the respondents. The researcher then had the research assistant issue copies of the questionnaire to the respondents to fill. The copies of the questionnaire distributed were collected immediately after they were filled. The researcher employed systematic sampling technique to select the households to get the respondents of the study. The researcher and his assistants numbered the houses at each ward starting from the ward head's house. Those households that fall under the even numbers (2, 4, 6, 8...) were selected until the total number of households needed for the study were obtained. Three weekswere used in collecting the data.

3.8Procedure for Data Analysis

The data collected wasanalysed using the following statistical tools;

1. Descriptive statistics of frequencies and percentages were used to describe the demographic characteristics of the respondents, Mean and standard deviations was used to answer the research questions.

2. One Sample t-test was used to test the formulated hypothesesas follows;

   Utilisation of primary healthcare services by women of childbearing age in Plateau State, Nigeria.

   Satisfaction with primary healthcare services provided for women of childbearing age in Plateau State, Nigeria.

   The types of primary healthcare services (health education, child immunization, child spacing, antenatal care, nutrition demonstration) provided for women of childbearing age in Plateau State, Nigeria

   while Pearson Product MomentCorrelations (PPMC) was used to test the last hypothesis on the relationship between utilisation and satisfaction with PHC services available for women of childbearing age in Plateau State, Nigeria. All hypotheses were tested at 0.05 level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

1. In order to,'Assessing Utilization and Satisfaction with Primary Healthcare Service among Women of Childbearing age in Plateau State, Nigeria', Statistical analysis of data collected was presented in this chapter. descriptive survey design was used for the study with the sample size of 384 and attrition of 10% added to make the sample size 420 for the total population of 321,506 women of child bearing age in plateau state.A total of 420 copies of questionnaire were administered to the childbearing age mothers, however 409, (97.4%) were successfully completed and returned. Descriptive statistics of frequencies and percentages were used to describe the demographic characteristics of the respondents, Mean and standard deviations was used to answer the research questions.

   One Sample t-test was used to analyse the formulated hypotheses 1. (To assess items on utilisation), 2. (To analyse items on satisfaction) and 3. (To measure items on types of PHC services), while Pearson Product Moment Correlations (PPMC) was used to test hypothesis 4. (To test the relationship between utilisation and satisfaction with PHC services) at 0.05 level of significance, this chapter also consistresults and discussion of findings

4.1 Results

Before the statistical analyses of the collected data are presented in this chapter, the demographic characteristics of the respondents are presented using frequencies and percentages as seen in

Table 2:Respondent's Demographic Characteristics

Variable	Options	Frequency	Percent
Age range	15 – 19 years	50	12.2
	20 – 24 years	56	13.8
	25 – 29 years	99	24.2
	30 – 34 years	91	22.2
	>34years	113	27.6
Total		**409**	**100**
Level of Education	Primary School Certificate	38	9.3
	Secondary School	169	41.3
	Tertiary Institution	202	49.4
Total		**409**	**100**
Marital Status	Married	273	66.7
	Single	49	12.0
	Divorced	50	12.2
	Widow	37	9.1
Total		**409**	**100**
Occupation	House wife	67	16.4
	Trading	185	45.2
	Civil Servant	107	26.2
	Farming	50	12.2
Total		**409**	**100**
Income level per month	Low income (N25, 000 – 49,000)	342	83.6
	Middle income (N50,000 – 99, 000)	58	14.2

	High income (N100, 000 – 150,000)	9	2.2
Total		**409**	**100**

Source: Field survey, 2022

Table 2. above revealed that, the total respondents involved in the study, 50 (12.2%) were between 15 and 19years. Respondents who were between 20 and 24years were 56 (13.8%) and 99 (24.2%) of the respondents were between 25 and 29years. Those between 30 and 34years were 91 (22.2%) and the remaining 113 (27.6%) were above 34years. The distribution in Table above shows that all the respondents were within childbearing age and would therefore be in position to provide adequate information onutilization and satisfaction with primary healthcare services in the state.

Distribution of the respondents by their educational attainment in Table 2 showed that only 38 (9.3%) had primary school education. Most 202 (49.4%) had tertiary education and 169 (41.3%) among the total respondents had secondary education. These distributions showed that almost all the respondents could be said to have the level of education that enabled them to access the provided services by the primary healthcare centres in the state which should afford them the knowledge of utilization and satisfaction with their services.

In term of marital status, 273 (66.7%) of the subject were married. Only 49 (12.0%) were singles and 50 (12.2%) were divorced. Those that were widowed accounted for 37 (9.1%) of the total respondents. By occupational distribution, 67 (16.4%) were Housewives, 185 (45.2%) were involved in trading and 107 (26.2%) were civil servants while 50 (12.2%) were farmers. The distribution showed that the respondents were drawn from different occupational orientations within the state.

Most 342 (83.6%) of the respondents were in the low-income level with less than ₦50, 000.00 per month. Those that were in the medium income level (₦50, 000.00 – ₦99, 000.00)among the

respondents were 58 (14.2%). Only 9 (2.2%) of the respondents were in the high-income group of more than ₦99, 000.00 per month. The distribution showed that the respondents represented a proportionate economic statuses representation of childbearing mothers in the state.

4.1.2 Answering Research Questions

Decision on the mean scores was based on the benchmark of 2.50 as the fixed mean.

Research Question one: Do women of childbearing age utilizes health care services provided by Primary Health Care (PHCs) in Plateau State? The respondent'sresponses on utilization of primary healthcare services among women of childbearing age in Plateau State, are scored using mean and standard deviations.

Table 3: Mean score of responses on utilization of PHCs services amongwomen of childbearing age in Plateau state.

