



## **An Overview of Factors affecting Women Performance in Some Primary Health Care Delivery in Jere Local Government Area of Borno State, Nigeria**

IBRAHIM MOHAMMED, AMINA RAMAT SAIDU,  
SADIQ ADEIZA SHEHU  
University of Maiduguri, Nigeria

**Abstract.** This study is on Primary Health Care Services, and factors Affecting PHC Service Utilization of the Health Facilities. It revolves around Factors Utilization of Primary Health Care Services. The study was carried out in Jere local government Area of Borno state. Having in focus some selected clinics which includes Yerwa Clinic Primary health care situated in Shehuri Ward, and Fatima Ali Sheriff Primary Health care in Maisandari ward were selected for the purpose of this study. Both primary and secondary data were analyzed in respect of this study. Oral Interviews were conducted and questionnaire distributed to elicit information in regard to women contribution in primary health care while textbooks, internet materials were used as part of secondary source of data. The major findings reveal that women played a very significant role in enhancing health service delivery within Jere local government Area of Borno State.

**Keywords:** Women, Participation and Health Care Delivery.

### **1. Introduction**

The primary health care (PHC) system is the first point of contact between the individual and the health system services, and it is the bedrock of national health care system. Nigeria adopted PHC as the grassroots of her National healthcare system and a priority for national development in 1986 and decades after, the PHC lacks the capacity to achieve its objectives. Primary health care (PHC) accelerates timely intervention during and after pregnancy and childbirth, a level for qualitative healthcare, which is easily accessible and affordable to the rural masses. Maternal and child health status have become important indicators for socio-economic development as well as health of the people of a country (Azuh, 2017).

The fundamental aim of primary health care (PHC) is to ensure universal access to available resources in order to provide adequate coverage of the most important health needs of the people. In the last 40 years, primary health care has evolved and developed globally. In Nigeria, primary health care implementation started in 1992 with the commencement of the programme in the local government areas (LGAs). Nigeria therefore became one of the first countries in the developing economies to have systematically decentralized the delivery of the basic health care services through local government administration.

The implementation of primary health care is still passing through diverse challenges (Alenoghena, et al 2014). Most of the Primary Health Care facilities in the country lack the capacity to provide essential and adequate health-care services to the members of their host communities. Such poor and insufficient services are the consequences of phenomena such as poor staffing, inadequate equipment, poor health workers distribution, inadequacy in the numerical strength of available qualified health services personnel, together with dilapidated condition of infrastructure, and lack of the availability of essential drugs (Aregbesola and Khan 2017). More concerned observations in Udentia & Udentia (2018) portray the practice of primary health care services in the country as being in a state of abysmal performance and inadequacies. Most primary health care (PHC) facilities located in various states in the country are in severe condition of disrepair with equipment and infrastructure being either absent or obsolete as the referral system is almost extinct (Udentia & Udentia, 2018).

Primary Health Care (PHC) is a grass-root management approach with the general aims and focuses towards providing health care services to communities. The concept of the operation of Primary Health Care was first published in 1978.

Hence, various countries have attained different levels of progress in implementing the strategy (Aigiemolen et al, 2014). Starting from its independence in 1960, there was little or absence of strong focus on health systems development in Nigeria (Aregbesola and Khan 2017). However, policy makers and political office holders of the time made efforts to establish and expand health-care infrastructures with much emphasis being placed on curative medicine rather than preventive medicine (Fatusi 2015). From 1975 to 1980, health system development was initiated with PHC as the cornerstone. In another view Oluwasogo and Sebutu (2020) posit that the inception of primary healthcare in Nigeria began with the advent of Basic Health Services, a concept which was introduced to be an integral part of the nation's third development plan in 1975. This innovation led to the establishment of 20 health clinics and 4 Primary Health Care (PHC) Centers which were spread across the local government regions. Furthermore, the launching of Nigeria's first comprehensive national health policy based on PHC took place in 1988. From 1986 to 1990, the then minister of health, Professor Olikoye Ransome-Kuti expanded PHC to all local governments, achieved universal child immunization of over 80%, and devolved responsibility for PHC to local government areas (Aregbesola and Khan 2017). He worked committed between 1985 and 1992 to ensure the implementation of PHC policy.

