PERCEPTION AND PATTERN OF UTILISATION OF N.O IDOWU PRIMARY HEALTHCARE CENTRE AMONG MOTHERS OF UNDER-FIVE IN ENIOSA-COMMUNITY, LAGELU LOCAL GOVERNMENT AREA, OYO STATE

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CERTIFICATION

I hereby certify that this study was carried out by Jennifer Ifeanyichukwu EGWU under my supervision in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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DEDICATION

I dedicate this research project to God Almighty who has been merciful and wonderful to me and my family. He has been my source of help and strength and is the reason for the success of this project work.

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ABSTRACT

Low-utilisation of primary healthcare centres is one of the major factors that could lead to maternal mortality. According to World Health Organisation, approximately 830 women daily from pregnancy and childbirth related causes, 99% of this maternal death occur in developing countries. Nathaniel Olabiyi Idowu Primary Health Centre is the first non-profit charitable health organisation providing health care to Eniosa rural community. Despite all the activities of the N. O. Idowu Primary healthcare centre such as organizing medical checkups and health education periodically for the community, there is still low utilisation of these services at the health care centre. This study explored the perception and pattern of utilisation of Nathaniel Olabiyi Idowu Primary Healthcare Centre among mothers of the under-five in Eniosa, Lagelu Local Government, Area Ibadan.

A cross-sectional survey was employed and a three-stage sampling technique was used to select 160 participants. A mixed method of qualitative and quantitative was used for this study. Five focus group discussions (FGDs) were conducted using a focus group discussion guide and semi-structured interviewer-administered questionnaire to collect quantative data. The questionnaire elicited information on socio-demographic characteristics, perception, pattern of utilisation of health services, perceived factors influencing utilisation of health services. A 9-point perception scale graded into negative (≤4) and positive (>4) was used to measure the respondents' perception. A 14-point utilisation scale graded into poor utilisation (≤7) and good utilisation (>7) was used to measure utilisation. Qualitative data was analysed using thematic approach while quantitative data were analysed with SPSS version 21 and presented in descriptive, and inferential statistics at 5% level of significance.

The findings show that the respondents belong to the mean age 29.1±5.5 years. A total of 92.5% of the respondents belong to the Yoruba ethnic group. Also, most of the participants across the FGD groups perceived the health centre as a good place to receive quality health care, 82.1% of the respondents had a positive perception but good utilisation was 26.9%. Also, perception was found to be significantly associated with the utilisation of N. O. Idowu Primary healthcare centre at p-value <0.05. Most of the women across the FGD groups prefered utilising other choices of health care than the health centre. There exists a significant association between occupation and utilisation of the N. O. Idowu Primary healthcare centre (p=0.026). Cost of service was one of the factors that encourage low utilisation.

Furthermore, there was no significant relationship between other factors influencing utilisation of health care and utilisation of health services. The cost of services was 0.7 less likely to increase health utilisation than any other studied factors which included distance of the health centre and attitude of the health workers (OR=0.724, 95% CI: 0.216-2.421).

Perception of the respondents was good while pattern of utilisation of the community health centre was poor. Therefore, health education in form of training and seminars should be carried out to increase utilisation and awareness of N. O. Idowu Primary healthcare centre services also cost effective methods and materials should be employed to increase utilisation.

Keyword: Utilisation, primary health centre, Mothers of under-five

Word count: 500

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GLOSSARY OF ABBREVATIONS

WHO:	World Health Organisation
PHC:	Primary Health Care
PMCTC:	Prevention of Mother to Child Transmission
USAID:	United States Agency for International Development
NPC:	National Population Commission
NACA:	National Agency for the Control of Aids
LGA:	Local Government Area
MCH:	Maternal and Child Health
HIV:	Human Immune Virus
UCH:	University of Ibadan teaching hospital
N. O. Idowu P. H C:	Nathaniel Olabiyi Idowu Primary Health Centre
ANC:	Antenatal care
OTCD:	Over the counter drugs
SPSS:	Stastical Package for Social Package.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

World Health Organisation (WHO) defined health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1948). The definition of health over time has been varying as people have been able to interpret health in different ways, however, activities to prevent or cure health problems and promote good health in humans have been undertaken by health care providers (Jadad and Grady, 2016). Health can greatly be influenced by a number of factors which include people's background, lifestyles, economic, social conditions, and spirituality. Also, studies over time have shown that a high level of stress can be said to affect the health of an individual (Jadad and Grady, 2016).

Health care is the maintenance or improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury and other physical and mental impairment in people. Health care is delivered by health professionals (providers or practitioners). Health care includes work done in providing primary care, secondary care, and tertiary care as well as in public health (Jadad and Grady, 2016). The primary health care facility is the first place of consultation for all patients within the healthcare system (National Population Commission, 2014). Primary health care is often used as a term for health care services that play a role in the local community; it can be provided in different settings, such as urgent care centres, which provide same-day appointments or services on a walk-in basis. Primary health care has the widest scope of health care, which includes all ages of patients, patients of all socioeconomic and geographic origin, patients seeking to maintain optimal health, also patients with all types of acute, chronic physical, mental and social health diseases (WHO, 2019). Continuity is necessary in primary health care as patients usually prefer to consult the same practitioner for a routine checkup and preventive care as well as health education and any time an individual has a need to inquire about a new health problem (Frost and Reiche, 2008).

The utilisation of health services is usually a consequence of the health-seeking behaviours of individuals in a community and these behaviours are affected by several determinants that

could be physical, political, and socio-economic and socio-cultural (Avan and Fatimi, 2002 as cited by Manzoor, Hashmi, and Mukhtar, 2009). The health system utilisation focuses on the act of seeking health care while the illness response process looks generally at the enablers or barriers to seeking health care. A study carried out in Ibadan, Oyo state, among childbearing women revealed that 6.3% of childbearing women utilise one of the very important functions of primary health care such as the antenatal. The study also indicated that age, culture, income, education, religion, marital status, and occupation significantly influenced the utilisation of the antenatal service. The study also revealed that although the utilisation of the antenatal service is low, the combination of socio-economic and demographic variables significantly influenced their utilisation (Ibor, Anjorin, Ita, Out and Bassey, 2011).

The common chronic illness usually treated at the health centre include hypertension, diabetes, asthma, depression and anxiety, back pain, arthritis, or thyroids dysfunction. Primary health care also includes many basic maternal and child health care services and vaccinations (Manzoor et al., 2009). Health centres are community-based and patient-directed organisations that deliver comprehensive, culturally competent, high-quality primary health services (Robert, Hsiao, Berman, and Reich. 2007). Health centres often integrate access to areas where economic, geographic or cultural barriers limit access to affordable health care services. Health centres deliver care to the nation's most vulnerable individual and family, including people experiencing homelessness, agricultural workers, residents of public housing and the nation's veterans. Health centres overcome geographic, cultural, linguistic and other barriers to care by delivering coordinated and comprehensive primary and preventive services. This care reduces health disparities by emphasizing the care management of patients with multiple health care needs and the use of key quality improvement practices (Robert et al, 2007).

According to studies in the United States, the National health interview survey found that skin disorder (42.7%), osteoarthritis and joint disorders (33.6%), back problems (23.9%), disorder of lipids metabolism (22.4%) and upper respiratory tract disease (22.1%), excluding asthma are the major reasons people access the primary health care services (Prasad, Basavaraj, Poovitha, 2015). Understanding the role of the health centre is very important. In the context of global population aging, with the increasing number of aging adults at greater risk of developing chronic non-communicable diseases, rapidly increasing demand for

primary health care services is expected in both developed and developing countries. WHO attributes the provision of essential primary care as an integral component of an inclusive primary health strategy (Robert et al, 2007) – the care will be focused on primary and some secondary care services. Awareness of consumer perception and pattern of utilisation is pivotal to the improvement of services to meet their needs. There is a dart of information to health services. This constitutes the focus of the study.

1.2 Statement of the problem

A health survey conducted in Nigeria in 2008 revealed that the majority of the people in the country have no health insurance coverage to cater for their bills (Nigeria Population Commission, 2009). This simply suggests that the majority of the people have to pay out of pocket making health utilisation dependent on socio-economic status. However, despite the effort of the partnership with the private sector to promote improved access to quality maternal health service individuals still lacked behind in the utilisation of these opportunities (Federal Republic of Nigeria, 2010). This means that the huge global and national investment aimed at effective health care delivery has not yielded the desired results because of poor utilisation and ultimately low access. According to Frost and Reiche (2008), the availability of interventions and services does not translate automatically to access, which means that some areas have health services but still do not utilise them. Gaps have also been made clear between individuals' needs and actual access to critical health services (National Population Commission, 2014). Sixty-one percent of mothers in Nigeria received antenatal care from a skilled provider, of this proportion of women, only fifty-one of them made at least four antenatal care visits during pregnancy (Adekunle, Oleyede, Okanlawn, 2006). This amounted to a 49%-point drop in utilisation between the first and the fourth visit to the hospital. In terms of child health, only 19% of the children aged between 12 to 23 months received all the basic vaccination as shown in the vaccination card (National Population Commission, 2014).

It is not enough for the service to be available, utilisation is most paramount, as patients may choose not to use service. The decision to use available health services depends fully on people's perception of the service and affordability of the health service. The decision of the people depends on their perception and judgment conditioned by factors such as their tradition and culture also perceived competence of the health staff, attentiveness, and responsiveness (Robert et al., 2008). It has been discovered that religion, cost of health service, the distance of health facilities, waiting time and quality of care contribute to the

non-utilisation of health facilities. Poor utilisation of health care facilities propelled by poverty, distance to the health facilities and education during and after delivery by pregnant and nursing mothers is the major cause of disease burden in children (Adekunle et al., 2006).

Many of the barriers to the use of maternal health services such as the educational status of women, low economic status and religion are not directly linked with access and quality of maternal health services (Freedman, Ramsey, Abuya, Bellows, Ndwiga, Warren, 2014). Most of these barriers are responsible for the difference in the utilisation of maternal health services in N.O Idowu primary health centre among women in the Eniosa community. Studies have estimated that 250,000 newborns die annually in Nigeria given the mortality rate 0f 48 per 1000 live birth (FMOH, 2005). The neonatal and maternal mortality in Nigeria was estimated as 1 in every 18 women die giving birth compared with 1 in 4800 in the US (Pitterson, 2010). In a survey conducted in February 2010, in Nigeria, it was reported that neonatal death ranges between 165 per 100,000 live births in the Southwest (Onumere, 2010).

Nigeria, the most populous country in Africa, has one of the highest maternal mortality rates in the world and like in most countries in the developing world, maternal mortality rates in Nigeria is still on the increase (Ujah, Aisien, Murtihur, Vanderjag, Glew and Uguru, 2005). The health utilisation pattern of maternal health care is very poor in Nigeria due to inadequate access to modern health services and poor utilisation, despite the government's commitment to deliver health facilities at the doorstep of common people through innovative approaches, such as the introduction of primary health care, the utilisation of health services in some part of Nigeria is still far below acceptable standard (FMOH, 2005). This is the same situation in the Eniosa community as the N. O. Idowu Primary healthcare centre is underutilised.

Maternal mortality is one of the major health challenges currently confronting Nigeria, as a result of its recognition by the member states of the United Nations as one of the priority development challenges that need to be urgently addressed, the global community has endorsed the reduction of maternal mortality as one of the eight-millennium development goal (United Nations, 2000). Nigeria with an estimated 150,000 -165,000 annual maternal death is ranked second as the country with the highest number of maternal deaths. Most of the deaths are said to be occurring in rural areas where two-thirds of the country's population lives require in-depth studies and quick intervention (WHO, 2005). According to the 1999 multiple indicator cluster survey, the maternal mortality ratio in rural areas is more than 828

maternal deaths per 100,000 live births which is more than double that of the urban area of 351 maternal deaths per 100,000 live births, With an estimated national mortality ratio of 704-1,000 per 100,000 live births and with about 2.4 million live births annually, some 170,000 Nigeria women die as a result of complication associated with pregnancy and childbirth (Federal Office of Statistics, 2000; UNFPA, 2000). Non-utilisation of the N. O. Idowu health centre will bring about the poor maternal outcome and increase the mortality ratio of the community affecting the country at large (N. O. Idowu Primary healthcare centre, 2019).

1.3 Justification of the Study

The study has the potential for yielding information relating to the facilitating and barrier factors which influence the pattern of utilisation of health services provided at the centre. With the availability of few records concerning the utilisation of maternal health care services in N. O. Idowu Primary healthcare centre, no documented research evidence exists to show the pattern of utilisation of the services among the mothers of under-five in Eniosa. The study is aimed at boosting awareness of factors that will, therefore, be useful for redesigning and providing services that are sensitive to the needs and socio-cultural peculiarities of the local populations. In addition, the result of the study would be potentially useful for designing or modifying a curriculum for primary health care in the said setting as well as similar settings.

This study will also help in designing community sensitive programme materials which would be useful in planning public enlightenment programme to increase uptake and utilisation of the health services provided at the N. O. Idowu Primary healthcare centre. It will expose the challenges affecting the utilisation of health services and help provide policy formulations and implementation for management of these challenges and problems in new effective and efficient ways. This study would also help in the adoption of measures that will help in revising existing health policies, increasing funding of health system and enactment of healthy public policies that will be favorable to both the health system and patients utilisation of the health facilities. The result of the study will help in ascertaining valid and valuable information that will help in carrying out meaningful training and curriculum review for health care providers who work in health centres generally.

1.4 Research Questions

1. What is the perception of under-five mothers relating to the health services provided by the health centre?
2. What is the pattern of utilisation of health care services among under-five mothers?
3. What are the perceived facilitating or inhibiting factors relating to the utilisation of the health care services among the under-five mothers?

1.5 Objectives of the Study

1.5.1 Broad Objective

The broad objective of the study is to investigate the perception, level of utilisation and factors hindering under-five mothers from utilising the N. O. Idowu Primary healthcare centre services in Eni-osa, Akinyele local government Area, Oyo state.

1.5.2 Specific Objectives

The specific objectives of the study are to:

1. Determine the perception of under-five mothers toward the health services provided by the health centre
2. Evaluate the pattern of utilisation of the healthcare services among mothers of under-five
3. Identify the factors influencing (facilitating or inhibiting) the utilisation of the healthcare services among the mothers of under-five.