Sn	Utilization of Primary Health Care (PHCs) services	Mean	Std. Dev.
1	I show up for health education sessions at the healthcare centre	3.57	0.686
2	I use family planning services which are been provided at the healthcare centre	3.35	0.862
3	I use the drugs provided to me at the healthcare centre	3.64	0.658
4	I take my child for immunization at the healthcare centre	3.72	0.599
5	I attend nutrition demonstration sessions for pregnant women at the healthcare centre	3.29	0.932
6	I go to the healthcare centre for treatment of disease	3.56	0.694
7	I attend antenatal care at the healthcare centre	3.66	0.665
8	I go to the healthcare centre for hospital delivery	3.58	0.713
	Aggregate mean	3.55	0.578

(Decision mean 2.50)

The table above:Reveals that most of the women of childbearing age, effectively utilized the services of taking children for immunization ($\bar{x}$= 3.72; SD. 0.559), as well as attending antenatal care (x= 3.66; SD= 0.605) respectively. The result of this study furthermore shows that generally

the participants made use of healthcare service as shown in table 3. Using the drugs provided at the centre ($\bar{x}$= 3.64; DS= 0.658), attending health education sessions ($\bar{x}$=3.57; SD= 0.686), attending health care centre during delivery ($\bar{x}$= 3.58; SD= 0.713).Using the aggregate mean, the result on utilisation of primary healthcare service showed that the participant's adequately attend demonstration session on nutrition for pregnant women ($\bar{x}$= 3.29; SD= 0.923)and participants make used of family planning services ($\bar{x}$= 3.35; SD= 0.862) when compared with other services generally, since the result are based on the decision mean of 2.50 the findings revealed that the respondents do use the services provided for women of childbearing age. All the mean scores of responses are above 2.50.

The aggregate mean score (3.55) is higher than the benchmark fixed for decision for agreement. This observation implied that the extent of utilization of Primary Health Care (PHCs) services by women of childbearing age in was very high.

Research Question two: Do women of childbearing age satisfy with health care services provided by Primary Health Care (PHCs) in Plateau State? The opinions of the respondents on satisfaction with services of the Primary Healthcare Units are scored in means and standard deviation in Table 4.

Table 4: Mean scoresof responses on satisfaction with PHCs services by women of childbearing age in Plateau state, Nigeria

Sn	Satisfaction with Primary Health Care (PHCs) services	Mean	Std. Dev.
1.	The health education sessions held at the healthcare centre is quite educative	3.57	0.665
2.	Family planning service provided at the healthcare centre are pleased me	3.32	0.835
3.	I am pleased with the essential drugs provided at the healthcare centre	3.61	0.667
4.	My child was immunized at the healthcare centre happily	3.66	0.634
5.	I enjoy the nutrition demonstration sessions for pregnant women which are often held at the healthcare centre	3.27	0.934
6.	I am pleased with the healthcare service delivery and treatment for disease at the health centre	3.54	0.664
7.	I like the way antenatal care service sessions are held at the healthcare centre	3.62	0.657
8.	I like the way I get attended to when I go to the healthcare centre for hospital delivery	3.54	0.720
	Aggregate mean	3.51	0.581

(Decision mean 2.50)

The table above. reveals that respondents could be said to be quite satisfied with healthcare services delivery and treatments issued at the primary healthcare centres in the state as indicated ($\bar{x}$= 3.54; SD= 0.664), an expressed satisfaction was interpreted from the responses ofparticipants onhealth education sessions usually held by the healthcare centres ($\bar{x}$= 3.57; SD= 0.665),

furthermore participants for satisfaction with Family planning services was considered pleased (x= 3.32; SD= 0.835) and were also satisfied with provision of essential drugs to women of childbearing agewho patronized the healthcare units($\bar{x}$= 3.61; SD= 0.667). Other services with which the respondents were satisfied with in the healthcare units were children's immunizations ($\bar{x}$= 3.66; SD= 0.634),nutritional demonstration sessions for pregnant women at the health centres were enjoyed by participants ($\bar{x}$= 3.27; SD= 0.934).Respondents were generally happy with the personnel handling women of childbearing age who patronized antenatal care at the healthcare units ($\bar{x}$= 3.62; SD= 0.657)and were contented with the way they were attended to when they visited healthcare centre for delivery services ($\bar{x}$= 3.54; SD= 0.720). From the aggregate mean score of 3.51 which is by far higher than the benchmark 2.50, and standard deviation of 0.581 it could be concluded that extent of satisfaction with Primary Health Care (PHCs) services by women of childbearing age in Plateau State was very high.

Research Question three: What are the healthcare services provided in Primary Health Care (PHCs) Units for women of child bearing age in Plateau state, Nigeria? The available Primary healthcare services in the state were scored in Table 5.Inmeans and standard deviations.

Table 5: Mean scores of responses on health care services available to women of child bearing age in Plateau state PHCs.

Sn	Healthcare services available to subjects	Mean	Std. Dev.
1	Health education services are been render at the health facility	3.56	0.604
2	Family planning service are done in the primary healthcare	3.47	0.630
3	Essential drug are been provided at the healthcare facility	3.57	0.657
4	Child immunization is practiced in the primary healthcare	3.58	0.660
5	Nutrition demonstration to pregnant women is obtained	3.29	0.913
6	Treatment of minor diseases are available	3.54	0.645
7	Maternal and child health service is always available	3.57	0.701
8	Water and sanitation services are provided at the healthcare facility	2.98	1.120
	Aggregate mean	3.44	0.591

(Decision mean 2.50)

The table above.Reveals that among the healthcare services available to women of child bearing age in the state Primary Health Care Units were Health education ($\bar{x}$= 3.56; SD= 0.604), Family planning$\bar{x}$= 3.47; SD= 0.630) and Child immunization ($\bar{x}$= 3.58; SD= 0.660). Also available were provision of essential drugs ($\bar{x}$= 3.57; SD= 0.657), nutritional demonstration for pregnant women ($\bar{x}$= 3.29; SD= 0.913), and treatment for minor diseases ($\bar{x}$= 3.54; SD= 0.645). Others included provision of maternal and child health services($\bar{x}$= 3.57; SD= 0.701) with Water and sanitation services ($\bar{x}$= 2.98; SD= 1.120). In Table 5, the aggregate mean score for the table was 3.44 and it is higher than the benchmark (2.50). These observations implied that the listed services of the

Primary Healthcare Units in the state could be considered adequately available to women of child bearing age in PlateauState.