The World Health Organization WHO (2014) defined health of women during pregnancy, childbirth, and the postpartum period. Maternal health care services (MHCS) are essentially promoted and preventive and provide avenues for the early detection of mothers at high risk of illness and mortality during pregnancy, labour and postnatal periods (Olugbenga-Bello, Abodunrin and Adeomi, 2011; WHO and UNICEF, 2010). Majority of women who utilize maternal health care services are not ill, and as pregnancy is a frequently and uneventful physiological process, it is logical to imagine that, given the slightest constraints, maternal health services would be underused. Women's experiences relating to continuity of care are mixed. In 2010, 92 per cent of women reported having a named midwife they could contact during pregnancy. However, 22 percent stated that they had been left alone, during or shortly after birth, at a time when it worried them. In 2013, 78 percent of maternity units reported that they provided one-to-one care for at least 90 per cent of women (National Audit Office Borno, 2013).

## 2. Review of Literature

According to World Health Organization (1978), primary health care is 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 that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It covers a wide range of health services, which includes diagnosis and treatment, health education, counseling, disease prevention and screening usually provided in a community by general practitioners, practice nurses, pharmacists or other health professionals working within a health facility. Service utilization refers to the extent to which people are making use of whatever services are already available in the community or at their organization. Therefore, health care service utilization is the extent to which people make use of the health care services available to them in their community (Hampton & Nagy, 2016). The extent to which these health services are utilized in developing countries is still very low resulting in many different negative consequences.

The emphasis by development planners and initiators to always involve people in development initiatives or systems that can bring the desired result of sustainable development is paramount, as scholarly literature seeks to understand reasons behind low/passive women performance especially in Health communication development. Over the last couple of decades, development communication and health communication have witnessed an unprecedented change in the trail of events. Women have been confronted with the challenges of improving their lives and welfare of their entire being, together with the trends of globalization and development. Research findings by scholars (Anifowose, 2004, Enejere, 1991, Bamidele, 2004 and Enemu, 1999) have all strongly advocated the necessity of active participation of women in health development and discourse, as this can help in addressing the challenges of low women participation in development as a whole. Women: is an adult female human. Prior to adulthood, a female human Performance: is defined as the action or process of carrying out or accomplishing an action. Task, or function. Primary Health Care: is the first level of contract for individuals, the family, and the community to provide health promotion, preventive, curative and rehabilitation services accordingly.

## 3. Women Development in Primary Healthcare Policies in Nigeria

Women's participation in health administration is a sine-qua-non for sustainable development of health communication in Nigeria, and an opportunity to develop their individual capacities (Anifowose, 1999). Ideally, active participation of

women in primary health care involves the decision that has to do with their lives. Women's participation in health administration involves activities such as involvement in drafting communicating strategies, being active from the stage of conception until the evaluation stage. However, the pursuit of this essential principle in development, according to Khan (2004), shows that women are generally left behind. Most times the women are seen, but not heard in health issues. In the hierarchy of development strides, they are at the lower 39 ladder as a circumstance of either cultural or patriarchal system associated with participation. They are seldom involved in national programmes, and even when they do, it is at the peripheral level. (Anifowose, 2004). The assumption that development planners make about women in society is almost never stated. This is obviously a challenge which no government can afford to ignore, more importantly, it has become increasingly clear that development or progress in people's welfare cannot be achieved where the needs and contribution of half of the world's population (women) are continually downgraded, marginalized or completely ignored (Bamidele: 2000) However, a cursory look at the pattern of women's involvement in health administration in Nigeria reveals abysmal low levels.