1.6 Research Hypotheses

Null hypotheses

The following hypotheses were used in the study

Ho1: There is no significant relationship between socio-demographic characteristics of the mothers of under-five and utilisation of the health care centre

Ho 2: There is no significant relationship between the perception of the health centre and the utilisation of health care services by mothers of under-five

Ho 3: There is no significant relationship between the factors influencing utilisation and the pattern of utilisation of health services by mothers of under-five

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview of Primary Health Centre

Children under-five faces multiple obstacles to good health. Among these are birth injuries, infection, malnutrition, home environment that lack intellectual stimulation and environments with polluted water and air (Rantham, Gregors, Cheung, and Cueto, 2007). Children worldwide under the age of five years died in 2011. Most of these deaths were due to preventable conditions where access to the simple and affordable intervention was possible (WHO, 2013). However, success in reducing childhood mortality needs more than the availability of adequate health services with well-trained health professionals. Families are the first people responsible for child care**,** success requires a partnership between health workers and families with community support (WHO, 2004). Therefore, improving families' care-seeking behaviours could contribute significantly to reducing child mortality in developing countries (Awoke, 2013).

In Nigeria, children suffer from short and long term adverse consequences of illness, malnutrition, and injuries including fewer educational opportunities and diminished future economic prospects (Royal Norwegian Embassy, 2008). Utilisation of healthcare services is an important determinant of health (Makenbach, Looman, Kunst, Habbema, and Maas (1988) and Bayo, Albert, Alfonso, Cortina, and Corella (1996) and this has particular relevance as a public health and development issue in low-income countries (Obrist, Iteba, Lengler, Makemba, and Mshana (2007). In fact, the utilisation of healthcare services for the most vulnerable and underprivileged populations has been recommended by the World Health Organisation as a basic primary healthcare concept (WHO, 1978). According to the suggestions of Gulliford, Figueroa, and Morgan (2002) and Obrist et al. (2007) healthcare should be universally accessible without barriers based on affordability, physical accessibility, or acceptability of services. Accordingly, increased use of health services should be a major target in many developing countries. (Sepehri, Moshiri, Simpson, and Sarma, 2008).

Health care system and the health care delivery by the Nigerians

The term health system also referred to as the healthcare system is the organisation of people, institution and resources that deliver health care services to meet the health needs of target populations. It includes issues of access to health services (involving recipient and the type of service), money to be spent, and resources (the availability of health workers and facilities). The overall goal of a healthcare system is to enhance the health of the population in the most effective manner possible in the light of a society's available resources and competing needs (Rantham et al., 2007).

The health care system in Nigeria is the responsibility of the three tiers of government which include the Federal, State and Local Governments with each tier responsible for the coordination of tertiary, secondary and primary levels of health care delivery respectively. The lowest tier is highly dependent on the immediate higher tier for financial provision and policy direction (Adeyemo, 2005). Recently, several fundamental health services provided in Nigeria are delivered through the primary health care system which is closer to the people making it essential that services rendered at this level of care are functional, available and utilised by those for whom it is provided (Gupta, Gauria and Khemani, 2003).

In 2009, documented studies show poor utilisation of health services for maternal health, only 39% of women deliver in the presence of a skilled birth attendant (UNICEF, 2010). In the recent times, HIV centres such as the Prevention of Mother to Child Transmission (PMTCT) of HIV have been a core focus of the government in the fight for the eradication of HIV, this service has been decentralized to the PHCs and despite this, a dismal 7% national uptake of PMTCT services was noted in a 2009 survey (NACA, 2010). The use of antenatal service can be directly related to the maternal mortality rate and the outcome of maternal and child health. Antenatal and immunisation services are some of the core services available in primary health care facilities (National Bureau of Statistics, 2009). More than 90% of the Nigerian population is without health insurance coverage (world social protection report, 2014).

According to the Nigerian demographic health survey (NDHS) in 2018, over 60% of pregnant women aged 15-49 deliver their babies at home without any antenatal care visits. In rural areas, this value reaches 76.9%. Women prefer to deliver at home instead of a health

facility (NPC and ICF Macro, 2014). The cost of health care and perceived low quality of care by the public have been argued to be the reason for poor utilisation of the health centre (Emmanuel, Gladys, and Cosmas, 2013). Also, health spending in Nigeria is low and this is responsible for the over-reliance on out of pocket payment for health care services (WHO, 2016) Insurance is Nigeria covers less than 10% of the Nigerian population (Onwujekwe, Hanson, and Uzochukwu, 2012). This leaves the most vulnerable populations at the mercy of health care services that are not affordable and this is a major problem since poor people constitute 70% of the Nigerian population (National Bureau of Statistics, 2010). People lack basic health services because they cannot afford it. The quality of health care services delivered is poor and remains a huge source of concern, most of the PHC facilities that are supposed to meet the needs of the poor and rural dwellers are in a poor state (Abdularaheem, Olapipo, and Amodu, 2012).

In the process of seeking health care, people will use services if they find them to be acceptable. These services are related to the nature and organisation of services which include their availability, accessibility, affordability and adequacy; this encompasses the health services approach (Peters, Garg, Bloom, Brieger, and Rahman, 2008). Livelihood assets include financial capital, physical capital, natural capital, human capital, and social capital. Financial capital comprises cash and credit whilst physical capital includes the infrastructure, equipment and means of transport. Natural capital refers to land, water, and livestock (Obrist, Iteba, Lengeler, Makemba, and Mshana, 2007)

The Component of Primary Healthcare System

Primary health care is defined by the WHO as a public approach that links social epidemiology, primary medical treatment and is the basis for setting priorities for maintaining the population's health. Furthermore, primary health care can be explained as the set primary basis of medical and preventive services to the population which is implemented through scientific and practical socially acceptable methods and technologies (WHO, 1978). The operation of primary health care is such that it serves as a place where the first contact of a person with a medical institution is established, the most massive form of servicing the general population and therefore should be as close as possible to residences and offices (Pfeiffer, 2003).

The primary health care system is developed in accordance with the specific conditions and needs of each country. PHC focuses on the needs of the local population (community) and

includes therapeutic, preventive, and rehabilitation services. The components of primary health care are involved in the coordination of the activities of other sectors of the economy that affect the development of agriculture, food industry, housing construction, communications, education, etc. (WHO, 1978). Elements of primary health care include the activities of clinical institutions, preventive and curative measures, and the search for practical solutions to local health problems.

The PHC model is based on the interaction of medical and epidemiological services, the precise identification of specific problems, the involvement of the population in solving health problems, and the availability of medical care. Childhood is a period of greatest vulnerability. Therefore, caring for babies has a prevalent significance. This approach provides global growth and prosperity for the next generations. Primary health care is an essential element of the new concept of public health. It's based on a quantitative assessment of various aspects of health problems and creating effective strategies to improve the situation. In developing countries, the primary health care system was seen as the avenue to achieve optimal health care for its population (Chatora and Tumusime, 2004).

Primary health care has the following components in Nigeria (Primary health care, 2019). The components include health education which promotes the ways of living healthy lifestyles and also to solve basic health problems, Sanitation and adequate supply of water**,** supply of clean, safe drinking water and basic sanitation measures regarding trash, sewage, and water cleanliness can significantly improve the health of a population, reducing and even eliminating many preventable diseases, food and nutrition, A balanced diet is essential for a healthy lifestyle proper nutrition can help to prevent malnutrition, starvation, diseases, and afflictions, maternal and child health care, immunisation is a widely accepted level of protection against a large number of communicable diseases. Immunisation can be used as preventive measures against various communicable diseases such as Tetanus, Diphtheria, whooping cough, and polio an essential element of primary health care is providing adequate care for children, mother, providing adequate counseling or family planning and safe sex methods, provision of essential drugs**,** providing essential drugs to those who need them. This makes the community safe and prevents the disease from escalating, treatment of communicable diseases, reproductive and family health, oral health care, mental health care, elderly geriatric care and eye care **(**WHO, 2019).

The Nature of Maternal Health in Nigeria

Maternal health care services include an extensive scope of health services mothers are given before pregnancy, during pregnancy, delivery and post-natal. Maternal health care services, therefore, comprise prenatal care, childbirth and postnatal care (Okeke, Oluwuo, Azil, 2016). According to Okeke et al. (2016), maternal health includes prenatal care and postnatal care of the mother and of the child up to the age of five years (Fadeyi, 2007). Many biological, economic, social, and cultural factors such as poverty, malnutrition, working condition, child marriage and gender inequities may compromise the health of pregnant women (Graczyk, 2007). Scholars such as Ufford and Menkiti (2001) and Lanre-Abass (2008) have identified early childbearing, cultural, logistical, and poverty, as a multifaceted condition that has many dimensions. Among the dimensions are poor access to public services and infrastructure, unsanitary environmental surrounding, illiteracy and ignorance, poor health, insecurity, violence, and social exclusion, as well as household income and food insecurity are life-shortening which can also increase a woman's risk of dying in the process of reproduction. Lule, Ramana, Epp, Huntington, and Rosen, (2005) have also noted that a woman's age, her ability to use reproductive health care services effectively, and general health status, including nutrition, contribute to poor maternal health.

The World Health Organisation (WHO) has noted that there is an urgent need for programmes that address the health and safety of pregnant adolescents and the need to teach young women the skills to build a successful future. The United States Agency for International Development (USAID) has also identified critical factors for improving adolescent maternal health: encouraging young women to use prenatal care to identify and treat malaria, anemia, and other health issues; providing obstetric care to ensure safe delivery for young mothers and their infants; and postnatal care to identify post-partum health issues, provide newborn care and offer contraception to accomplish birth spacing (Graczyk, 2007). These factors are also applicable to all women during pregnancy. Providing quality reproductive health services enables women to balance safe childbearing with other aspects of their lives and, it also helps protect them from health risks, facilitates their social participation, including employment, and allows girls to continue and complete their schooling (UNFPA, 2000).

Ensuring reproductive health does not only involve the provision of modern quality health services and attendance to the same, but also personal health consciousness during pregnancy. While some scholars and writers have advocated for the availability of basic comprehensive and formal obstetric and gynaecological care in order to substantially reduce the incidence of maternal mortality, other researchers have found out that even when formal skilled care is available, women may not seek or receive it (Igun, 1989). This is especially so in countries such as Nigeria where informal and formal healthcare services coexist and are viewed as veritable options for reproductive healthcare (Izugbara and Ukwayi, 2004).

Orubuloye and Oni (1996) identified patent medicine stores where personal relationships between the customers and owners of the medical stores, free consultancy, and flexible pricing, serve as the alternative source of care for many. The importance of starting prenatal care as early as possible, even before pregnancy was emphasized by Ben-joseph (2007), even though this may not always be possible or practicable. The sooner healthy lifestyles begin in pregnancy, the better the chances of ensuring the mother's health and that of the baby. Ideally, prenatal care should start before pregnancy. It is necessary for a woman to get ready for pregnancy, to consult a health care provider for a complete checkup to make sure she is in good health.

Women and their health have largely been influenced by African traditional culture. Owing to the patriarchal nature of most of these African societies, diverse inequities are being perpetrated against women. ''It is not just what is done to women, but what is not done for them'. In Nigeria, where many people live in poverty and the health infrastructure is poor, maternal health cannot be anything but below the average. According to the World Bank (1994), the obstacles to better health in Nigeria are not limited to events such as malnutrition, lack of drugs, and so on, rather an enabling environment for good health has been impeded by more deep-seated problems like weakness of political commitment to better health. There are other known factors aside from medical conditions responsible for maternal mortality in Nigeria. These factors include but are not limited to social, economic and cultural factors, which have a direct influence on maternal mortality (Muoghalu, 2016).

Harrison (2009) has observed that Nigeria has one of the worst records of maternal death in the world and it is worsening with time in some areas. The report has shown that 10% of the maternal deaths that occur in the world each year take place in Nigeria (PMMN, 1992).

Interestingly, maternal mortality in most of the rural areas in Nigeria is caused by other precipitating factors that are non-medical. These factors range from poverty, low level of education or absence of it, prohibited food, low purchasing power, and certain harmful cultural beliefs and practices; more so, with the introduction of user charges in state and federal-owned hospitals, high percentage of women, especially in the rural areas, now patronize faith clinics and traditional practitioners as alternative health care (Ibrahim, 2016). the health care system in Nigeria is bedeviled with the challenges of quality service delivery, poor attitudes of staff to patients, lack of expertise, lack of or poor equipment, and shortages of essential drugs. Erratic and epileptic power (electricity) and water supply and the health sector as a whole are in a state of comatose. Nigeria healthcare system was ranked by 187th among 190 United Nations member states (WHO,2016)

Awareness of Under-Five Mothers about Healthcare Services

A mother's awareness refers to personal knowledge, beliefs, and attitudes which are achieved through a number of ways. These include; education, interaction with people around, types of media and personal experiences among others. A mother's level of awareness on a certain topic directs affects and determines her behaviour and practices and this could be related to health and illness as her level of awareness on health directly affects her health practices. High awareness means good knowledge about disease prevention methods, selection of proper ways of treatment and promotion of health (Henry, 2003). Maternal and Child Health services embrace all the services for mothers throughout the childbearing age which is from the onset of puberty 9 years of age to menopause which is 45 and above and also services for children from conception through adolescence. Services rendered by the primary health care are to include: promotive, preventive, curative and rehabilitative services for mothers and under-five children in line with the millennium development goal five which is to reduce maternal mortality (WHO, 2004).

A study carried out in a primary health centre in Ezeagu local government area on women of childbearing age showed that 53.6% of women were aware of maternal health services and 53.9% were aware of the child health services available in only public and private hospitals they didn't seem to know that such services were also rendered in the primary health care centres (National population commission, 2009). Awareness of available services is important for consumers (mothers of under-five children) to make use of the services especially in a community like Eni-osa where the primary health care system, patent

medicine vendors and traditional method seems to be the only available option. A lack of awareness of services would mean that the mother of under-five children would be incurring huge indirect costs and at the same time travel too far to obtain primary health care services. This would prove to be a major challenge in reducing maternal mortality and the death of children under the age of five children (Mpembeni, killewo, Leshabari, Maassawe, Jahn, Mushi and Mwakipa, 2007). Findings from this study show that mothers do not utilize the services at the primary health care service but bypass the formal treatment process also resources will be wasting at the primary health care since the women do not know these services exist in the first place so they do not benefit from it. (National Population Commission, 2009). Another study in Tanzania evaluating use pattern of maternal health care services show that women limit the role of the primary health care to just immunisation for children and antenatal and skilled delivery for mothers which is very limited as the primary health centre offers so much more (Ethiopian central statistical agency, 2008).