Research Question four: What is the relationship between utilization and satisfaction of healthcare services provided by Primary Health Care (PHCs) Units for women of childbearing age in Plateau State, Nigeria? The mean scores for determining the relationship between utilization and satisfaction with the healthcare services provided for women of childbearing age by the Primary Health Care units in the state are compared in Table 6.

Table 6: Comparison of mean aggregate of responses on Utilization and satisfaction with health care services rendered to women of child bearing age in Plateau state PHCs.

Variables	N	Mean	Std. Dev.	Std. Error	Mean difference
Utilization	409	3.55	0.578	0.029	0.04
Satisfaction	409	3.51	0.581	0.029	

(Decision mean 2.50)

The results on table 6 above revealedmean aggregates of the two variables compared with the same pattern of scoring by the respondents and the mean difference was just 0.04. Both scores for utilization and satisfaction were all higher than the benchmark average of 2.50. This implies a positive pattern of responses for the two variables by the women of childbearing age who patronized the primary health care units in the Plateau State. The extent of relationship between the two variables was tested in the related null hypothesis of the study, this means that there is a significant relationship between utilisation and satisfaction with primary healthcare service among women of childbearing age in Plateau state.

4.1.2 Test of Hypotheses

The null hypotheses formulated to test the significance of the expressed opinions on utilization and satisfaction with healthcare Service provided by Primary Health Care Units for Women of Childbearing agein the state. The hypotheses were tested using one sample t-test to establish extent of utilization, and satisfaction with the health services and the Pearson Product Moment Correlation Coefficient was used to determine the relationship between utilization and satisfaction with the provided health services. The hypotheses were tested at the fixed probability of 0.05 level of significance.

Hypothesis I:Utilisation of Primary Health Care Services by women of Childbearing Age in Plateau State is not significant.

Table 7 shows the summary of the test result one sample t-test used to compare the observed mean with the benchmark to determine the extent of utilization of the provided health services by the Primary Health Care Units.

Table 7: One sample t-test analysis on utilization of primary healthcare services rendered by the Primary Health Care Units for WCBA in Plateau State.

Variables	N	Mean	Std. Dev.	Std. Error	t-value	df	p-value	Decision
Utilization	409	3.55	0.578	0.029	36.615	408	0.000	Rejected
Test mean	409	2.50	0.000	0.000				

(T-critical at 408 df = 1.96, $p < 0.05$)

The result in Table 7 aboveshows that the utilization of the health care services provided by the Primary Health Care Units for women of childbearing age in Plateau state was significant. The observed t-value(36.615)obtained at 408 DF is higher than the critical value of (1.96) the observed p-value (0.000) is also lower than the fixed value ($p < 0.05$),these observations provide sufficient evidence for rejecting the null hypothesis, Utilisation of Primary Health Care Services by women of Childbearing Age in Plateau State is not significant.Therefore,was

rejected.Meaning that women of childbearing age utilises health care facilities in Plateau State Nigeria.

Hypothesis II: There is no significant satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria.

Table 8: One sample t-test analysis on satisfaction with healthcare services obtained by women of childbearing age in Plateau State' Primary Health Care Units

Variables	N	Mean	Std. Dev.	Std. Error	t-value	df	p-value	Decision
Satisfaction	409	3.51	0.581	0.029	35.277	408	0.000	Rejected
Test mean	409	2.50	0.000	0.000				

(T-critical at 408 df = 1.96, $p < 0.05$)

The result on table abovereveals that,satisfaction with the health care services provided by the Primary Health Care Units as indicated in the table was adequate and significant. The observed t-value (35.277) obtained at 408 df is higher than the critical value of (1.96) the observed p-value (0.000) is also lower than the fixed value ($p < 0.05$), these observations provide sufficient evidence for rejecting the null hypothesis, which states that There is no significant satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria. Therefore, was rejected. Meaning that women of childbearing age were satisfied with the healthcare services provided for them by primary healthcare centres in Plateau State.

Hypothesis III: The healthcare services rendered at the Primary Health Care Units for women of childbearing age in Plateau State, are not significant.

Table 9: One sample t-test analysis on healthcare services rendered at the Primary Health Care Units for women of childbearing age in Plateau State,

Variables	N	Mean	Std. Dev.	Std. Error	t-value	df	p-value	Decision
H/services	409	3.44	0.591	0.029	32.312	408	0.000	Rejected
Test mean	409	2.50	0.000	0.000				

(T-critical at 408 df = 1.96, $p < 0.05$)

The result on the table above reveals that the available health care services in the Primary Healthcare Units in the state were significantly adequate. The observed t-value (32.312) obtained at 408 DF is higher than the critical value of (1.96) the observed p-value (0.000) is also lower than the fixed value ($p < 0.05$), these observations provide sufficient evidence for rejecting the null hypothesis, which states that, the healthcare services rendered at the Primary Health Care Units for women of childbearing age in Plateau State, are not significant was therefore rejected. Meaning that the healthcare services provided for women of childbearing age in primary healthcare units, Plateau State is significant.

Hypothesis IV: There is no significant relationship between utilization and satisfaction of healthcare services provided by Primary Health Care (PHCs) Units for women of childbearing age in Plateau State, Nigeria.

The result of the Pearson Product Moment Correlation procedure used to establish the extent of relationship between utilization and satisfaction with the health care services provided by the Primary Health Care Units is summarized in Table 10.