In spite of the entire quest for their participation, the objectives and benefits, Nigerian women still suffer a lot of constraints which militate against their personal and national development. The passive role assigned to women in development especially in developing countries, and Nigeria has been so entrenched that the growing concern with the plight of women has not been able to easily dislodge it. According to Ojobo (2001), Women are less informed about issues of development and less able to be exposed to health administration and less likely to be concerned with participation in development intervention because of the way they are being regarded in the whole process. Various policies and interventions in primary health seems to prepare the necessary measures to ensuring that women are adequately taken care of, especially as primary health have much concern for women and children. The area that concerns governments, NGOs and international donor agencies such as W.H.O. and UNPF is in the child and maternal health. For instance, statistics of June 2011 states that maternal mortality rate per 100,000 births for Nigeria in 2010 was 840. This is compared with 608.3 in 2008 and 473.4 in 1990. To address this alarming situation, several bodies, international and local have fashioned out strategies and policies to reduce child mortality and improve maternal death.

In Nigeria, policy making in health is considered as serious business because the goal of Primary Health Care (PHC) was to provide accessible health for all

by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade. According to Abdurraheem (2012), the following issues tends to inundate or shroud the achievements of these policies owing largely to the following reasons namely lack of political will/attitude to public policy implementation, poor implementation design, conception and discipline, poor program leadership and management, lack of resources, corruption, sectionalism and ethnic biases, egocentrism and duality/multiplicity of public policies, cultural and religious factors, selective and non-implementation budgets and misplaced priority are the paradoxes of public policy implementation, which has continued to militate against public policy success in the country.

In all these factors, scholars, female activist and feminists are worried and are assertive that women who are predominantly the major beneficiaries of primary health care are not given adequate opportunity to contribute in what really concerns them at the level of policy making. This has however generated debates which is basically premised on the platform that governments marginalization of women in playing key and active role in politics, health, education etc has resulted in less representation in policy making especially in the areas of health is appalling. However, what seems to be overtly conspicuous in terms of participatory gap is the fact women are often not squarely involved in the policy planning as well as implementation and general framework. A lot of arguments have ensued in the direction that women's roles are not limited to domestic responsibilities and the fact that women play significant roles in nation building and ought to be given opportunities to contribute meaningfully in nation building processes such as policy formulation. The argument in favor of women is centered on the assumption that the prevalence of unequal power relation resulting in disproportionate distribution of rights and privileges to women has been a great issue of concern leading to different interventions by individuals and women's groups to eradicate such concepts. This is against the background that women have in no small measure advance the course of this country especially struggles to correct acts of discrimination and violence which have been in existence since the 19th century.

Formation of women's movements has led to several interventions by women in social and political landscape which has further helped to improve their status at the grassroots, national and regional levels. Worthy of mention is the ideology of Feminism in Nigeria which emerged out of the demands of women to improve women's status and eliminate debilitating factors that deprive women of enjoying

their full human rights. According to Adamu (2006) women in Nigeria have faced a wide spectrum of experiences in navigating through several hindrances that have confronted them.

The culture of patriarchy, male chauvinism and anarchy has undermined the rights of women and the outcome of this is the exploitation and marginalization of women in the affairs of development both at the private and public spheres. Recently, however, more women in most countries and particularly in Nigeria are beginning to get involved and participate in development intervention, but as Anifowose (1999) rightly pointed out, their participation is still at the peripheral level. Women are being manipulated in development process. A process he described as detrimental to health development in Nigeria. This study aligns with the need to involve women in primary healthcare communication but very importantly, it looks beyond just involving women in the process of primary health communication, but active participation with diverse women groups across communities, because only by forging interactions among diverse groups with divergent views can genuine participation and development processes be forged.

#### 4. Role of women Approach in Primary Health Care

The reaction against modernization, and to some extent the realization of global structural imbalances, gave rise to various participatory approaches. They share the common intent of actively involving people who were the subjects of development in shaping the process, but in most cases, this is where similarity ends and a diversity of differences begin. People's participation became defined in many different ways, and in turn led to numerous unresolved disagreements. According to White (1999), authentic participation of grassroots people may still be more of an ideal than a reality. Individuals and agencies actively engaged in development are conscientiously struggling to move beyond theorization to achieving this ideal. Based on White's observation and inquiry, there seems to be an ever-increasing overt recognition of the need to involve oppressed and disadvantaged people in the flow of decision making and action required for decision development. But it is not as though that recognition will facilitate participation of the people and make it happen. It would not be appropriate for a development professional to talk about participation as being pretty simple. But to "walk the talk" with a commitment to make communication happen is not easy. White (1994) points out different types of participation that can be found during projects which may include either development

projects or health interventions projects; these include:

**Passive performance:** People participate by being told what is going to happen or has already happened. It is a unilateral announcement by an administration or a project management without listening to people's responses. This has been the usual approach of bringing development to the people. It is assumed they know what the people want. (White, 1994)

**Participation by Consultation:** People participate by being consulted, and external agents listen to views. These external agents define both problems and solutions, and may modify these in the light of people's responses. Such consultative process does not concede any share in decision making, and professionals are under no obligation to take on board people's views. (White, 1996).

**Participation for Material Benefit:** People participate by providing resources such as labour, in return for food, cash or other material incentives. Much on farm research falls in this category, as farmers provide the fields but are not involved in experimentation or the process of learning. It is very common to refer to this as participation yet; people have no stake in prolonging activities when incentives end.

**Interactive Participation:** People participate in joint analysis, which leads to action and the formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple objectives and make use of systematic and structural processes. These groups take control/ownership over local decisions and so people have a stake in maintaining structures or practices. (White, 1996)

**Self-Mobilization:** People participate by taking initiative independent of external institutions to change systems. Such self-initiated mobilization and collective action may or may not challenge existing inequitable distribution of wealth and power.

**Functional Participation:** People participate by forming groups to meet predetermined objectives related to the project which can involve the development or promotion of external initiated social organization. Such involvement tends not to be at early stages of project cycles or planning, but rather after major decisions have already been made. These institutions tend to be dependent on external initiators and facilitators, but may become self-dependent.

**Participation in Information Giving:** The information being shared belongs to the external professionals. People participate by answering questions posed by extractive research using questionnaires, surveys of such similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared nor checked for accuracy. White's

(1994), offers some insights into different interests at stake in various forms of participation as a way of working out how people make use of participation, it can be useful tool to identify conflicting ideas about why or how participation is being used at any particular stage in a process. Types of participation such as these can be read as implicitly suggesting a progression towards a more “genuine” type of participation. When these types of participation are contextualized, however, they become more ambiguous. Participation through information giving for example might limit more active engagement, although it could be argued that transparency over certain kinds of information opens up the possibility of collective action in monitoring the consistency of rhetoric with practice. But keeping a flow of information going is in itself important. What people are participating in, conditions how their participation might be evaluated. Delegated power over choosing the kind of Primary health care structure in the name of “patient involvement”- in the absence of any involvement in decisions on what the Primary Health Care does, may count for little in genuine participation. Different purposes, equally demand different types of engagement by different kinds of participants.

A process that sought only the engagement of small group of articulate elite community members is different to one in which community members delegate power to such group to engage with the authorities to receive information and be consulted on key issues.

## 5. Methodology

The data for this study was obtained from both primary and secondary sources. The primary source was the questionnaire that was distributed to the respondents and interview conducted. While the secondary data were the journals, text books and internet materials consulted and analyzed.

The data obtained through the method discussed above was quantitatively presented and significance of data to see whether deviations of the actual observation (observed frequency) from the expected outcome are significant so that it may lead to the acceptance or rejection of the null hypothesis.

It is evidently clear that the process if research involves emerging questions and procedures, data typically collected in the participants setting data analysis inductively building from particulars to general themes, and the researcher making interpretation of the meaning of the data (Cresswell) Qualitative research is exploratory and researchers use it to explore a topic when the variables and theory base are unknown. For example, Morse

(1991) on ideological perspectives (Lather,1991), to philosophical stances (schwandt, 2000)

## 6. Discussion of Findings

The result of this study shows that some of respondent are of the view that first ante-natal check-up be done in the first 3 months, this is in line of the study of James, (2008), antenatal care should begin before pregnancy when a couple is considering having a child, and it should continue throughout pregnancy. The goals include providing the best care for the pregnant woman and the unborn child, as well as preparing the mother-to-be for the delivery of a healthy baby.