Maternal mortality can drastically be reduced if women know and use available and appropriate services in their communities a study by Indacochea, and Leachy, 2009) it was found that the use of services are more strongly correlated to the socio-economic and demographic phenomenon and also related to the organisation of health service delivery systems. This is affected by availability, accessibility, quality, cost, social structure, comprehensiveness of service, and health beliefs (Williams, and Collins, 2005). However, evidence in Nigeria and from other countries shows that rural women tend to use less of these services for themselves and their children (National Population Commission, 2009).

Strong and indispensable is the role of knowledge in utilisation of services. According to a study by Babolola and Fatusi, (2009). The result strongly showed that women only know more about ANC and delivery services for maternal health and immunisation for children (Lubbock, and Stephenson, 2008) For example, a study in Tanzania evaluated use pattern of maternal health services. The results show that the use of ANC was universal compared to other services such as skilled delivery, and this decreased with maternal age (Mpembeni, Killewo, Leshabari, Massawe, Jahn, Mushi, and Mwakipa, 2007).

2.2 Perceptions of Under-Five Mothers Toward Health Services

Maternal health care services in health systems constitute a large range of curative and preventive health services of particular importance to the health of women of reproductive age and their infants. It includes population-based services such as behavior change and health communication (e.g., promotion of antenatal care) (World Bank, 2008). Maternal health care services aimed at reducing maternal mortality and morbidity by ensuring that pregnant women remain healthy throughout pregnancy, deliver safely to healthy babies and recover fully from the physiological changes that occur during pregnancy (Obionu, 2007).

Maternal health care service quality is the application of those necessary multisectoral services required to ensure a state of physical, mental, social, and perhaps spiritual well-being of mothers in the community, and their offsprings. (This includes services required to minimize the noxious consequences of preexisting or concurrent health hazards or conditions, and upgrade the health and social functioning of those women who require it (Lane and Kelman, 1975). Quality of care is an important determinant of health outcomes (Cohen, 2005) Community defined dimensions of quality of maternal health care include access to a maternal facility in the community; treatment that is delivered in a respectful and timely fashion; respect for traditional practices and use of indigenous language; a clean and well-equipped facility, transportation, and free services (Maternal and Neonatal Health Programme, 2003). The component of the provided maternal health care service from the clients' perspective also connotes quality. In a study on mothers' perspectives of the quality of postpartum care in Central Shanghai, China, the mothers indicated that to improve the quality of services further, greater emphasis should be placed on health education on child care; more time allocation for discussion with health workers during their postpartum home visit so that their questions and concerns should be addressed effectively; access to health workers in times of need rather than during official time alone, provision of continuous training for maternal and child health workers with respect to child care (Lomoro, Ehiri, Qian and Tang, 2002)

Client's satisfaction with the quality of care is the degree to which the clients' desired expectations, goals and or preferences are met by the health care provider and or service. (Debono and Travaglia, 2009) Satisfaction and dissatisfaction indicate clients' judgment about the strengths and weaknesses, respectively, of the service (Chow, Mayer, Darzi and

Athanasiou 2009). Some studies have reported that women may generally express satisfaction with the quality of services despite some inconsistencies between received care and their expectations of the facilities. According to (Oladapo, Iyaniwura, Sule –Odu, 2008) women were satisfied with the care received, interpersonal relationship and the infrastructures for providing care. Health education and communication in the local language are also stressed to improve client satisfaction (Buchi, Cignacco, Luthi, and Spirig, 2006). However, a study by Dowswell, Renfrew, Gregson, and Hewison (2001) has revealed women's dissatisfaction with maternal care. Reasons for dissatisfaction in this study were long waiting time, poor laboratory services, and inadequate medicine supply and health worker's negative attitudes. Health workers have often treated women rudely. Furthermore, women's perception of care often determines clients' willingness to comply and continue with the service rendered (Dowswell et al. 2001).

The Essential condition for bringing about change in human behaviour and improving norms and other variables it is only when this concept is properly understood that health care is provided in a manner that is acceptable to those for whom it is provided (Hausmann, Muela, Ribera and Nyamongo, 2003). Perception is one of the prominent determinants of the utilisation of health services (Roberts, Hsiao, Berman and Reich, 2008). Utilisation is only an indicator of effective availability, as clients (mothers of under-five children) may choose not to use health services, even when it is available. The decision to use available health services depends on the people perception and judgment which is often time conditioned by some factors like accessibility, their traditions, and culture which include important aspects like courtesy, responsiveness, attentiveness, and perceived competence of the health staff or worker (Singh, Haqq and Mustapha,1999). The client's perception (mothers of under-five children) is determined by the people's level of satisfaction with the health service as well as their assessment of the attitude of health workers which often determines whether they will return for further care in the future. Maternal health care services are aimed at reducing maternal mortality and morbidity by ensuring that pregnant women remain healthy throughout pregnancy, deliver safely to healthy babies and recover fully from the physiological changes that occur during pregnancy (Obionu, 2007). According to the World Health Organisation, quality health is defined as that care which consists of poor performance according to standards now this is a very important determinant of health outcomes (Roemer, 1988).

Clients (mothers of under-five children) satisfaction with quality of health care services only occurs when the clients desired expectation, goals, and preference are met by the health care provider or service when a client (mother of under-five children) shows satisfaction or dissatisfaction, it indicates the client (mother of under-five children) judgment about the strengths and weakness respectively of the services (Debono, 2009). The reason for dissatisfaction in most of the studies includes long waiting time, no or poor laboratory services, inadequate medicine supply, and health care workers, and health care worker's negative attitudes. Health workers often treat these women rudely. Furthermore, women's perception of the quality of care often determines if mothers of five children will comply and continue with the rendered service (AL-Mandhari, 2002). According to Nikiema, Kameli, Capon, Sondo, Martin-Prevel (2010), most women who utilise antenatal care (ANC) services in sub-Saharan Africa do not receive adequate attention; as care providers are overwhelmed by the number of pregnant women seeking ANC. Consequently, some have argued for the adoption of focused ANC, in which case a woman attends ANC four times during pregnancy at specific intervals for uncomplicated pregnancies. This allows for adequate attention to be given to each pregnant woman and provides an opportunity for monitoring of high-risk pregnancies. Advocates of this strategy believe that this will enhance the quality of ANC services provided as well as reduce morbidity and mortality associated with high-risk pregnancies (Mrisho, Obsrist, Schellenberg, Haws, Mushi, and Mshinda, 2009)

Quality of care is imperative in optimising uptake (effective utilisation) of maternal and child health services (Hutchinson and Agha, 2011). In developing countries including Nigeria, standards of quality of care are often set by health managers and care providers. Although there are several policies and guidelines to ensure the quality of care, the extent to which they are adhered to is not well known. According to Uzochukwu. Onwujekwe, Akpala .2004, many patients in southeast Nigeria are poor and ignorant, hence they often feel that they are not in a good position to influence the type and quality of services they receive even if their expectations are not met. Reducing maternal mortality and morbidity through increased service utilisation, in turn, requires public health interventions built on a clear understanding of women's perception of maternal care services within their cultural context (Lubbock, Stephenson, 2008). Subjectively, assessment of patients' perception of healthcare services is one of the ways of measuring the quality of healthcare. Besides using the outcome of care as a basis for measuring the quality of care, clients' perception of care provides another opportunity of assessing the quality of care based on their perspective.

Understanding clients' perceptions of healthcare services provide an opportunity for identifying deficiencies in healthcare as well as motivators and barriers to uptake healthcare services (Uzochukwu, Onwujekwe, Akpala, 2004). Knowing the perception of women would also help in gathering inputs of recipients of healthcare services for the purpose of establishing more patient-friendly services, and using the same to improve quality of care (Mairiga, Kawuwa, and Kullima. 2008). It has been argued that the perception of illness is affected or influenced by different belief systems in societies (Jegede, 1998; Kitts and Roberts, 1996). As Nwabuaze (2003) has explained, the social perspective on health has it that though the presence of the disease may be a biological phenomenon, the culture of the people may sometimes contain anti-health social habits. For instance, most of the time they rely on home remedies to solve minor problems. Jegede (1998) has observed that "it is not all the time you go to the hospital. In those days our grandparents used to single-handedly handle their wards" medical problems without much recourse to any external help." The common problems that can greatly increase women's risk in childbirth are delays in recognizing a 43 developing problem; delay in deciding to act, and delay in reaching services because of erroneous belief about pregnancy. In a study by Idowu (2011), the majority of women believed that maternal health challenges are normal during pregnancy and as such are not so disposed to proper and adequate antenatal care.

2.3 Pattern of Utilisation of Health Care

2.3.1 Delay in Seeking Service

Maternal mortality has been linked to women's healthcare decision-making power at the household level in many low and middle-income countries (Ganle, Obeng, Segbefia, Mwinyuri, Yeboah, Baatiema, 2015). In some parts of Asia, distance to the health facilities, cost of access to skilled care, practices at health facilities such as horizontal birth position, episiotomies, the presence of male staff and mothers' desire to have family members nearby were common reasons for home deliveries (Sychareun, Hansana, Somphet, Xayavong, Phengsavanh, and Popenoe, 2012). Also, in some communities in Ghana and other sub-Saharan African countries, decisions regarding the birth location were commonly made by the woman's husband, mother, mother-in-law or other relatives. (Amzat, 2015) and (Sumankuuro, Crockett and Wang, 2015). Thus, a pregnant women's ability to choose a healthcare provider, act on her preferences, and to be sufficiently financially empowered to take the lead in deciding on reproductive and pregnancy care has significant impacts on service utilisation outcomes (Sumankuuro, 2018., and Ganle et al. ,2015)

2.4 Factors Affecting the Utilisation of Healthcare Services

2.4.1 Access to healthcare

In a study carried out in Nepal, it was observed that clients who lived greater than 2km from the primary health clinics had low utilisation of health facilities and will seek maternal health services such as deliveries at home (Yadav, 2010). Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing the disease, reducing unnecessary disability and premature death, and achieving health equity for all. Facilitators to access to care include insurance coverage, health services, and timeliness of care. When considering access to health care, we talk about 'the timely use of personal health services to achieve the best health outcomes.' It involves three processes: The clients (mothers of under-five children) gaining entry into the health care system, accessing a location where needed health care services are provided (geographic availability) and finding a health care provider whom the patient trusts and can communicate with the personal relationship (Idowu, 2011). This could impact one's overall physical, social, and mental health status and quality of life (National health care quality report, 2013).

Certain factors serve as barriers to access to healthcare services. These factors include high cost of care, Inadequate or no insurance coverage, lack of availability of services, and Lack of culturally competent care. These barriers to accessing health services lead to Unmet health needs, Delays in receiving appropriate care, Inability to get preventive services, Financial burdens and Preventable hospitalizations. Access to care varies based on race, ethnicity, socio-economic status, age, sex, disability status, sexual orientation, gender identity, and residential location (Falkingham, 2003). People with a usual source of care have better health outcomes, fewer disparities, and lower costs. Having a primary care provider who serves as the usual source of care is very important it can help in developing meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community (Hadley, Willis, and Gabe, 2011). Having a usual Primary care provider is associated with Greater patient trust in the provider, better patient-provider communication, and increased likelihood that patients will receive appropriate care, lower mortality from all causes, improving health care services includes increasing access to and use of evidence-based preventive services. A study also shows long distances, lack of funds for transportation and lack of transport systems as reasons also given by 68%, 54%, and 77% respectively of respondents for non-utilisation of health care services in a middle belt

Nigerian state, Rivers state. These same reasons were cited as the reason for non-utilisation in southwestern Nigeria (Adeyemo, 2005).

The health system in Nigeria is generally poor and even worse in the rural areas of the country. Poor maternal health and maternal death are strongly associated with substandard health services and lack of available medical equipment and supplies at the time of labor, delivery, and immediately after birth (Maternal Health Supplement and Hartmann, (1993) reporting on Bangladesh noted that the colonial legacy of inadequate infrastructure and lack of trained personnel present very real problems to the development of health services. This situation is similar to Nigeria where several decades after independence, little has been done to overcome this legacy. Health services, especially those that deliver primary and preventive services, are either lacking or underutilised in most rural communities. Ideally every pregnant woman, as Adetokunbo and Gills, 2003 have noted, should have access to the minimal module of maternal health services consisting of three elements;

1. Community-based services (primary health care)
2. Essential obstetric care at a first referral centre to deal with complications
3. Effective communication and transportation between the community-based services and the first referral centre.

All these are either lacking in most rural communities or are insufficient resulting in poor maternal health. In some rural communities in Nigeria motorable roads are non-existent and only footpaths are available. Because most of these rural communities are usually inaccessible, the cost of medical services there is extraordinarily high and only very few people can afford it. Furthermore, in most rural communities there is no safe water. Poor sanitation and disposal of fecal matters according to World Bank (1994) also complicate health matters. These pose serious health hazards for women particularly in rural areas where a significant proportion of women live and where ponds, streams, rivers which are the only source of water are usually contaminated.

2.4.2 Socio-cultural Factors that Affect Health Service Utilisation

Culture

Culture is generally defined as the way of life of a group of people; it is usually an accepted code of behaviour for the group of individuals or communities. This way of living or belief will affect the individual's attitude toward health care or also will directly affect other factors

directly or remotely related to seeking care. In most developing countries especially in rural areas, women are given very limited decision making roles and this affects the act of seeking care (Shaikh and Hatcher, 2004). Culture influences health behaviour in so many dimensions. For instance, culture influences the way in which illness is acted upon in Nigeria (Dawitt, 1994 as cited by Kitts, and Roberts, 1996; Erinosho, 2005). Cultural factors include gender norms, child marriage, and early pregnancy, nutritional taboos, particularly during pregnancy, certain birthing practices, female genital mutilation, and widow inheritance. The result for individual women and girls is the mitigation of their health or their quality of life. What all these practices have in common is that they evolve from, or are in reaction to, the preference for male children (Dawitt, 1994 as cited by Kitts and Roberts, 1996). These factors condition women‟s reproductive intentions; that is, the number of children they want and how they want their births spaced. Women do not always get the support they need to fulfill their reproductive intentions. In some settings fearing reprisal from disapproving husbands or others, many resorts to clandestine treatment, especially in the use of family planning (UNFPA, 2000). Therefore, cultural restrictions limit choice. Belief about appropriate behaviour can reduce access to health information and care and impair its quality. Direct taboos and indirect restrictions deter women from discussing their health needs and risks, while women who cannot read or readily associate with others have difficulty finding health information and taking healthy steps toward safety in pregnancy. “Women are controlled with those local customs, whereby a woman can make no decision by herself until the husband has decided” (Kowalewski et.al, 2000). Cultural beliefs such as reduced exposure to medical care in early pregnancy; ingestion of herbs and use of traditional birth attendants were seen as means of protecting and preserving the unborn child in a community in South Africa (Ngomane and Mulaudzi, 2010). Shared culture and language facilitate information sharing and influence service utilisation within communities, sharing the same language even in a multi-ethnic setting usually will affect the utilisation of health care (Deri, 2005).