Table 10: Relationship between utilization and satisfaction with healthcare services rendered at Primary Health Care Units for women of childbearing age in Plateau State.

Variables	N	Mean	Std. Dev.	Std. Error	r-calc.	df	p-value	Decision
Utilization	409	3.55	0.578	0.029	0.918	407	0.000	Rejected
Satisfaction	409	3.51	0.581	0.029				

(T-critical at 407 df = 0.098, $p < 0.05$)

The result Table 10 above shows that utilization significantly correlates with satisfaction of the health care services provided by Primary Health Care Units for women of childbearing age in the state. The observed correlation coefficient (r-calc.) obtained at 407 degrees of freedom was (0.918) is higher than the T- critical value (0.098),theobserved level of significance p-value was (0.000) lower than ($p < 0.05$). These observations did not provide sufficient evidence for retaining the null hypothesis which states that, there is no significant relationship between utilization and satisfaction of primary healthcare services among women of childbearing age in Plateau State, Nigeria. Was therefore rejected. Meaning that there is a significant relationship between utilisation and satisfaction of with Primary Healthcare Services among women of childbearing age in Plateau State.

4.3Discussion

Utilization and satisfaction with primary healthcare services by women of childbearing age in Plateau State was assessed in this study. The study found that most of the childbearing age women involved in the study effectively utilized the services which included health education sessions and family planning. It was found that the Primary Health Care Units provided drugs to the women of childbearing ages with different diagnosis along with children immunization. The study found that women of childbearing age in the state effectively utilize primary healthcare services provided by the Primary Health Care Units which included food and nutritional demonstration sessions for pregnant mothers, treatment forminor diseases and delivery services. In the text in the test of significance of the expressed opinions of the respondents on the utilization of the available health services, it was found to be significant ($p = 0.000$), signifying that women of childbearing age in Plateau State utilises healthcare services provided by the Primary Health units. The finding of this study is similar to findings from a previous study by Gudu and Addo (2017) who assessed factors associated with utilization of skilled service delivery among women in rural Northern Ghana and reported that almost all of the mothers (97.3%) attended or received antenatal care at their last pregnancy with 75.0% of them having four or more ANC visits and that the proportion of women who received ANC and utilized skilled delivery services was high (91.5%).

For satisfaction with Primary Healthcare services, the finding of this study reveals that women of childbearing age who patronized the Primary Health Care Units in the state were significantly satisfied with the available primary healthcare services ($p = 0.000$).The study found that expressed satisfaction was linked to health education sessions usually held by the Primary Health Care centres, Family planning services and provision of essential drugs to women of

childbearing agewho patronized the Healthcare Units. Other services of the Primary Health Care Units associated with the expressed satisfaction by the respondents were children's immunizations, food nutritional demonstration sessions for pregnant women, delivery and treatment forminor diseases at the Health Care Centres. The study found that apart from the provisions of those services, respondents were generally happy with the personnel handling of childbearing age women who patronized the services of the Healthcare Units. The expressed satisfaction with the services was found to be statistically significant. The finding of this study are in line with previous study by Ewunetu, Mekonnen and Anteneh (2019) who revealed that Satisfaction involves the collection of factors such as the service provider's knowledge, medical and communications skill, personal attributes, accessibility, the convenience of location and the surrounding area, resource availability. The finding here is consistent with Al-mandari, (2018) who reported that satisfaction of Women of childbearing age is very necessary since they are an important group in the population of a country and constitute 21% of the whole population of a country and are a determinant in the utilization of maternal health care services. The finding here is consistent with findings from a previous study by Kebede, Belachew, Selbana and Gizaw (2020) who investigated maternal satisfaction with antenatal care and associated factors among pregnant women in Hosanna town, Ethiopia. Revealed that, generally around three-fourths of the respondents were satisfied with the service that they received, most of the clients were satisfied with privacy, approaches of care from the care provider, interpersonal and technical aspects, facility-related factors, and cleanness of the centre. The study found that respondents were generally of the view that healthcare services available to women of child bearing age in the state Primary Health Care Units were adequate. It was found that the services included Health education, Family planning and Child immunization. It was found that respondents were of the

view that provision of essential drugs, Food nutritional demonstration for pregnant women, and treatment for minor diseases were available in the Primary Health Care Units. Other services found to be viewed as available included provision of Maternal and child health service along with Water and sanitation services which were provided by the Primary Health Care Units in the state. In the test of the extent of this availability of health care services, the expressed opinions of the respondents, was found to be significant. The finding here contradicted the findings of Al-Mailam (2019) who reported on why women do not utilize primary health for pregnancy care, revealed the quality of care as one of the reasons and this includes provider's competence, negligent and unfriendly attitudes of PHC providers, physical environment and facilities, inadequate supply of drug, lack of man power, long waiting time and inappropriate referrals and that to many women who mentioned the quality of care as a barrier, they would rather give birth at home than go to a primary healthcare facility.

This study found positive and significant relationship between utilization and satisfaction with healthcare services provided by Primary Health Care Units for women of childbearing age in the state. The result of the correlation between the utilization of health care services provided by Primary Health Care Units and satisfaction with the services by women of childbearing age who patronized the Primary Health Care Units was found to be highly positive and significant, $p = 0.000$ ($p < 0.05$). The study found the relationship to be linear implying that more utilization would likely lead to better satisfaction by women of childbearing age who patronized the Primary Health Care Units across the state. The finding of this study is similar to findings of a previous study by Yohannes, Tarekegn and Paulos (2013) who assessed mothers' utilization of antenatal care and their satisfaction with delivery services in selected public health facilities of

Wolaita Zone, Southern Ethiopia and reported that utilization and satisfaction with services provided for the subjects was correlated.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This research assessedutilization and satisfaction with healthcare service provided by Primary Health Care Units for women of childbearing age in Plateau state. Assessing the utilisation and satisfaction with Primary Health Care Services of the enrolees, it is crucial to assure the continuous attractiveness of primary healthcare services for women of childbearing age in the state and others.