James, (2008) noted that during antenatal visits tests are performed on both the mother and fetus to assess any potential risks, to treat any maternal or fetal complications, and to monitor the growth and development of the fetus. In addition, counseling and guidance are provided regarding the various aspects of pregnancy, including weight gain, exercise, nutrition and overall health.

Antenatal care is crucial to maternal and infant health. Women who receive early and continuous antenatal health care have better pregnancy outcomes than women who do not; a pregnant woman who receives no antenatal care is three times as likely to give birth to a low-birth-weight infant (one that weighs less than 5.5 pounds or 2500 grams as one who receives the appropriate care, and she is four times as likely to have her baby die in infancy (James, 2008).

According to White (1999), authentic participation of grassroots people may still be more of an ideal than a reality. Individuals and agencies actively engaged in development are conscientiously struggling to move beyond theorization to achieving this ideal. Based on White’s observation and inquiry, there seems to be an ever-increasing overt recognition of the need to involve oppressed and disadvantaged people in the flow of decision making and action required for decision development. But it is not as though that recognition will facilitate participation of the people and make it happen. It would not be appropriate for a development professional to talk about participation as being pretty simple. But to “walk the talk” with a commitment to make communication happen is not easy.

Mairiga (2003). Maternal and child healthcare which aims at ensuring a healthy mother and baby throughout pregnancy and childbirth, involves the screening of patients, the treatment of anaemia, malaria, urinary tract infections and sexually transmitted infections, as well as the identification and management of pregnancy-related

complications such as hypertensive disorders, diabetes, abnormal presentations and providing information about family planning and how and when to access medical care when complications arise. This development was stimulated by the realization that while maternal mortality due to puerperal sepsis, hemorrhage and obstructed labour has declined during the early years of the 20th century if these eclampsia-related deaths are to be averted, as it is supposed, interventions would be needed early during the pregnancy to measure blood pressure, identify women at risk of ecliptic convulsions and take measures to reduce blood pressure whenever possible (WHO, 2003). According to Sumithra, (2006), maternal and child health care services are essentially promotive and preventive. James (2008) noted that prevention measures that reduce maternal and infant mortality and promote the health of all childbearing women and their newborns should start before conception and continue throughout the postpartum period.

Bichi, (2007). The provision of special care for women during pregnancy through the public health services is a relatively late development in modern obstetrics. Not until the late 1930s did the United Kingdom authorities decide that women should be offered regular checkups during pregnancy as an integral part of maternity care. This development was stimulated by the realization that while maternal mortality due to puerperal sepsis, hemorrhage and obstructed labour has declined during the early years of the 20<sup>th</sup> century if these eclampsia-related deaths are to be averted, as it is supposed, interventions would be needed early during the pregnancy to measure blood pressure, identify women at risk of ecliptic convulsions and take measures to reduce blood pressure whenever possible (WHO, 2003).

Webster (2001) conducted a survey to examine satisfaction with health care provided and to compare differences in service use in the first four weeks after birth between depressed and non-depressed women who attended bookings in Royal Women's Hospital. The results indicated that 16% of the women were dissatisfied with the health service providers and this contributed to their not utilizing the services. This suggests that for some women to use health services they must be satisfied with the quality of the services and the service providers as well. Therefore, hospitals should strive to improve on the quality of the services they provide to their clients in order to attract the consumers to utilize the services.

## 7. Summary

Perceptions of Primary Health Care Services, Factors Affecting PHC Service Utilization at the Health Facility, Factors Limiting Utilization of

Primary Health Care Services and Summary of Literature Review, Chapter three of the study deals on the Research design. The study was carried out in Jere local government Area of Borno state. Yerwa Clinic Primary health care situated in Shehuri Ward, and Fatima Ali Sheriff Primary Health care of Maisandari ward were selected for the study. The study population includes a selection of facility staff and users that had used the clinic within a certain period.