In Nigeria, ethnicity is an important determinant of utilisation of health services; certain tribes in the south, east and middle belt region are more likely to use maternal health services than their counterparts in the northern parts of the country (Babalola and Fatusi, 2009). According to Salami & Taiwo (2012), certain cultural practices have been observed as responsible for incidences of maternal and infant mortality in Nigeria and other parts of the sub-Saharan African societies. In the same vein, Nwokocha (2003) cited in Elem and Nyeche (2016) has discovered in a study conducted among Ibani people in Rivers State on pregnancy

outcomes that incidences of maternal mortality rate are on the increase and outcome of pregnancy (which could either be positive or negative) is affected by socio-cultural factors. women are saddled with numerous tasks of reproduction, home management, and community building, among others. They are defined by their reproductive function, coupled with the very many household chores of providing for and keeping the home front. They enjoy no special attention or care during pregnancy which makes many of them tired and experiences fatigue during pregnancy. However, what is required of maternal mothers at this time are improved nutrition, rest, and focused antenatal care as well as moral and financial support (Okeke et al., 2016) Unfortunately, these experiences are very rare for many Nigerian women. Hence maternal mortality has become a public health issue as statistical evidence shows that at every moment, a woman dies from difficulties of pregnancy, bringing the maternal mortality rate for Nigeria to 3200 per 100,000 live births (Nigeria Demographic Health Survey, 2008).

2.4.3 Education

The current female literacy rate for Nigeria was estimated at 61%. (WHO, 2013) However, the six political zones of Nigeria have differences based on commonality in ethnic, religious and cultural inclination. Interestingly, studies on maternal mortality in some states of these zones have reported a maternal mortality ratio of up to 1,791 per 100,000 live births. (Kullima, Kawuwa, Audu, Geidam, and Mairiga,2009) and Guerrier, Oluyide, Keramourou, and Grais, 2013) which nearly doubled reports from the Southern part of Nigeria (Ibeh, and Okpala, 2013) and Nwagha, Nwachukwu, Dim, Ibekwe, and Onyebuchi,2010). While education is related to socio-economic class, nevertheless, data shows it influences health behavior and the utilisation of health services when income level was controlled. (Yego, Byles, Williams, and Nyongesa.2014). Studies have demonstrated that women who have gone beyond the primary school level are more likely to have a higher number of antenatal clinic visits and deliver in a health facility compared to unschooled women (Ahmed, Creanga, Gillespie, and Tsui, 2010) and Desai, Howard, Oshiambo, Katana, and Hamel, 2013).

However, other studies have shown that educational attainment does not always lead to the appropriate use of health services. (Sharp, Ross and Cockerharn, 1983). For example, educated people were found to miss follow up visits, fail to comply with the full treatment

regimen and more comply with self-prescribed regimens compared to their illiterate colleagues that belong to similar socio-economic levels or reside in similar neighborhoods (Sharp, Ross, and Cockerharn, 1983). Furthermore, it has been reported that uneducated women account for disproportionately high maternal and neonatal morbidity, mortality and disabilities due in part to their low health cultural capital and lack of autonomous status to negotiate their reproductive rights within the family structure (Olarewaju, 2013) and Wang, Alva, Wang, Fort, 2011). Raising levels of education delays age at marriage and age at first delivery while increasing opportunities for better-paying jobs. Furthermore, women in the developed countries delay childbearing and have few numbers of children compared to the high fertility rate of 5 or more in the sub-Saharan African countries. Women who wait till 20-30 have better pregnancy outcomes. (Patra, 2016).

Overall, the level of educational attainment enhances the ability of a woman to overcome negative cultural norms, enhance her skills to bargain for autonomy within the family and community structure and ultimately take appropriate health-related actions compared to her illiterate counterpart (Mekonne, 2003). The possible consequence of education on female reproductive health comprises late marriage, deferred childbearing, lowering of the fertility rate, greater independence on reproductive health choices, independence to freely decide on when and where to seek medical attention without approval from anybody and economic empowerment. Education enhances a woman's ability to communicate effectively with health providers and participate in the decision-making process based on the various management options regarding her prevailing reproductive issues even though, education is related to personal and family income levels. (Shim, 2010). The educational status of women and their partner seem to have a direct correlation to utilisation of health services especially for childcare and antenatal services. In a Vietnamese study, mothers who had higher educational levels will take their children for care more readily than those with lower education (Hong, Dibley, and Tuan, 2003).

In rural northern Nigeria, a positive correlation between a higher level of education and utilisation of primary health service was observed and same was also observed in middle belt region of Nigeria where mothers or husbands who had a primary school education will utilize antenatal services than those who had a lower level of education or no education at all (Kabiru, Iliyasu, Abubakar and Sani, 2005; Awusi, Anyanwu and Okeleke, 2009). Home deliveries may be encouraged due to the belief, perceptions, and culture of certain

communities. While analyzing maternal and child services in primary health care centres in rural Vietnam, Duong, Binns, and Lee (2004) observed there was an increased tendency for persons living with extended family members to have higher rate of home delivery, although these women would usually attend antenatal clinics and even bring back their children for immunisation but would prefer to deliver at home.

2.4.4 Poverty

Poverty is the state of not having enough material possesions or income for a person's basic needs, poverty occours when a person cannot meet a mimimum level of living standard, compared to others in the same time and place (United Nations Educational Scientific and Cultural Organisation, 2015). Poverty endangers the health and lives of many in developing countries since the most widespread and severe poverty occurs in countries such as Nigeria, Togo, Liberia and so on (Federal Office of Statistics, 2000). Poor access to and utilisation of quality reproductive health services contribute significantly to the high maternal mortality level in Nigeria. According to the 2003 Nigeria Demographic and Health Survey, 30% of Nigerian women cited the problem of getting money for treatment, while 24 percent cited the problems of accessibility to health facilities and transportation as a reason for not receiving health care. (National population commission, 2004). Again, 14% reported the problem of ignorance of where to go for treatment, while one in ten women complained of the bottlenecks in getting permission to visit hospitals (National Population Commission, 2004).

The Nigerian health system as a whole has been plagued by problems of service quality, including unfriendly staff attitudes to patients, inadequate skills, decaying infrastructures, chronic shortages of essential drugs and the well-known 'out-of-stock: syndrome (National population commission, 2003). The structural arrangement of the society, particularly in rural areas means that most women especially those of childbearing age are economically dependent on men. Also, the nuclear family's economic dependence on its extended family according to (PMMN, 1992) can equally cause a delay in seeking service. When a husband lacks funds, money must be solicited from other family members to pay for a woman's medical care. Sometimes these people make decisions about where to seek care, they can override the family and make decisions that may have negative consequences. Poverty is a major cause of maternal mortality, as it prevents many women from just not seeking antenatal care, but also taking time to rest and eating a balanced diet which is essential to safe pregnancy are absent (Lanre-Abass, 2008).

2.4.5 Availability of Infrastructure and Staffing and its Effect on Utilisation

Distance and physical accessibility stand as a critical point to the utilisation of health care services for everyone especially mothers of under-five children, however, other barriers such as infrastructure and proper staffing are also present to discourage utilisation of health care services. An effect of poor infrastructure was seen in a South African clinic where non-functioning diagnostic equipment in a clinic with high TB client load, had an X-ray machine that was described as forever broken down thereby affecting patient satisfaction with provided services (Nteta, Mokgatle-Nthabu, and Oguntibeju, 2010). The availability of staff, technical competence of available staff and the attitude of the staff to clients (mothers of under-five children) have a positive or negative effect on the utilisation of health services at the primary health care level.

A study in Guinea notes that the technical competence of the health care personnel, interpersonal relationship between patient and provider, availability of services and effectiveness of clinic personnel are important determinants of utilisation (Haddad, Fournier, Machouf and Yatara, 1998). Communication and relationship between the patients and the provider is an important element in determining satisfaction with primary health care services provided (Anderson, Weisman, Camacho, Scholle, Henderson and Farmer, 2007). Also poor staff attitude at the primary health care clinics; non-availability of drugs and perceived high cost of treatment are all barriers to utilisation of health services at primary health facilities (Solome, Wamala, Galea, State, Peterson and Pariyo, 2009). Poor staff availability due to low staff numbers in primary health care facilities in Nigeria make it almost impossible for facilities to operate on a twenty-four-hour basis and women end up resorting to the use of traditional birth attendants or other providers even when they had attended antenatal clinics (Babalola and Fatusi, 2009).

2.4.6 Use of Herbal Methods

The use of herbal medicines is believed to be increasing in many developing and industrialized countries (Ernest, 2002). Herbal medicine is defined as a plant-derived material and preparations are perceived to have therapeutic benefits, it contains raw or processed ingredients from one or more plants (Nikolajsen et al.., 2011) it include herbs, herbal materials, herbal preparations, and finished herbal products that contain parts of plants or other plant materials as actual ingredients (WHO,2008). It has been estimated that 80 % of the population living in rural areas in developing countries depends on traditional medicine

for their health needs, they also use these herbs during pregnancy. (Who, 2016). While the use of herbal medicines in pregnancy varies considerably between countries, many times same herbs are used, Evidence from the study in African continent suggests wide variability in use of herbal medicines during pregnancy, also 68% of herbal use was reported in a Nigerian study (Kennedy et al.., 2013). In another study in Uganda, a low percentage of 12 % use of herbal medicine was believed to be a contributing factor to poor access and use of maternal healthcare services, including antenatal care (ANC) services and health facility delivery (Titilayo, 2009). Services aimed at reducing the high maternal death rate, currently at 438 per 100,000 live births was not properly utilised (Lamorde et al.., 2010)

2.4.7 Use of Patent Medicine Vendors

In Nigeria, Patent medicine vendors are usually the first choice for health care, it is a recognized primary source of orthodox drugs for both rural ad urban populations, especially the poor (Salako et al.., 2001). In addition to selling drugs, they are also a major source of advice about illness and drug therapy (Ross-Deganan et al., 1996).

The patent medicine seller can be defined as a person without formal pharmacy training, who sells orthodox pharmaceutical products on a retail basis for profit (Brieger, 2004). Patent medicine stores are owned by the holders of patent and proprietary medicine vendor's licenses. Ordinarily, the patent medicines should be sold in their original packs. Over-the-counter (OTC) drugs are the only drugs authorized to be sold by the vendors, but they generally sell all types of drugs as determined by their financial capability. The PMS has a wide distribution, especially in low-income countries, and data on their actual number are difficult to obtain (WHO, 1997).

The reasons people prefer drug shops include geographical accessibility, shorter waiting times, more reliable drug stocks, longer opening hours, greater confidentiality, more personable social interaction, ease of seeking advice, lower cost and flexible pricing policies and no separate fee charged for advice (Brugha, 2002). However, one of the problems associated with home management and self-medication with drugs from these sellers is that in most cases, neither the drug seller nor the consumer is aware of the correct dosage and duration of treatment (Guarlink, 1998).

2.4.8 Other factors affecting utilisation of health services

Economic status

A large number of studies have shown that a woman's position in the household largely determines her range of acceptable reproductive options (Orubuloye and Ajakaiye, 2002; Das Gupta, 1997; Falkingham, 2003; Ogujuyigbe and Liasu, 2007). A Women‟s status is a broad concept that encompasses multiple facets of women‟s lives. It has been defined as the degree of women‟s access to (and control over) material resources (including food, income, land and other forms of wealth) and to social resources (including knowledge, power and prestige) within the family, in the community and in society at large (Dixon, 1975). Opportunity cost and financial problems related to the situation of being far from home (extra money for food, shelter, and clothes) are the main causes of maternal health (Kowalewski, et.al. 2000). Given the limitations on women‟s earnings in both formal and informal employment, and their complete exclusion from the cash economy in some cases, the extent to which poor women, particularly those who head households, can afford expenditures (associated with health care) such as taking enough rest, and eating balanced diet is questionable. Because of their economic status, women overwork themselves to support the family, and this has an adverse effect on their health (Azim and Lotfi 2011). According to the United Nations (1991), women who become pregnant in developing regions face a risk of death due to pregnancy.

2.4.9 Self-medication

Self-medication is defined as self-administration of medication not prescribed by or in a manner not directed by a physician (Guarlink,1998) and is regarded as part of self-care among patients assuming the responsibility of the medical personnel to treat or prevent illnesses by using non-prescription or prescription-only medicines (POMs) (Hughes, McElnay, Fleming, 2001). Self-medication may extend to prescription and herbal drugs and may be propagated by counselling or advice offered by health care professionals (Kamat and Nichter, 1998). Self-medication carries a serious risk of drug interactions, polypharmacy, misdiagnosis, excessive drug dosage use, prolonged drug use, incorrect drug choice, rare but severe adverse events, dependence or abuse and increased antimicrobial resistance. The main reason for self-medication as reported from different countries include; the feeling that the condition/disease is mild thus not requiring doctor’s consultation, previous good experience of treating similar illness, prompted by a pharmacist, feeling of independence to take care of him/herself and non-availability of doctors (Haider and Thaver, 1995; Afolabi, 2009).

Advertisement by pharmaceutical companies or their agencies on drugs has also been established as a promoting factor for self-medication (Tykbiduki, 2013). Lack and absenteeism of trained staff, unreliable drug, and medical equipment supply chains, resource constrains and sometimes health system failure are factors that boost self-medication (Gross, Schellenberg, Kessy, Pfeiffeer, and Obrist, 2011; Manzi, Schellenberg, Hutton, Wyss, Mbuya, Shirma, Mshinda, and Tanner, 2012) and affect delivery of maternal health services to women thus driving this group to self-medication and alternative medicine seeking.

2.7 Conceptual Framework

The theoretical framework that will be used for this research is the ecological model. The ecological model explores the perception of the utilisation of the health centre among mothers of under-five.

Individual factors: This focuses on the characteristics of the individual, age, education, knowledge and perceived need of maternal care, whether the mother of under-five sees the health centre as the first choice of care in case of any health emergency and feels quality health care will bring about better health outcomes for everyone. There may be constraints as the mother might think of the cost of acquiring this health care and may have personal beliefs or a bad first-hand experience.

Interpersonal relationships: This highlights the effect of close ties such as; family structure, friends, family tradition, intimate partners and peers and this could influence an individual's decision-making process. Good testimonies from neighbours and friends will enhance the patronage of the health care centre.