Primary Healthcare Centres derived their importance in proximity to the people and their accessibility to most prospective patrons especially in rural communities in any state, country or at the global level. Their services include treatment of minor disease and injuries, provision of Ante-natal and Postnatal services, immunization of against communicable diseases among others. The role of Primary Health Care centres allows for integration of health care services across the population and the entire spectrum of health care system of any state or country. It is recognition of Primary Health Care services that the Federal Government included mental and dental care as well as primary eye care as components within the mandate of the Primary Health Care system in the country. Client's utilisation and satisfaction with healthcare services has gained widespread recognition as a measure of quality of any Health Care system (Akpala, 2018). Existing interventions to reduce maternal mortality in Nigeria have centred on health-seeking behaviour and access to services, with little focus on the social and cultural factors that influence maternal mortality (Kana, Doctor, Peleteiro, Lunnet& Barros, 2019).

This study was therefore set out to assess utilization and satisfaction of health care services provided by Primary Health Care Centres in Plateau state, Nigeria. The research design that was

employed in this study isdescriptive surveydesign, the population was 321,506 comprising of women of childbearing age in Plateau State. A sample size of 384 was recommended by research Advisor (2006), with an attrition of 10% added, Ferguson (1970) to arrive at 420 samples for the study. Base on the following variables, utilization, satisfaction and available health services a researcher designed questionnaire centered on four objectives which formulated the research questionswas vetted and validated by professionals before used for data collections, 420 questionnaires was distributed to the selected participants by the researcher and 2 research assistants, 409questionnaires was retrieved for analysis. Multi-stage sampling technique was used for the study, Data collected were analysed with the Statistical Package for the Social Sciences (SPSS), IBM version 26. Statistical procedure used included descriptive statistics of frequency and percentages was used for demographic characteristic of respondents, while mean and standard deviation was used for testing the research questions, null hypotheses 1 (on utilisation),2 (on satisfaction) and 3 (on available health services) were tested using one sample t-test, and Pearson Product Moment Correlation Coefficients was used to test the relationship between utilization and satisfaction of health services by the women of childbearing age. The testsof hypotheses were carried out at the fixed significant level of 0.05.

5.1.1 Summary of Findings

1. The utilization of healthcare services provided by Primary Health Care units for women of childbearing age in Plateau State, Nigeria is significant ($p = 0.000$).
2. The satisfaction with primary healthcare services among women of childbearing age in Plateau State, Nigeria is significant ($p = 0.000$).
3. The healthcare services provided by Primary Health Care centres for women of childbearing age in Plateau State, Nigeria are significant ($p = 0.000$).

4. There is a significant relationship between utilization and satisfaction of primary healthcare services among women of childbearing age in Plateau State, Nigeria (p = 0.000).

5.2 Conclusions

Based on the findings of this studythe following conclusions were drawn:

1. Women of childbearing age in Plateau state utilizehealth care services provided by Primary Healthcare Centers. Because the outcome for testing the hypotheses on utilization which states that; Utilization of primary healthcare services by WCBA in Plateau State is not significant, reveled The observed t-value (36.615) obtained at 408 DF is higher than the critical value of (1.96) the observed p-value (0.000) is also lower than the fixed value ($p < 0.05$), these observations provide sufficient evidence for rejecting the null hypothesis. Therefore, the Ho was rejected, the participants utilized the primary healthcare services.
2. Women of childbearing age who utilize health care services rendered by Primary Healthcare Centersin Plateau Stateare satisfied with the services. Because the result obtained from testing the Ho which states that, there is no significant satisfaction with PHC service rendered to WCBA in Plateau State revealed The observed t-value (35.277) obtained at 408 DF is higher than the critical value of (1.96) the observed p-value (0.000) is also lower than the fixed value ($p < 0.05$), these observations provide sufficient evidence for rejecting the null hypothesis, Therefore, the Ho was rejected. The participants were satisfied with the healthcare services provided for them.
3. The health care services rendered in Primary Health Care Centers for Women of childbearing age in Plateau state is significant. In the sense that the result for the testing the Ho which states that, the healthcare services rendered at the PHC for

WCBA in Plateau State is not significant revealed The observed t-value (32.312) obtained at 408 DF is higher than the critical value of (1.96) the observed p-value (0.000) is also lower than the fixed value ($p < 0.05$), these observations provide sufficient evidence for rejecting the null hypothesis, therefore, Ho was rejected. The healthcare services rendered to the participants in Primary Healthcare Units, Plateau State was significant.

4. The utilization of health services provided by Primary Health Care Centres is significantly related to the satisfaction of Women of childbearing age who patronized them. Because the outcome for testing the Ho which states that; There is no significant relationship between utilization and satisfaction of healthcare services provided by primary healthcare among women of childbearing age in Plateau State, Nigeria. Revealedthat the observed correlation coefficient (r-calc.) obtained at 407 degrees of freedom was (0.918) is higher than the T- critical value (0.098), the observed level of significance p-value was (0.000) lower than ($p < 0.05$). These observations did not provide sufficient evidence for retaining the null hypothesis, therefore the Ho was rejected. Meaning that there is a significant relationship between utilisation and satisfaction with Primary Healthcare Services among women of childbearing age in Plateau State.

5.3 Contributions to Knowledge

Thisstudy has contributed to knowledge in the following dimensions:

1. It was established that; women of childbearing age in Plateau state utilize health care services at the Primary Health Care Centers.