## 8. Conclusion

It was concluded that the community participation in Primary healthcare in Maiduguri Metropolis of Borno State are significantly adequate. Utilization of ante-natal services using pregnant woman in attending antenatal service in clinic, the health care personnel are friendly, helpful and considerate. Attitude of women regarding the antenatal care Treatment by health care providers in maternal and child health services are satisfactorily.

## 9. Recommendations

The following recommendations were made based on the findings of Study:

- There should be regular supervision of the PHC facilities in the rural areas by the LGA health department and the State Ministry of Health to improve and sustain the quality of the services offered.
- Government and other stakeholders in maternal health services should ensure active participation of the community in PHC programmes including the involving them in the management of PHC facilities in their communities.
- Government should put in place specific policies and programmes that will encourage men participation in maternal health care of their wives. Such policies should address the constraints to men's participation maternal health care of their women and ensure reward for men that actively encourage their wives' utilization of maternal health services especially in the rural areas.
- Effective community enlightenment programme should be put in place in the rural areas by both the government and non-governmental organizations to improve the utilization of maternal health services by women.

## References

Adebayo, B. (2010). *Maternal and Child Health Status in Nigeria: A speech at a News*

- Conference Organized by the State Ministry of Health on the First Round of the 2010 Maternal Newborn and Child Health Week in Lagos on Thursday 20th May, 2010
- Annet, N. (2004). *Factors Influencing Utilization of Postnatal Services in Mulaga and Mengo Hospitals*, Kampala, Uganda. Unpublished Thesis University of the Western Cape.
- Ardefia GJRA, Paz-Pacheco E, Jimeno CA, Lantion-AngFL, Paterno E, JubanN. (2010) Knowledge, attitudes and practices of persons with type 2 diabetes in a rural community: Phase I of the community-based diabetes self-management education (DSME) program in San Juan, Batangas, Philippines. *Diabetes Research Clinical Practice*. 2010;
- Audu, M.H. (2009). *Constraints in the Utilization of Primary Health Care Services in Taraba State*. Unpublished Thesis, Ahmadu Bello University, Zaria.
- Bamanah, H. (2014). *Maternal and Child Health Project*, Bangladesh Association for Maternal and Neonatal Health, Bangladesh.
- Baumann LC, Opio CK, Otim M, Olson L, Ellison S. (2010) Self-care beliefs and behaviors in Ugandan adults with type 2 diabetes. *The Diabetes Educator*. March-April 2010;
- Bichi, M.S. (2017). *Factors responsible for the underutilization of Maternal and Child Health Services Among Childbearing Mothers in Selected Local Governments of Kano State*. Unpublished Thesis, Bayero University Kano.
- Colberg SR, Sigal RJ, Yardley JE, et al. Physical activity/exercise and diabetes: a position statement of the American Diabetes Association. *Diabetes Care*. 2016;39(11):2065—2079
- Collins Gem, D.T (2010). *English Dic.*) Debora, M.B (1991). *Obsgeiligs and Gyaegglogy*Universgg of Columbia.
- Dr. William Lumu. *Whatyou should know about your diabetes*. Kampala: Lumax Press; 2010
- Family Health, (2002). *Parental care Mary land Health and Mental Ijyjne WWW*. 4 woman gov.
- Gazali, W.A (2010). *Socio cultural context of reproductive Health and Gender issues Borno state, Nigeria*.
- Hawthorne K, Edwards AGK. (2010) Culturally appropriate health education for type 2 diabetes in ethnic minority groups: A systematic and narrative review of randomized controlled trials. *Diabetic Medicine*. 2010;
- Hjelm K, Nambozi G. (2008) Beliefs about health and illness: A comparison between Ugandan men and women living with diabetes mellitus. *International Nursing Review*. 2008; 55(4):434- 441.
- Ojo O. A and Briggs, E.B. (2013). *Textbook of midwives in topic Long/van group*.
- Spencer, L.M.D (2003). *Obstetrics and GvaecolQgy First Edition*, Los Angels, CA.
- Womens health, (2003). *Health and human services*. Us Dept, od Health NWHC office on women health nover.