Community and social level factor: This focuses on the community at large, A Person learns from his or her community. A social relationship occurs and functions in the community, presence of schools, neighborhood, and workplace could all be a driving force for an individual's behaviour. Most women would patronize cheaper options of care if they are well respected and recognized at the same time. Sadly, other means of care such as traditional medicine bears these features.

Organisation and health system level factor: this has to do with the avalability of services and behavior of health workers. Institutional effect influences the participation of mothers of under-five in health care services; the health care system does not seek the opinions of their clients (mothers of under-five) before implementing a new activity or programme that affects them directly. Some health workers are not equipped with the necessary skill to educate the women on simple and cost-effective means they could maintain and better their health and that of their children also the health care system do not maintain a cordial and jovial relationship with the mothers of the under-five. Instead, they make them feel uneducated and not important.

The ecological framework brings into light the interaction between the different factors at a different level with the equal importance of the influence of factors within a single level. The family is the most important unit in society and the family. Mothers and children are a large chunk of the family. The study hopes to explore factors influencing the health care utilisation

of under-five mothers and also enhance the relationship between the health centre and mothers of under-five. Thus the ecological model is aimed at both addressing and enhancing the interpersonal and organisation- health system level of care.

SOCIO-ECOLOGICAL MODEL

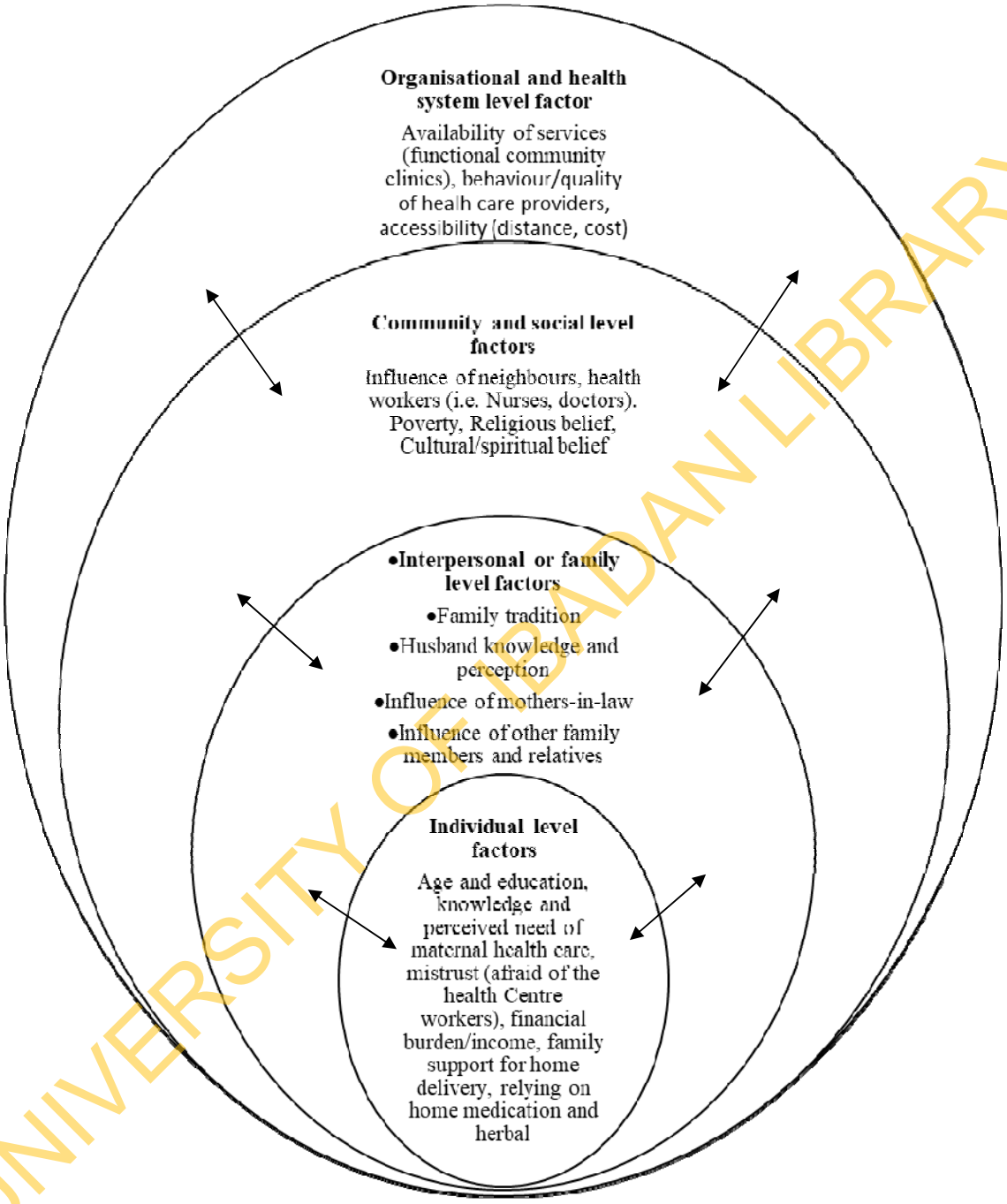

Figure 2.1: Conceptual framework on perception and utilisation of N.O. Idowu Primary Health Centre

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A descriptive cross-sectional survey using pretested interviewer-administered semi-structured questionnaire and Focus Group Discussion guide were used to measure the perception and pattern of utilisation of the N. O. Idowu Primary healthcare centre by mothers of under-five. The study also documented the factors influencing utilisation of the health-care centre.

3.2 Description of Study Setting

N. O Idowu comprehensive health centre is located in Eni-osa. Eni-osa is a border village in Ibadan Oyo state, which is in Lagelu local government. Eni-osa is a rural settlement with a land area of 310,850 square kilometres. It is said to have been in existence for over 50 years. Eni-osa community is said to derive its name from the childhood mortality situation in the settlement. It was very common for children to die before attaining the age of puberty in the community. A family delivered a child and decided to take this child to the Osa shrine to pray for protection against death. The child was then named Eni-osa. The child survived and grew to be a prosperous farmer and hunter. The settlement was then named after the child (Eni-osa) that was protected by Osa from dying. There are 47 villages in Eni-osa. The community is headed by a traditional ruler with a traditional royal title of 'Baale'.

The community residents speak different languages which include English, Yoruba and Igede. However, the most common language is Yoruba. Majority of the settlers are farmers while those in the transitory area are mostly civil servant. Most farmers engage in subsistent farming and a few engage in commercial hunting. The crops grown in the community include maize, cocoa, kola nut, yam, pepper and cassava. A few of the residents are involved in poultry farming.

Eni-osa community is divided into two main parts by a road. One part consists of seven zones called Eni-osa 1 while the other part consists of a group of houses make up eight zones called Eni-osa 2, making a total of 15 zones. A zone in the community consists of a group of houses ranging from 8 to 15 houses. The development of the community is facilitated by the Landlord and Tenant Association. The association is headed by an elected chairman. The community has one government primary school and two private, secondary school.

There is a primary health-care facility in the community; it was donated to the community by a man named Nathaniel Idowu. The primary health care centre was upgraded to a comprehensive health centre in 2017. The most common illnesses experienced in the community are malaria, hypertension, peptic ulcer, diarrhoea and upper respiratory tract infections. The mode of transportation in the community is called Okada (Adiele, 2019). N. O. Idowu Primary healthcare centre was established in September 1997 in Eniosa to provide primary health care services to the people. These services are provided lately in collaboration with the college of medicine and the University of Ibadan teaching hospital (U.C.H). The perception of the consumers relating to the services is yet to be well investigated. In addition, the pattern of utilisation of the services provided at the health centre has not been fully explored. The N.O Idowu primary health centre cover approximately 25 km square within Lagelu LGAs of Oyo State and caters to an estimated population of 359,944. They are the first non-profit, private charitable health organisation providing health care to rural Nigerian communities.

The N.O Idowu Primary Health Centre started off as a church clinic in September 1997, for the benefit of the congregation of St. James Anglican Church, Eniosa. The late Chief Nathaniel Olabiyi Idowu (1934-2010) was approached by the church for financial support for the clinic so that its benefits could be enjoyed by the Eniosa Community at large. Chief Idowu engaged the services of Tulsi Chanrai. The Eniosa centre remains the centre hub and has been renovated to a standard comprehensive health centre, comprising a primary healthcare centre, a secondary care health centre and a theatre complex. The Sagbe and Ajara health posts have received a facelift with plans of erecting purpose-built health centres in the nearest future. N. O. Idowu Primary healthcare centre are designed to address the health needs of the community at an affordable cost and provide sustainable healthcare to people within their communities. The centres attend to an average of 2,000 patients in a year.

3.3 Study Population

The study population consists of mothers of under-five children in Eni-osa community Akinyele local government. There are 15 zones in Eni-osa community, conducting this study among this population will serve to inform the necessary stakeholders on how to improve the health care of the people of the Eni-osa community.

3.4 Sample Size Determination

Prevalence of non-utilisation of the health care centre in Ibadan North West is stated at 90% (Adebayo and Asuzu 2015). The sample size (n) of this study was determined using the Leslie kish formula for single proportion for descriptive studies.

$$n = \frac{Z^2 Pq}{d^2}$$

Where n = minimum sample size

Z = standard normal deviation set at 1.96 normal interval

P =prevalence, 0.9 is the prevalence of non utilisation of the health centre in Ibadan north west as stated at 90% (Adebayo et al., 2015)

q = proportions that does not have the characteristics being investigated; q = 1- 0.9 = 0.1

d = acceptable difference; using 5% (d = 0.05)

$$n = \frac{1.96^2[0.9(0,1)]}{0.05^2}$$

$$n = 138$$

A non-response rate of 10% was added to get 154 respondents which were subsequently increased to 160. Therefore, the total number of respondents for this study was 160.

Table 3.1 Distribution of Respondents by Zones

S/N	Names of zones	No. of houses
1	Ifesowapo	31
2	Glory	11
3	Success	20
4	Temidire	29
5	Isokan	27
6	Grace and glory	25
7	Alafia	23
8	Zion goodwill	25
9	Obanijesu	31
10	Ogo-Oluwa	40
11	Ayagaga	21
12	Kotilo	17
13	Favour	25
14	Abaepo	40
15	Alada	35
Total		**400**

3.5 Sampling Technique

A Three-stage sampling technique was adopted to select the sample population from the community

Stage 1: There are 15 zones in Eni-osa. All the 15 was used to recruit the sample population from Eni-osa community.

Stage 2: Proportionate method was used to select the total number of respondents from each zone. In order to determine the number of respondents selected from each zone, the total number of each house in each zone was multiplied by the sample size (n) and divided by the total number of the entire houses in the zone.

The number of respondents from the zones =

$$\frac{\text{Number of houses in each zone} \quad X \quad \text{sample size}}{\text{Total no of the entire house in zone}}$$

Stage 3: At the final stage, a mother of under-five was selected at random within houses in each zone

Table 3.2: Proportionate Distribution of the Zones

Zones	**Total**	**Sample size determination**	**No of respondents**
Ifesowapo	31	31/400 x 160	12
Glory	11	11/400 x 160	4
Success	20	20/ 400 x 160	8
Temidire	29	29 / 400 x 160	12
Isokan	27	27 /400 x 160	11
Grace and glory	25	25 /400 x 160	10
Alafia	23	23 / 400 x 160	9
Zion goodwill	25	25 / 400 x 160	10
Obanijesu	31	31 / 400 x 160	12
Ogo-Oluwa	40	40 / 400 x 160	16
Ayagaga	21	21 / 400 x160	8
Kotilo	17	17 /400 x 160	7
Favour	25	25 / 400 x160	10
Abaepo	40	40 / 400 x 160	16
Alada	35	35 / 400 x 160	14
Total	**400**		**160**

3.6 Inclusion Criteria and Exclusion Criteria

Inclusion criteria

Mothers of under-five children who are resident in Eniosa community were included in this study.

Exclusion criteria

Women with children older than five years of age and women with no children at all were excluded from the study.

3.7 Instrument for Data Collection

Quantitative method

Quantitative method was used for data collection using self-administered questionnaires. The questionnaire was developed using information derived from the literature on perception and utilisation of health care services. The instrument had five sections. The first section was designed to elicit data on socio-demographics of the respondents. The second section was used to determine the perception of the women on the issue of utilisation of N. O. Idowu Primary healthcare centre while the third section explained the pattern of utilisation of the N. O. Idowu Primary healthcare centre. Section four documented the factors influencing child utilisation of N. O. Idowu Primary healthcare centre

3.7.2 Qualitative method

A Focus Group discussion (FGD) guide was developed for the focus group discussion which contains questions that were used to gain an in-dept understanding of the perception and utilisation of the N. O. Idowu Primary healthcare centre among mothers of under-five in Eni-osa community. The questions were open-ended because the intent of the focus group was to promote discussion. The focus group arrangement was purely mothers of under-five from different zones. The under-sample of the focus groups were stratified by zones making it a total of five groups. The participants shared similar knowledge and background, which encouraged sharing of information as well as deeper and more detailed insights. The sample for the FGD have individuals with characteristics of the overall population which gave the researcher a better understanding of the research.

Six to nine participants were recruited per group to enhance the effectiveness of the focus group discussion. Focus group guide was developed for the purpose of the study. The participant was identified and a contact list was developed. Research assistants and note-taker

were employed during the course of the study. The moderator and note-taker were trained so as give similar administrations under similar conditions.

3.8 Data Collection Procedure for Quantitative Method

The data was collected by the researcher with the assistance of three research assistants who were trained prior to the time of data collection. The research assistant was given adequate information about the objective of the research project, data collection process, sampling procedure and the content of the questionnaire and focus group guide to avoiding mistakes that may affect the result.

The researcher also provided adequate supervision to the research assistant and participated in data collection. The researcher also checked for completeness and error before leaving the field.

3.8.2 Data Collection Procedure for Qualitative Method

The responses from the participants from the FGD were grouped together and coded and analysed according to the objectives of the study. The findings were described, interpreted and reported in narrative forms. A conducive environment was used. The needed materials for the study include note pad, biros, focus group guide, tape recorder, and list of participants, sign-in sheet, consent forms and refreshment.

3.9 Validity of the Instrument

Validity refers to the accuracy of an instrument that is, how well it measures what it is supposed to measure. In order to measure the validity of the instrument, the face and the content validity are ensured by comparing its items with similar studies and by matching them with stated objectives, research questions and set hypotheses. Construct validity was ensured by making sure variables in the theoretical framework are represented in the instrument. The instrument was scrutinized by experts in the health promotion and education to validate the instrument and my supervisor was consulted to give a valid template of how the instrument should be. All the correction and suggestion were edited before the questionnaires were given to the study participants.