2. It was contributed that; women of childbearing age are satisfied with the health care services provided by Primary Health Care Centers in Plateau state.
3. It was established that; health care services rendered in Primary Health Care Centers for Women of childbearing age in Plateau state are adequate.
4. It was added that; utilization of health services provided by Primary Health Care Centers in Plateau State is significantly related to the satisfaction withwomen of childbearing age who patronized them.

5.4Recommendations

Based on the conclusion reached in this study, the following recommendations were made:

1. Health educators should intensify their enlightenment/education campaigns on Maternal and child care so as to encourage women of child bearing age in the state to sustain the existing utilization of health care services provided by Primary Health Care Centers in the state.
2. TheState Ministry of Health should continue to work closely with community structures and the state government so as to achieve ownership at all levels which in turn will further sustain the availability of healthcare services rendered at the primary healthcare level across the state.
3. TheState Ministry of Health in collaboration with Primary Healthcare Development Agency and Implementing Partners in the State should further continue to provide technical support for healthcare workers so as to enable them continue their work efficiently; thereby sustaining the satisfaction women of childbearing age derive from patronizingthe healthcare services at the health centers.

4. The state Ministry of Health should continue to work in close relationship with media houses so as to continue on-air sensitization and sharing of testimonies from healthcare beneficiaries so as to further sustain the utilization of healthcare services among the populace.

5.5 Suggestions for Further Studies

The following topics are suggested for those interested to carry out further research in this area;

1. Determinants of utilization and satisfaction with healthcare service provided by Primary Health Care Units for women of childbearing age in Plateau state.
2. Assessment of utilization and satisfaction with healthcare service provided by Secondary Health Care centres for women of childbearing age in Plateau state.
3. Assessment of perceived satisfaction with healthcare service provided by Primary Health Care Units for women of childbearing age in Plateau state.

5.6 Limitation of the Study

During the research the researcher experienced the following constrain which tend to put him out from completing the study, it is not easy dealing with humans as behaviours varies within individuals, the researcher phases some individual difficulties which led to rendering some of the distributed questionnaire invalid 420 copies was distributed but at the end of collection 409 was retrieved but was considered valid for the study due to attrition,

The researcher also experienced financial difficulties due to distance and transportation cost which led to extension of data collection period, weakness and researcher depression.

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APENDIX I

DEPERTMENT OF HUMAN KINETICS AND HEALTH EDUCATION
FACULTY OF EDUCATION
AMADU BELLO UNIVERSITY, ZARIA

QUESTIONNAIRE ON "ASSESEMENT OF UTILIZATION AND SATISFACTION WITH PRIMARY HEALTHCARE SERVICES AMONG WOMEN OF CHILDBEARING AGE IN PLATEAU STATE, NIGERIA"

Dear Respondent,

The aim of this study is to access the utilization and satisfaction with primary healthcare service among women of childbearing age in Plateau State, Nigeria. You are expected to be very honest in answering this question, bearing in mind that all your response for this study will be treated confidentially, thanks.

Yours sincerely

FIDELIS,JelkyesYerse

Instruction: Please tick (√), the option which best describes your opinion.

Section A: Demographic Characteristics of Respondents

1. **Age Range:**

   (a) 15 – 19 years ( )
   (b) 20 – 24 years ( )
   (c) 25 – 29 years ( )
   (d) 30 – 34 years ( )
   (e) 35 – 39 years ( )

2. **Level of Education**

   a. Primary School Certificate ( )
   b. Secondary School ( )
   c. Tertiary Institution ( )

3. **Marital Status**

   a. Married ( )
   b. Single ( )
   c. Divorced( )
   d. Widow ( )

4. **Occupation**

   a. House wife ( )
   b. Trading ( )
   c. Civil Servant ( )
   d. Farming ( )

5. **Economic Status per month**

   a. Low income (N25, 000 – 49,000) per month ( )
   b. Middle income (N50,000 – 99, 000) per month ( )
   c. High income (N100, 000 – 150,000) per month ( )

Instruction

Please tick (√) against each statement in the space provided which best describes your feeling or your opinion

SA – Strongly agree

A – Agree

D – Disagree

SD – Strongly disagree

Section B: Utilization of primary healthcare services among women of childbearing age in Plateau State, Nigeria.

S/NO	Statement	SA	A	D	SD
1	I show up for health education sessions at the healthcarecentre				
2	I use family planning services which are been provided at the healthcare centre				
3	I use the drugs provided to me at the healthcare centre				
4	I take my child for immunization at the healthcare centre				
5	I attend nutrition demonstration sessions for pregnant women at the healthcare centre				
6	I go to the healthcare centre for treatment of disease				
7	I attend antenatal care at the healthcare centre				
8	I go to the healthcare centre for hospital delivery				

Section C: Satisfaction of primary healthcare services among women of childbearing age in plateau State, Nigeria.

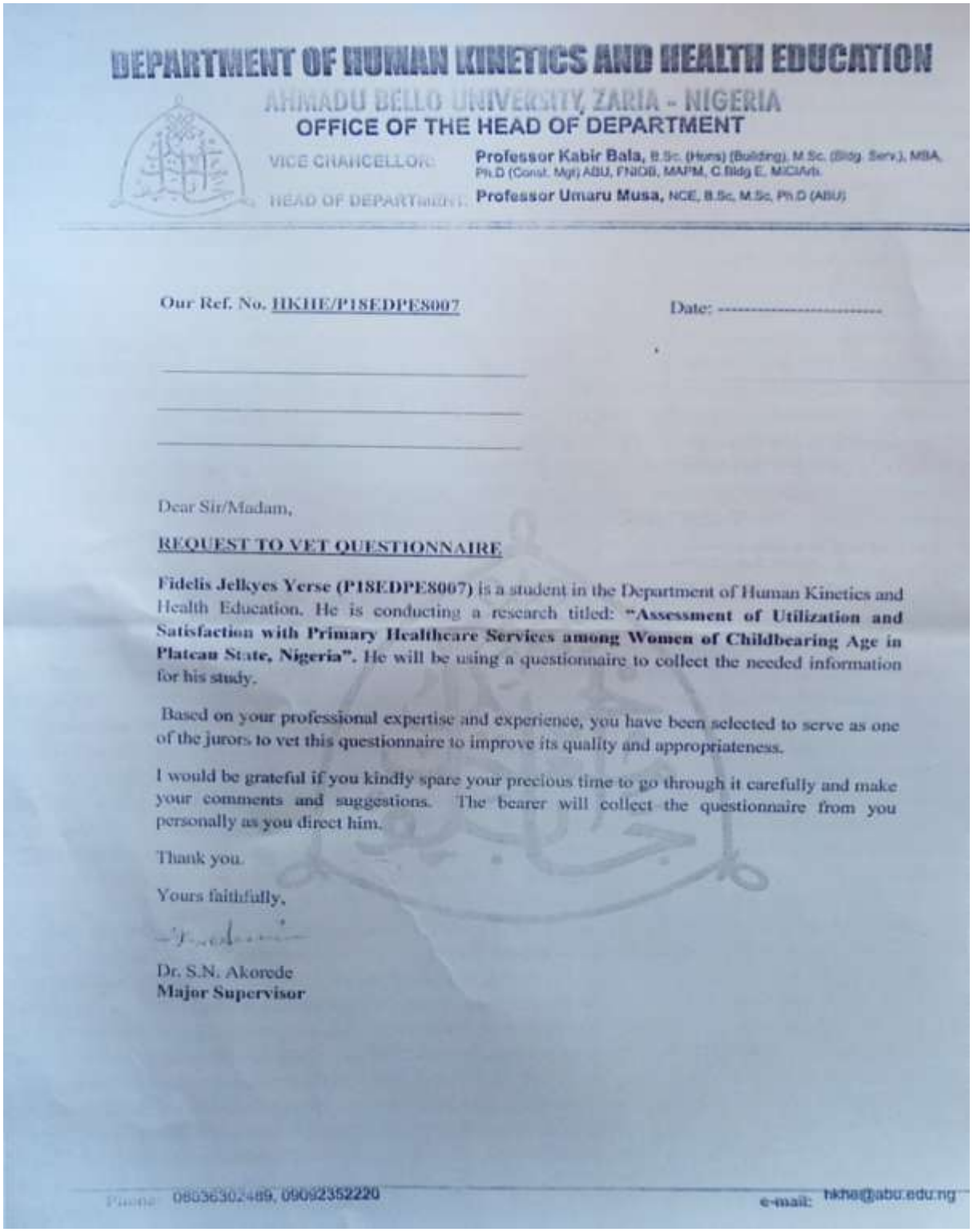
S/NO	Statement	SA	A	D	SD
1	The health education sessions held at the healthcare centre is quite educative				
2	Family planning service provided at the healthcare centre are pleased me				
3	I am pleased with the essential drugs provided at the healthcare centre				
4	my child was immunized at the healthcare centre happily				
5	I enjoy the nutrition demonstration sessions for pregnant women which are often held at the healthcare centre				

6	I am pleased with the healthcare service delivery for treatment of disease at the health centre				
7	I like the way antenatal care service sessions are held at the healthcare centre				
8	I like the way I get attended to when I go to the healthcare centre for hospital delivery				

Section D: Types of healthcare services at the primary healthcare for women of childbearing age in Plateau State, Nigeria.

S/NO	Statement	SA	A	D	SD
1	Health education services are been render at the health facility				
2	Family planning service are done in the primary healthcare				
3	Essential drug are been provided at the healthcare facility				
4	Child immunization is practiced in the primary healthcare				
5	Nutrition demonstration to pregnant women is obtained				
6	Treatment of minor diseases are available				
7	Maternal and child health service is always available				
8	Water and sanitation services are provided at the healthcare facility				

APPENDIX II



DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

AHMADU BELLO UNIVERSITY, ZARIA - NIGERIA

OFFICE OF THE HEAD OF DEPARTMENT

VICE CHANCELLOR: Professor Kabir Bala, B.Sc. (Hons) (Building), M.Sc. (Bldg. Serv.), MBA, Ph.D (Const. Mgt) ABU, FNIOB, MAPM, C.Bldg E, MCIArb.

HEAD OF DEPARTMENT: Professor Umaru Musa, NCE, B.Sc, M.Sc, Ph.D (ABU)

Our Ref. No. HKHE/P18EDPE8007 Date: ----------

Dear Sir/Madam,

REQUEST TO VET QUESTIONNAIRE

Fidelis Jelkyes Yerse (P18EDPE8007) is a student in the Department of Human Kinetics and Health Education. He is conducting a research titled: **"Assessment of Utilization and Satisfaction with Primary Healthcare Services among Women of Childbearing Age in Plateau State, Nigeria".** He will be using a questionnaire to collect the needed information for his study.

Based on your professional expertise and experience, you have been selected to serve as one of the jurors to vet this questionnaire to improve its quality and appropriateness.

I would be grateful if you kindly spare your precious time to go through it carefully and make your comments and suggestions. The bearer will collect the questionnaire from you personally as you direct him.

Thank you.