3.10 Reliability of Instrument

Reliability of an instrument is a measure of the consistency in which the instrument will measure what it is supposed to measure. An instrument is reliable if it gives similar results after administrations under similar condition. In establishing the reliability of the instrument,

the researcher applied the pre-test technique. The pre-test technique is a process whereby the researcher shall administer the constructed questionnaire to 10% of the total study population but the filled questionnaire for the pre-test shall not be used in the final work analysis. The pre-test was carried out mothers of under-five in Ido, a peri-urban community in Ido local government. Copies of the questionnaire were administered to 10% of the total sample size. The Cronbach alpha measurement and reliable co-efficient measure were carried out on the pre-test questionnaire to know how reliable the instrument is. A co-efficient of 0.9 was obtained.

3.11. Quantitative Data Analysis

Serial numbers were written on the copies of the questionnaire for easy data entry and recall. A coding guide was developed along with the data collection tool in order to facilitate its analysis. Questionnaires were reviewed to ensure consistency and completeness. Cleaning and coding of data for analysis were also done. Using the coding guide, the data collected was carefully entered into the statistical software and analysed using descriptive statistics such as mean, median, mode and frequency table and inferential statistics such as chi-square test. The results obtained from the statistical package for social science (SPSS version 21) analysis was summarised and presented in tables and chart.

Respondent's perception of utilisation on N. O. Idowu Primary healthcare centre was measured on a 9-point perception scale. Perception score (PS) of ≤ 4 was rated as negative perception and scores > 4 was rated as postive perception. A 14-point scale was used to measure utilisation of the N. O. Idowu Primary healthcare centre, where a score of ≤ 7 was rated as poor utilisation and a score >7 was rated as good utilisation. reported in percentage.

3.11.1 Procedure for Thematic Analysis of Qualitative Study

The participant's identity was kept anonymous to protect their identity in the report. The focus group discussions were tape-recorded and transcribed, it went through several phases of analyses. A preliminary analysis was conducted in order to get a general sense of the data. The responses from the participant from the focus group discussion were grouped together, coded and analysed according to the objectives of the study. The findings were described, interpreted and reported in narrative form.

3.12 Ethical Consideration

Ethic approval for the study was obtained from the Oyo State Research ethic review committee (Ref. No. AD13/479/1443) to ensure the proposed study meets all the principles and national guidelines in research involving human participants.

Beneficence to participants: The findings from this study will add to the limited body of knowledge about the health care utilisation in primary health care facilities in the study areas. It will better equip stakeholders on how to promote utilisation of the health centre.

Non-maleficence (non-harmful) to participants: The study did not involve utilisation of any clinically material. No harm to respondents who choose to participate in the study. Only the time needed to respond to the questionnaire and focus group discussion was required of the participants.

Informed consent/Confidentiality: A valid written inform consent was obtained from the study participants through appended signature on the informed consent form after the adequate provision of information. All identifiers were removed from the questionnaire and focus group guide and confidentiality was ensured through the protection of data collected from participants

Dissemination of findings: To ensure study responents and participants are informed about the information gathered, the result of the findings will be sent to the community.

Translation of Instrument to the local language: the instrument was translated from English to Yoruba, the local language to ensure proper understanding.

3.13 Study limitation(s)

During the data collection process, there were challenges faced in assessing the mothers of under- five in the community on the imminisation days due to movement in and out of the community and most of them were in a hurry to meet up with their commercial activities but I was able to pacify them of the importance of the study for health promotion.

CHAPTER FOUR

RESULTS

4.1 Socio-demographic Characteristics of Respondents

The study comprises of 160 respondents in the quantitative aspect of the study while five focus group discussions were conducted for the qualitative aspect involving six participants per group. The socio-demographic profile of the respondents is presented in Table 4.1. The age of the respondents was 29.12±5.5 years. Many (52.5%) were between the ages of 20 to 29 years. The majority (92.5%) of the respondent were Yoruba, while 1.3% were Hausa, 0.6% were Igbo and the remaining 6% represented others (other ethnic groups in Nigeria). More than half (61.3%) of respondents were Christian. For the level of education of the women, 63.7% have secondary education. Most of the respondents were married (93.8%). For the women occupation, 56.9% were traders.

Table 4.1: Socio-Demographic Characteristics of Respondents (N=160)

Socio-Demographic Characteristics	Frequency	Percent (%)
Age of respondents (in years)		
Below 20 years	4	2.5
20 - 29 Years	84	52.5
30 - 39 years	66	41.3
40 years and Above	6	3.8
Level of education		
No formal education	7	4.4
Primary	23	14.4
Secondary	102	63. 7
Tertiary	28	17.5
Level of education of husband		
No formal	19	11.9
Primary	15	9.4
Secondary	93	58.1
Tertiary	33	20.6
Marital Status		
Single	5	3.1
Married	150	93.8
Separated	4	2.5
Divorced	1	0 .6
Occupation		
Farmer	9	5.6
Trader	91	56.9
civil servant	9	5.6
house wife	11	6.9
others	40	25.0
Those that visited the N. O. Idowu Primary healthcare centre		
Yes	81	50.6
No	79	49.4

Mean age = 29.12 ± 5.5 years; Maximum age = 43 and Minimum age =18

4.2 Perception of Respondents to Utilisation of the N. O. Idowu Primary healthcare centre

Majority of the Respondent across the groups perceive the health centre as a good place to receive quality health care. A respondent said the health centre was moderate as it lacked drugs and essential materials. So, it cannot be seen as completely good yet. Another respondent complained that the health centre lacked health staff but said they seem to be trying their best.

"……. their services are now okay, we are happy with it in Eni-osa, gone are the days when there was no doctors on ground but now 24 hours there is a doctor on ground doing what they know how to do best (R1G3)

"……. I would say the service is good now but N. O. Idowu Primary healthcare centre needs more health staff, the health workers usually do work meant for two to three health workers. This need to be improved on. (R5G3)

"……. drug is issue we were using Okada to go and purchase every drug prescribed every now and then. But the place is a very good place to seek health services due to their competency (R6G1)

When the respondents were probed on the question of if N. O. Idowu Primary healthcare centre will be a last option of care if all other health places fail to provide better treatment, the respondents all agreed that N. O. Idowu Primary healthcare centre will be the last option for them as they have seen improvement in the level of care.

"……. yes, we can rely on the hospital if other places failed because they are really trying their best (R3G4)

Table 4.2 presents the respondents' perception of the utilisation of the N. O. Idowu Primary healthcare centre among mother of under-five. More than half of the population sample had a positive perception (82.1%) of the utilisation of N. O. Idowu Primary healthcare centre while 17.9% had a negative perception. Majority of the respondents (82.1%) disagreed that traditional homes are safer than the N. O. Idowu Primary healthcare centre. Also, 75.6% disagreed that patent medicine vendors are more reliable compared to the primary health care centre and 82.1% agreed that using herbal remedy or traditional herbal home is affordable than Ido health centre while 39.7% agree that the Idowu health centre does not have plenty of health workers. Majority (87.2%) disagreed that the Ido health centre is not reliable, 87.2% disagree that the health workers at N. O. Idowu Primary healthcare centre abuse patients, 87.2% disagree that the health workers are hostile and not supportive and 79.5% disagree that

traditional remedy or self-medication works faster than the N. O. Idowu Primary healthcare centre

Table 4.2: Perception of respondents (n= 81)

Statement	Agree n (%)	Disagree n (%)	Undecided n (%)
Traditional herbal homes are safer than N. O. Idowu Primary healthcare centre	4(5.1)	64(82.1)	10(12.8)
Patent medicine vendors are more reliable compared to N. O. Idowu Primary healthcare centre	8(10.3)	59(75.6)	11(14.1)
Those who use herbal remedies do not fall sick frequently compare with those who use the N. O. Idowu Primary healthcare centre	4(5.1)	60(76.9)	14(17.9)
Using herbal remedy or traditional herbal home is more affordable than the N. O. Idowu Primary healthcare centre	64(82.1)	4(5.1)	10(12.8)
I think the N. O. Idowu Primary healthcare centre does not have plenty of health workers	31(39.7)	26(33.3)	21(26.9)
I think the Idowu health centre is not reliable	5(6.4)	68(87.2)	5(6.4)
Health workers at the N. O. Idowu Primary healthcare centre abuse patient	7(9.0)	68(87.2)	3(3.8)
The health workers at N. O. Idowu Primary healthcare centre are hostile and not supportive	8(10.3)	68(87.2)	2(2.6)
Traditional remedy or self-medication works faster than going to the N. O. Idowu Primary healthcare centre	8(10.3)	62(79.5)	8(10.3)

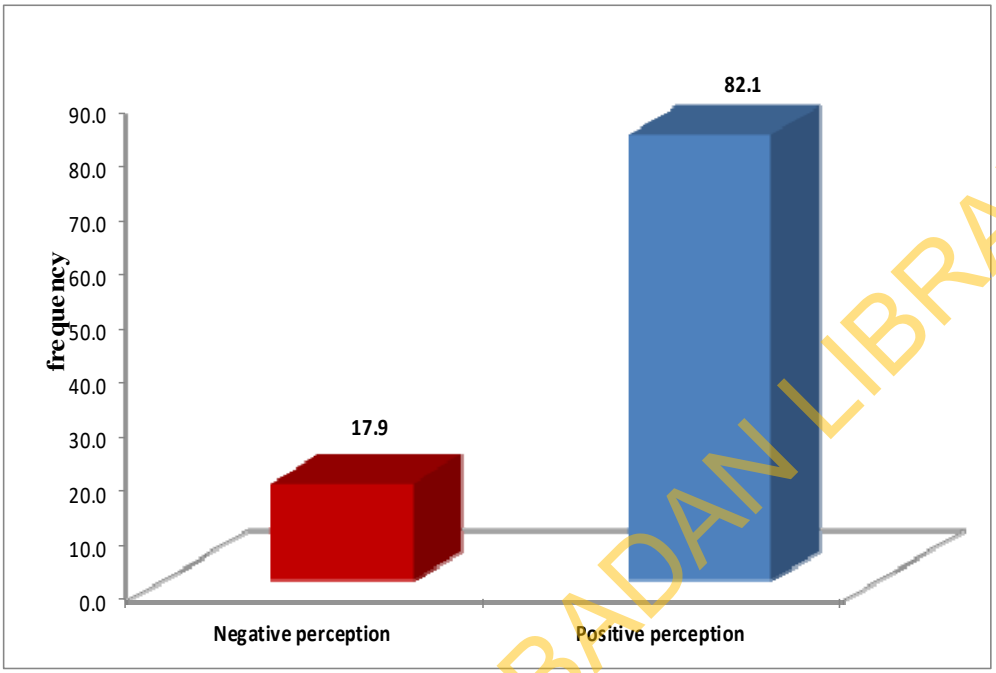

Figure 4.1: Perception of mothers of under-five towards N. O. Idowu Primary healthcare centre

4.3 Utilisation of Health Care Services at N. O. Idowu Primary healthcare centre

On the utilisation of health services at N. O. Idowu Primary healthcare centre across the five focus group discussions, majority of the women said they patronize N. O. Idowu Primary healthcare centre, many others said they prefer to patronise the health centre in the neighbouring community Olorunda while some other participants said that a lot of mothers of under-five patronize a woman in the community who claim to be a nurse in University teaching hospital but operates from a room in her home while say some women use traditional homes and herbs because of little money. Below is the opinion that is similar to all their responses.

"……mainly it is N. O. Idowu Primary healthcare centre phc that mothers of under-five usually seek for health services in Eni-osa …… (R1G3)

Some participants spoke opined that N. O. Idowu Primary healthcare centre demands money before treatment and is expensive so most women patronize a nurse who works in UCH, who will rather collect payment later

"……there is a woman in the community called Iya Agbomola, this woman has much patronage of children of under-five, if you have money with you or not whenever mothers go there she will first take the child and take care of him or

*Her, but if its quarter (*N. O. Idowu Primary healthcare centre*) they will first ask for money, money, money……. (R3G2)*

After further probing, some women said that they use herbs to manage ill-health. They said that mothers do not use traditional homes. Their responses include the following:

"……. No, no, no, no, people don't go to traditional homes……. (R4G1)

"……. women use herbs a lot and they are still doing it, we cannot eradicate that…… (R5G1)

Some other women said mothers of under-five patronise patent medicine vendors, that is, the chemists.

"……. yes. Some do go to the chemist to purchase drugs like headache drugs e.t.c. There was a time a woman went to chemist to purchase drugs for stomach ache and she was given drugs for another thing, unfortunately she lost the pregnancy. (R2G4)

4.3 b. Utilisation of Health Care Services at N. O. Idowu Primary healthcare centre

For the utilisation of the health centre, 50.6% have visited the N. O. Idowu Primary healthcare centre while 40.6% have never visited the health care centre. On the pattern of utilisation of the health centre among mothers of under-five, 73.1% of the mothers of under-five had negative utilisation of the health centre while 26.9% had postive utilisation. During pregnancy, 43.0% of the respondent visited the health centre during pregnancy while 57.0% of the respondents did not use the health centre at any point of their pregnancy. Less than half of the respondents had care from hospitals outside the community (44.4%). most of the respondents visited the health centre (61.8%) while at the third trimester. As regards the place of delivery most preferred, 34.6% preferred delivery at N. O. Idowu Primary healthcare centre. When asked why the preference of home delivery, majority of the respondents (64.0%) said it was preferred because it cost less, 12.0% of the respondents said because they did not like the attitude of health workers in the N. O. Idowu Primary healthcare centre, 8.0% of the respondents said home delivery is comfortable, When asked where mothers of under-five would prefer to have their babies in the community if they could not leave the community for childbirth, majority of the respondents (64.9%) picked the N. O. Idowu Primary healthcare centre as their preferred choice, (Table 4.3).

On the services that mothers of under-five have ever used, 83.3% of respondents have used antenatal services, 88.5% of respondent have used the delivery services in N. O. Idowu Primary healthcare centre and 56.4% of the respondent have used family planning consultation in N. O. Idowu Primary healthcare centre.

4.3 b. Continuation of Utilisation of Health Care Services at N. O. Idowu Primary healthcare centre

51.3% of respondents have received education on proper nutrition. Also, 61.5% of respondents have taken vaccination during and after pregnancy at N. O. Idowu Primary healthcare centre, 52.6% of the respondents have utilised post-natal services, 47.4% of respondents have utilised care after miscarriage services while 71.8% of the respondents have utilised minor illness treatment (Table 4.3.1).