Yours faithfully,

Dr. S.N. Akorede
Major Supervisor

Phone: 08036302489, 09092352220 e-mail: hkhe@abu.edu.ng

APPENDIX III

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

AHMADU BELLO UNIVERSITY, ZARIA - NIGERIA

OFFICE OF THE HEAD OF DEPARTMENT

VICE CHANCELLOR: **Professor Kabir Bala**, B.Sc (Hons) (Building), M.Sc. (Bldg. Serv) MBA, Ph.D (Const. Mgt) ABU, FNIOB, MAPM, C.Bldg E, MICIArb

HEAD OF DEPARTMENT: **Professor Umaru Musa**, NCE, B.Sc, M.Sc, Ph.D (ABU)

Date: 20th December, 2021

Dear Sir,

LETTER OF INTRODUCTION FOR DATA COLLECTION: FIDELIS YERSE JELKYES P18EDPE8007

Fidelis J. Yerse with the registration number P18EDPE8007 is a Postgraduate student of the above named Department. He is conducting his research work on Assessment of Utilization and Satisfaction with Primary Health Care Services among Women of Child Bearing Age in Plateau State, Nigeria, for which your ward has been selected as part of the areas for data collection.

Kindly avail him all necessary support as all information gathered in the course of the research work will be used strictly for academic purpose.

Kind regards.

Akoredesen

Dr. Akorede S. Nuruddeen

Major Supervisor

08036302489, 09092352220

email: nkhe@abu.edu.ng

APPENDIX IV

PLATEAU

State in Nigeria

Subdivision

The population development in Plateau as well as related information and services (Wikipedia, Google, images).

The ⋯ icon links to further information about a selected division including its population structure (gender, age groups, age distribution).

Name	Population Census 1991-11-26	Population Census 2006-03-21	Population Projection 2022-03-21
Plateau	**2,104,536**	**3,206,531**	**4,717,300**
Jos North	...	437,217	643,200
Jos South	237,408	311,392	458,100
Mangu	187,397	300,520	442,100
Shendam	...	205,119	301,800
Qua'an Pan	141,082	197,276	290,200
Pankshin	...	190,114	279,700
Bassa	121,652	189,834	279,300
Barkin Ladi	...	179,805	264,500
Bokkos	95,218	179,550	264,100
Kanam	113,500	167,619	246,600
Wase	102,336	159,861	235,200



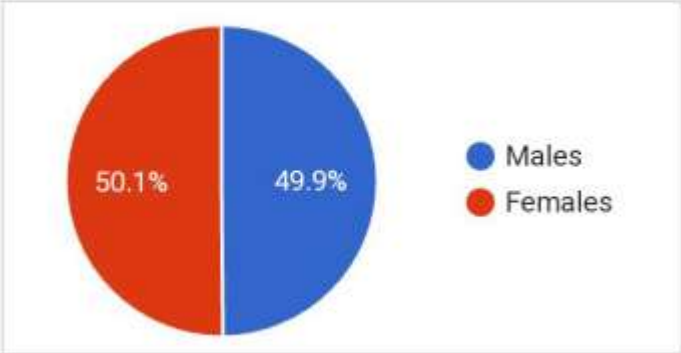
Wase	102,336	159,861	235,200
Langtang North	94,707	142,316	209,400
Riyom	...	131,778	193,900
Kanke	...	124,268	182,800
Langtang South	47,108	105,173	154,700
Mikang	...	96,388	141,800
Jos East	...	88,301	129,900
Nigeria	**88,992,220**	**140,431,790**	**216,783,400**

Source: National Population Commission of Nigeria (web), National Bureau of Statistics (web).

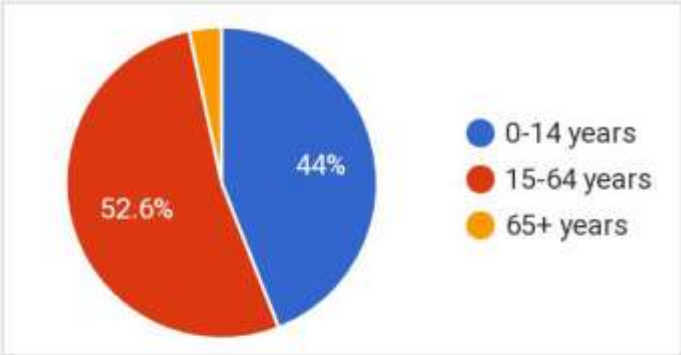
Explanation: The population projection assumes the same rate of growth for all LGAs within a state. The undercount of the 1991 census is estimated to be about 25 million. All population figures for Nigeria show high error rates; census results are disputed. Area figures are computed using geospatial data.



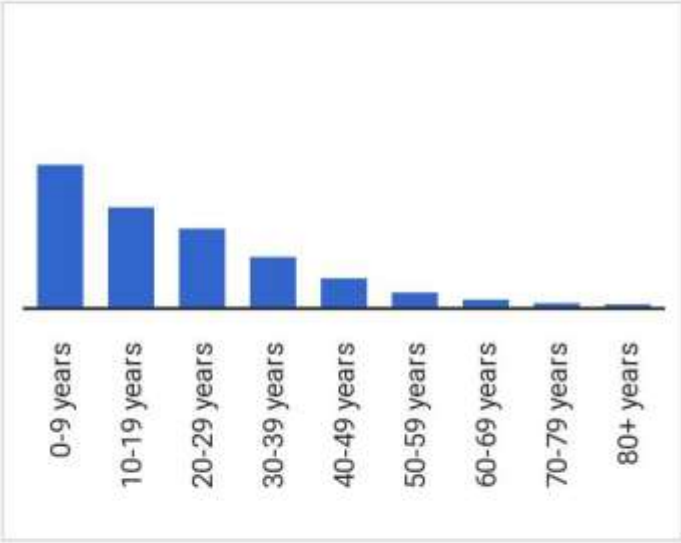
Further information about the population structure:



Gender (C 2006)	
Males	1,598,998
Females	1,607,533



Age Groups (C 2006)	
0-14 years	1,411,031
15-64 years	1,687,381
65+ years	108,119



Age Distribution (C 2006)	
0-9 years	1,030,393
10-19 years	724,539
20-29 years	575,677
30-39 years	368,130
40-49 years	228,122
50-59 years	125,65
60-69 years	72,346
70-79 years	44,563
80+ years	37,102