When asked about health services respondents were currently using, 87.2% were using antenatal services, 85.9% were using delivery services, 61.5% of the respondents were involved in family planning consultations. More than half of the respondents (57.7%)

received vaccination during pregnancy, 74.4% used the services of the health centre for minor illness treatment (Table 4.3.2).

On the utilisation of health care services among under-five children, 87.2% of the respondents said they have used the immunisation services for their under-five children, 75.6% of respondent have used growth monitoring services in the N. O. Idowu Primary healthcare centre, 66.7% of respondents had treated teething problems at N. O. Idowu Primary healthcare centre for their under-five children, 67.9% had treated diarrhoea, 78.2% had taken their under-five for treatment of minor illness and 69.2% have had their under-five use tepid sponging at the N. O. Idowu Primary healthcare centre (Table 4.3.3).

On the utilisation of services currently in use by under-five children at the N. O. Idowu Primary healthcare centre, the majority (83.3%) of the respondent's under-five are currently receiving an immunisation, 70.5% of the respondent's under-five are still using growth monitoring services. 76.9% of the under-five are still taking treatment for minor illness 64.1% of the respondents are still using tepid sponging (Table 4.3.4).

Table 4.3: Utilisation of health care services (n=81)

Statement	Frequency n=81	Percent %
Have you ever visited the N. O. Idowu Primary healthcare centre when pregnant		
Yes	34	43
No	45	57.0
If No how did you get health care during pregnancy		
Traditional birth attendant	19	42.2
Family members	6	13.3
Hospital outside the community	20	44.4
If Yes at what trimester of the pregnancy did you visit N. O. Idowu Primary healthcare centre?		
First trimester	6	17.6
Second trimester	21	61.8
Third trimester	7	20.6
Which place of delivery do you prefer		
Home delivery	25	32.1
Idowu health care delivery	27	34.6
Hospital outside the community	26	33.3
If home delivery, why		
It is comfortable	2	8.0
It is against local custom	1	4.0
It is safer	2	8.0
Costless	16	64.0
Attitude of health workers in the health centre	3	12.0
Others	1	4.0
Which place would you prefer to have your baby in the community		
Idowu health care centre	50	64.9
prayer house	5	6.5
traditional home	21	27.3
a chemist who is a nurse	1	1.3

Table 4.3.1: Utilisation of health care services provided at the N. O. Idowu Primary healthcare centre for nursing and pregnant mothers (services ever used)

Service ever used	Freq.	Percent (%)
Antenatal service	65	83.3
Delivery services	69	11.5
Family planning consultation	44	56.4
Health Education	37	47.4
Breastfeeding methods and styles	38	48.7
Proper nutrition	40	51.3
Vaccination during and after pregnancy	48	61.5
Post-natal services	41	52.6
Care after miscarriage	37	47.4
Minor illness treatment	56	71.8

Multiple responses

Table 4.3.2: Utilisation of health care services provided at the N. O. Idowu Primary healthcare centre for nursing and pregnant mothers (services currently utilising)

Services currently utilising	Freq.	Percent (%)
Antenatal service	68	87.2
Delivery services	67	85.9
Family planning consultation	48	61.5
Health education	37	47.4
Breastfeeding methods and styles	38	48.7
Proper nutrition	40	51.3
Vaccination during and after pregnancy	45	57.7
Post-natal services	36	46.2
Care after miscarriage	36	46.2
Minor illness treatment	58	74.4

Multiple responses

Table 4.3.3: Utilisation of health care services provided at the N. O. Idowu Primary healthcare centre for under-five children (services ever used)

Services ever used	Freq.	Percent
Immunisation	68	87.2
Growth monitoring	59	75.6
Ear piercing for female children	32	41.0
Circumcision for the male child	44	56.4
Treatment of teething problems	52	66.7
Treatment of diarrhea	53	67.9
Treatment of minor illness	61	78.2
Tepid sponging (The process of using cold water to reduce extreme fever)	54	69.2

Multiple responses

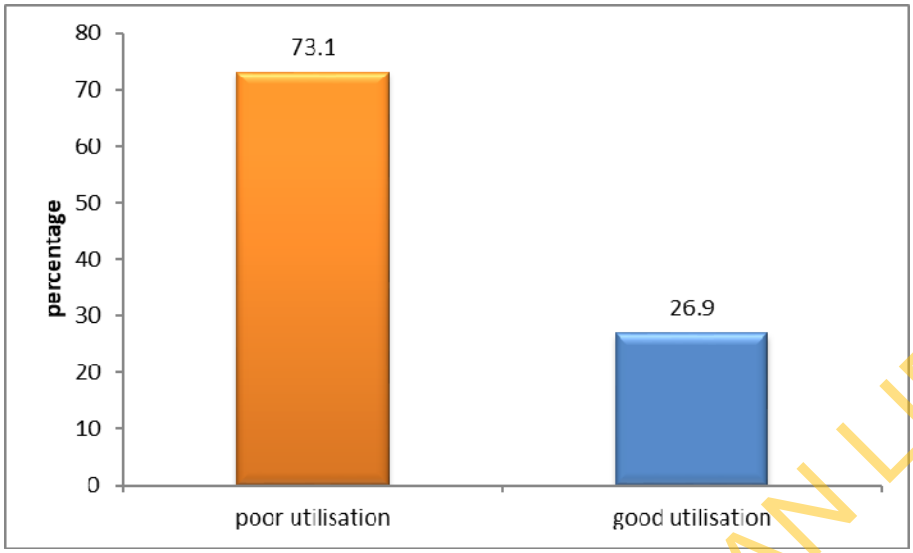

Figure 4. 2: Pattern of utilisation

Table 4.3.4: Utilisation of health care services provided at the N. O. Idowu Primary healthcare centre for under-five children (services currently using)

Services currently using	Freq.	Percent
Immunisation	65	83.3
Growth monitoring	55	70.5
Ear piercing for female children	27	34.6
Circumcision for the male child	39	50
Treatment of teething problems	46	59
Treatment of diarrhea	60	76.9
Treatment of minor illness	60	76.9
Tepid sponging (the process of using cold water to reduce extreme fever)	50	64.1

4.4 Utilisation for under-five children

For health remedies, many of the respondents said they would treat at home first, if there is no improvement, they would use the health centre. The majority mentioned delivery, severe malaria, typhoid, measles, cough, catarrh, stomach ache and any form of illness as illness that could be attended to at the N. O. Idowu Primary healthcare centre as what could take them to the health centre for their under-five treatment. Some of the responses include:

> *'.....When a child is sick, after home treatment, when there is no improvement the only option that is left is to take the child to N. O. Idowu Primary healthcare centre phc……' (R3G2)*

> *'.....Teething sickness, increased body temperature, vomiting, that is coupled with stooling…these are health problems that could make under-five visit the health centre' (R6G2)*

When probed further on the choice of place to carry out immunisation for the under-five, majority of them picked the N. O. Idowu Primary healthcare centre.

> *'…… yes. Children 0–59 months are being given normal routine immunisation at N. O. Idowu Primary healthcare centre health care'*

4.4 Utilisation for under-five children

In the table below, the utilisation of health care for the under-five is presented in Table 4.4. Majority of the respondents (64.1%) have taken their under-five to N. O. Idowu Primary healthcare centre for care. The respondents who had not taken their under-five children gave the following places as their option of care traditional home (46.4%) Also, 67.9% of the respondents received their under-five children immunisation in the community. Of this percentage, the majority (98.1%) received their immunisation at the N. O. Idowu Primary healthcare centre, When asked on the right time to seek health care for under-five, 57.7% of the respondents reported they would seek health care if there is no improvement from self-medication, 37.2% would seek health care the moment they notice the child is sick, On the decision of who decides where health should be sought when the child is sick, 42.5% of the respondents reported that both parents make the decision, 30.8% reported only the father makes the decision (Table 4.4)

Table 4.4: Utilisation of health services for under-five children **N=81**

Statement	Freq.	Percent (%)
Have you taken your under-5 child(ren) to N. O. Idowu Primary healthcare centre for care before		
Yes	50	64.1
No	28	35.9
If no, where do your under-5 child(ren) receive health care		
Traditional herbal home	4	14.3
Prayer house	3	10.7
Chemist	13	46.4
Self-medication from mother	4	14.3
Hospital outside the community	4	14.3
Did your under-5 child(ren) receive his or her immunisation in the community		
Yes	53	67.9
No	25	32.1
If yes, where did your under-5 child receive the immunisation services		
Idowu health centre	52	98.1
Outreach for immunisation	1	1.9
What time would be right to seek health care for your under-5 at the N. O. Idowu Primary healthcare centre		
The moment you notice the child is sick	29	37.2
When herbal traditional remedy fails	3	3.8
When there is no improvement from self-medication	45	57.7
When there is no other option of care	1	1.3
Who decides where health should be sought from when the child is sick		
Father	24	30.8
Mother	20	25.6
Both parent	33	42.3
Others	1	1.3

4.5 Awareness of health care services provided for pregnant, nursing mothers and under-five children

Most of the respondent across the group mentioned that they were aware that they handle maternal and under-five care but they said the services were filled with challenges such as unavailability of drug as a major challenge, some of the participants said there was no challenge, as they were pleased with the services a few others mentioned slow response due to cash first policy as another challenge and two respondents mentioned lack of staff as an issue especially absence of the doctor, A few other respondents mentioned that a major challenge was rejection of emergency cases. They, however, concluded that the services were far better with the present administration and staff where they were not properly attended to once it was late at night unlike the last administration. Some of the respondents mentioned some of the services rendered as antenatal, delivery, immunisation, treatment of minor illness and even surgery

'…… yes I'm aware they do have services for mothers and under-five children, it's expected it's a hospital but it's too stressful they don't have enough drugs (R2G4)

'…… there are challenges but the one I encountered personally was that during the time I had my baby's delivery, there were no drugs, my spouse went out throughout to buy drugs and I think it was a challenge (R2G1)

'……I know they take delivery, they do Antenatal, and immunisation. I had my baby I am carrying there. The service was nice. (R5G4)

'……Yes oh, they can perform surgery on pregnant women, I heard it from a woman that just delivered at N. O. Idowu Primary healthcare centre phc not quite long while discussing about their services. She said they are now very good to the extent of performing surgery on a pregnant woman (R4G1)

4.5b Awareness of Health care services provided for pregnant and nursing mothers

On the awareness of the health care services, most (80.8%) of the respondents are aware of the antenatal services at the N. O. Idowu Primary healthcare centre, 52.6% of respondents are aware that N. O. Idowu Primary healthcare centre carries out health education for pregnant and nursing mothers, 51.3% of the respondents are aware of education on proper introduction to complementary feeding for under-five children, 56.4% of respondents are aware of

vaccination during pregnancy, 52.6% of the respondents are aware that activities that promote physical activity during pregnancy is enhanced in N. O. Idowu Primary healthcare centre, 57.7% of the respondents are aware of the checkup monitoring of health during pregnancy, 55.1% of the respondents are aware of diagnosis, treatment and care during pregnancy in N. O. Idowu Primary healthcare centre, 56.4% of the respondents are aware of provision of safe and effective drugs during pregnancy, 83.3% of respondents are aware of delivery services in the N. O. Idowu Primary healthcare centre, 53.8% of the respondents that have ever utilised the health centre said they are aware the N. O. Idowu Primary healthcare centre carries out delivery. 46.2% of the respondents are aware that the N. O. Idowu Primary healthcare centre offers care after miscarriage, 56.4% of the respondents are aware that the health centre offer advice on different family methods, 65.4% of the respondents are aware that the N. O. Idowu Primary healthcare centre gives treatment for minor illness during pregnancy and after delivery (Table 4.5).

Table 4.5a: Awareness of health care services provided to pregnant and nursing mothers

Statements	Aware (%)	Not aware (%)
Antenatal services	63 (80.8)	15 (19.2)
Health education throughout pregnancy	41 (52.6)	37 (47.4)
Nutrition during pregnancy	38 (48.7)	40(51.3)
Breastfeeding styles and proper posture	39(50.0)	39(50)
Proper introduction to complementary feeding for under-5 children	40 (51.3)	38 (48.7)
Vaccination during pregnancy	44(56.4)	34(43.6)
Diagnosis, treatment and care during pregnancy	43(55.1)	35(44.9)
Promoting physical activity	41(52.6)	37(47.4)
Provision of safe and effective drugs during pregnancy	44(56.4)	34(43.6)
Checkup monitoring of health during pregnancy	45(57.7)	33(42.3)
Delivery	65(83.3)	13(16.7)
Post-natal services (care of mother after delivery)	42(53.8)	36(46.2)
Care after miscarriage	36(46.2)	42(53.8)
Advice on different family planning methods	44(56.4)	34(43.6)
Treatment of minor illnesses during pregnancy and after delivery	51(65.4)	27(34.6)

4.5b Continuation of Awareness of Health care services provided for pregnant and nursing mother

On the health care services provided for under –five, most (92.3%) of the respondents are aware of immunisation services for under-five at the N. O. Idowu Primary healthcare centre. 78.2% of respondents are aware of growth monitoring for under-five, 69.2% of the respondents are aware of treatment of teething problems in children of under-five in N. O. Idowu Primary healthcare centre, 79.5% of the respondents are aware that the N. O. Idowu Primary healthcare centre treats minor illness in under-five children, 38.5% of the respondents are aware that female under-five children can pierce their ear holes at the health centre,48.7% of the respondents are aware that male under-five can be circumcised at the N. O. Idowu Primary healthcare centre, 66.7% of the respondents are aware that diarrhoea of the under-five can be treated at the N. O. Idowu Primary healthcare centre, 66.7% of respondents are aware of the service of tepid sponging (the process of using cold water to reduce extreme temperature) (Table 4.5b)

Table 4.5b: Awareness of health care services provided for under-five children at the N. O. Idowu Primary healthcare centre **N=81**

Statement	Aware n (%))	Not Aware n (%)
Immunisation	72(92.8)	6(7.7)
Growth monitoring	61(78.2)	17(21.8)
Treatment of teething problem in children of under-5	54(69.2)	24(30.8)
Treatment of minor illness	62(79.5)	16(20.5)
Piercing of ear hole	30(38.5)	48(61.5)
Treatment of diarrhea	52(66.7)	26(33.3)
Tepid sponging (the process of using cold water to reduce extreme fever)	52(66.7)	26(33.3)

4.6 Factors influencing utilisation of health services (Barrier factors)

On the factors affecting utilisation of health services, Majority of the discussant across the groups said that N. O. Idowu Primary healthcare centre hospital has changed for good as they cannot mention any serious reason to be discouraged from utilizing the health services been rendered in the health centre. Some other respondents mentioned unavailability of modern equipment and poor services, some others said late medical attention, and sometimes unavailability of health staff especially the doctor, unavailability of drugs and lastly the cash first policy, high cost of services and rejection of emergency cases. Some of the responses include:

"……Doctors not been on ground can discourage women from going to the health centre, for example, I went there for medical services and the doctor attended to me nicely and asked me to come back for review but on getting there severally I didn't meet him(R2G4)

"……..There is no factor that can discourage me from seeking for treatment from there (R3G1)

"…….Asking me for money before treatment would definitely discourage me from visiting N. O. Idowu Primary healthcare centre phc, Instead I will go to where treatment can be rendered to me with love (R5G4)

"……..Money, money, money is the major problem, many people in the community encounter, before service rendered they ask for money, you must pay for drugs prescribed to crown it all, if you are there to see doctors for complaint due to no changes from previous treatment you will be asked to pay again ……(R1G5)

"……Rejection of emergency cases is the major problem I know of… (R6G5)

4.6 Factors influencing utilisation of health services (Barrier factors)

The identified barrier factors influencing utilisation of health services is presented in table 4.7, these factors include; cost of services (75.6%), distance to the health centre (5.1%). Rude nurses and rude worker (9.0%) lack of empathy and referral from a health worker at 3.8%. (Table 4.6)

Table 4.6: Barrier factors influencing utilisation of Health care services by mothers of under-five

Barrier Factors	Yes	Percent (%)
Cost of services	59	75.6
Distance to the health centre	4	5.1
Attitude of health workers	9	11.5
Non-availability of health staff	10	12.8
Long waiting time	4	5.1
Services not well provided	2	2.6
Non-availability of drugs	11	14.1
Rude nurses and health workers	7	9.0
Lack of empathy and referral from health workers	3	3.8

4.6.1 Perceived factors affecting utilisation of the N. O. Idowu Primary healthcare centre (Facilitating factors)

Many participants of the focus group discussion across the groups mentioned that they would patronize the health centre more if they will be attended to promptly, nicely even without much cash at hand. Some others mentioned friendly nurses, health workers, and modern equipment, while a few mentioned that what would encourage them is a positive result, in terms of health improvement. Some of the responses include:

> *"……If they are very competent, in the sense that every sickness treated at N. O. Idowu Primary healthcare centre phc results in positive improvement, this will encourage me to visit the pch often and often. (R5G3)*

> *"……If mothers with her sick child is being attended to promptly and nicely even without much cash at hand, this will encourage mothers to visit the health centre always even when they have plenty money. (R3G3)*

> *"……. A friendly and conducive environment will definitely encourage patients to visit the phc. (R3G3)*

4.6.1 Perceived factors affecting utilisation of the N. O. Idowu Primary healthcare centre

Facilitating factors that could encourage the use of health services include; distance to the health centre (85.9%), the attitude of the health worker (78.2%), provision of free or subsidized health care (89.7%), health education for under-five mothers (89.7%), majority (91%) of the respondents picked health insurance plan for mothers of under-five as a facilitating factor (Table 4.6.1).

Table 4.6.1: Perceived factors affecting the utilisation of the N. O. Idowu Primary healthcare centre (Facilitating factors) N=81

Facilitating factors	Freq.	Percent(%)
Distance to the health centre	67	85.9
Attitude of health workers	61	78.2
Provision of free or subsided health care	70	89.7
Health education for under-five mothers	70	89.7
Health insurance plan for mothers of under-five	71	91.0

4.7 Quality of health care services and personnel

On the quality of health services, many participants across the group said that they were satisfied with their maternal care services provided by N. O. Idowu Primary healthcare centre, they say the staff render the services with care and competency however some of the respondents stressed on the need to reduce cost of service and improve their services. however, a few of the respondents said negative reports from clients (friends and family) shows the health centre does not give satisfying services to everyone.

> *"……the services are very very okay to me, I even delivered the baby I am carrying now there (R1G1)*

> *"……. I am not used to the health centre but what I have heard as report is that the health centre is not good not to talk of their services (R6G2)*

> *"……. Their services are not okay with me; they ask for money before anything which is not too good (R3G5)*

> *".... Their services are okay, immunisation, Antenatal clinic and other services are rendered with utmost care and competency. (R2G5)*

When probed further, the discussant across the group said that the quality of care was very okay but they look forward to improving on some areas like staff employment and modern equipment and better services. A participant also agreed with the services been very good but said it will be better if they could increase the immunisation schedule

> *"..... The quality of service is okay but government should employ more staff on ground in order to enhance their performance and services, modern equipment should be provided in every department of the health centre (R6G1)*

> *".... The quality of service is okay especially for immunisation but it will be better if they could change the schedule from once in a month back to every week. This will also increase patronage. (R4G3)*

4.7 Quality of health care services

When asked the kind of activity that takes place in the health centre, 39.7% received anti-malaria treatment, 37.2% received immunisation counselling, 9.0% had their blood pressure checked, 6.4% had their blood pressure checked, 3.8% received breastfeeding counselling, and 3.8% received newborn counseling. When asked if the N. O. Idowu Primary healthcare centre opens up for 24 hours, 71.8% of the respondents said yes while 9.0% said no. On the question of been attended to quickly or spending much time at the N. O. Idowu Primary healthcare centre, 83.3% of the respondents are attended to quickly, 15.4% of the respondents spend much time, 1.3% of the respondents are not always attended to quickly. On the issue of qualified health personnel, 92.3% of the respondents reply that the personnel are qualified while 7.7% of the respondents say the health personnel are not qualified. When asked if the N. O. Idowu Primary healthcare centre always opens on time, 75.6% said yes, 5.1% said no. On the issue of the health centre having modern equipment, respondents that said yes were 69.2% while those that said no were 3.8%. On the issue of if the health workers are confidential with information, 83.3% said yes while 2.6% said no (Table 4.7).

Table 4.7: Quality of health services

Statement	Freq	Percent
Activity that takes place when you visit the health care centre		
Weight is recorded	7	9.0
Blood pressure is measured	5	6.4
Receive breastfeeding counselling	3	3.8
Receive newborn counselling	3	3.8
Receive immunisation counselling	29	37.2
Receive anti-malaria treatment	31	39.7
Is the N. O. Idowu Primary healthcare centre open 24 hours daily		
Yes	56	71.8
No	7	9.0
Are you attended to quickly or you spend much time during visits		
I spend much time	12	15.4
I am being attended to quickly	65	83.3
I am not always attended to quickly	1	1.3
Do they have qualified health personnel		
Yes	72	92.3
No	6	7.7
Is the N. O. Idowu Primary healthcare centre always open in time		
Yes	59	75.6
No	4	5.1
N. O. Idowu Primary healthcare centre has modern equipment		
Yes	54	69.2
No	3	3.8
I don't know	21	26.9
The health workers are confidential with information		
Yes	65	83.3
No	2	2.6

4.8 Hypotheses testing

Hypotheses one: There is no association between socio-demographic characteristic and utilisation of N. O. Idowu Primary healthcare centre services among mothers of under-five in Enio-osa

Fisher exact test was used to test this hypothesis. The result revealed that there is a statistically significant association between respondent's occupation and utilisation of health services (p= 0.026). However, other socio-demographic characteristic showed no significant association with utilisation of N. O, Idowu health care centre services among mothers of under-five in Eni-osa. (Table 4.8)

Table 4.8: The association between socio-demographic characteristic and the utilisation of N. O. Idowu Primary healthcare centre among mothers of under-five in Eniosa

Variables	Utilisation Score Category		Df	X^2	p-value
	Negative (%)	Postive (%)			
Age (Years)					
Below 20 years	4(100)	0(0.0)	3	1.287	0.790*
20-29 years	62(73.8)	22(26.2)			
30=39 years	47(71.2)	19(28.8)			
40 years and Above	5(83.3)	42(16.7)			
Ethnicity					
Yoruba	108(73.0)	40(27.0)	3	2.246	0.542*
Igbo	1(100)	0(0.0)			
Hausa	1(50.0)	1(50.0)			
Others	8(88.9)	1(11.1)			
Level of Education					
Non-formal education	7(100.0)	0(0.0)	3	3.803	0.275*
Primary	19(82.6)	4(17.4)			
Secondary	73(71.6)	29(28.4)			
Tertiary	19(67.9)	9(32.1)			
Level of education of husband					
Non-formal education	17(89.5)	2(10.5)	3	4.322	0.224*
Primary	9(60.0)	6(40.0)			
Secondary	69(75.0)	23(25.0)			
Tertiary	23(69.7)	10(30.3)			
Marital Status					
Single	5(100.0)	0(0.0)	3	1.916	0.639*
Married	109 (72.1)	41(27.3)			
Separated	3(75.0)	1(25.0			
Divorced	1(100)	0(0.00)			
Widow	0(0.0)	0(0.00)			
Others	0(0.0)	0(0.00)			
Occupation					
Farmer	8(88.9)	1(11.1)	4	10.251	0.026*
Trader	69(75.8)	22(24.2)			
Civil servant	7(77.8)	2(22.2)			
Housewife	11(100)	0(0.0)			
Others	23(57.5)	17(42.5)			

***significant**

***fishers exact test statistics was used.**

Hypotheses two: There is no association between perception and utilisation of N. O. Idowu Primary healthcare centre among mothers of under-five in Eniosa

Fisher exact test was used to test for the association between perception and utilisation of respondents. The result revealed that there was a significant association between perception and utilisation of the health centre with p-value < 0.05. Thus, we reject the null hypotheses there is no association between perception and utilisation of N. O. Idowu Primary healthcare centre among mothers of under-five in Eniosa.

Table 4.8.1: Respondents' Perception and Utilisation of the N. O. Idowu Primary healthcare centre

Variable	Utilisation score category		Df	X2	P-value
	Poor	Good	1	0.867	0.028*
Negative	6(42.9)	8(10.3)			
Positive	29(46.9)	35(53.1)			

***significant**

4.9 Logistic regression for significant association

Table 4.9 shows the logistic regression analysis which establishes that is no significant association between factors influencing utilisation of health care and utilisation of health service. From the analysis, the cost of services is 0.7 times more likely to influence utilisation than any other studied factors (OR=0.724, 95%CI: 0.216-2.421). at p-value <0.05

Table 4.9: Relationship between factors influencing the utilisation of health care and utilisation of health service

Factors influencing utilisation of health services	Sign.	OR Exp (β)	95% CI Lower	95% CI Upper
Barrier factors				
Cost of services	0.00*	0.724	0.216	2.423
Distance to the health centre	0.356	3.082	2.282	33.652
Attitude of health workers	0.558	0.405	0.020	8.354
Non availability of health staff	0.630	0.682	0.144	3.240
Services not well provided	0.999	0.000	0.000	0.000
Non availability of drugs	0.426	1.935	0.381	9.198
Long waiting time	0.586	0.426	0.020	9.198
Rude nurses and health workers	0537.	2.714	0.114	64.733
Lack of empathy and referral from health workers	0.580	0.414	0.018	9.460
Provision of free or subsided health care	1.000	0.000	0.000	0.000
Health education for mothers of under-five	0.999	0.000	0.000	0.000
Health insurance plan for mothers of under-five	1.000	0.405	0.000	0.000

***significant**

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

The implications of the result are discussed in this chapter under the following heading: socio-demographic characteristics of respondents, perception of mothers of under-five towards utilisation of N. O. Idowu Primary healthcare centre, pattern of utilisation of the N. O. Idowu Primary healthcare centre by mothers of under-five, factors influencing the utilisation of health care services by mothers of under-five, awareness of under-five mothers about services ongoing and the quality of care rendered in N. O. Idowu Primary healthcare centre. The chapter ends with a conclusion and recommendation.

5.1.1 Socio-Demographic Characteristics of Respondents

The mean age of the respondents was 29.12±5.5 years. This is the average age of the under-five mothers in Eniosa community. The respondents were females since the study is purely female gender-based. The predominant ethnic group among the respondents was Yoruba. this is so because the study was conducted in the south-west region of the country where the majority are Yoruba.

5.1.2 Perception of under-five mothers towards N. O. Idowu Primary healthcare centre utilisation

Majority of the respondents disagreed that traditional herbal home use is safer than the N. O. Idowu Primary healthcare centre primary health care centre. This is similar to the findings of Nyeko et al. (2016) in a study conducted in Northern Uganda where some of the respondents stated preference of health care centre to the use of herbal medicine even though general use of herbal medicine was stated as common. In contrast to the findings of this study, Salako et al. (2001) reported medicine vendors as the first choice for health care and a recognized primary source of orthodox drugs for both rural and urban populations, especially the poor. Most of the respondents (76.9%) in this study disagreed with patient medicine vendor being a reliable source of care compared to the health centre because they believe that the patent medicine vendors are not educated and qualified enough to handle serious health challenges. The difference in the findings might also be as a result of the study area. Many (76.9%) of the

respondents disagreed with using a herbal remedy to prevent frequent sickness compared to the health care centre. This is in line with the findings from Peprah et al. (2019) where it was concluded that personal beliefs (belief or disbelief) about herbal medicine is clearly born out of satisfaction for the herbal product or satisfaction from the health care services. Majority of the respondents (76.9%) agree that herbal remedy is more affordable than N. O. Idowu Primary healthcare centre. This is similar to the findings of Nordeng et al. (2010) in Ghana, where pregnant women studied were enabled to use herbs particularly due to limited income and accessibility to health care as herbs are free or cost very little. Some of the respondents (39.7) agree that there is a shortage of health workers in N. O. Idowu Primary healthcare centre, which corroborates the findings of Abimbola et al. (2016) that persistently low and inequitable distribution of health workers remains a major challenge in the Nigerian health sector. A high percentage of the respondents (87.2) agreed that the N. O. Idowu Primary healthcare centre is a reliable place for health, which is similar to the findings of Lawn et al. (2008) that there are encouraging signs at all levels of a shift toward embracing a more comprehensive menu of health intervention, health centres are becoming better and so more reliable.

Majority of the respondents disagreed that health workers abuse patients and are hostile and not supportive. This is in line with the findings of Okafor et al. (2014) in a study conducted in Enugu, South Eastern Nigeria which reported a high prevalence of proper patient treatment suggesting a possible regional or cultural link with respectful maternal care. Majority of the respondents disagree that traditional remedy or self-medication work faster than going to the N. O. Idowu Primary healthcare centre which is line with the findings of WHO (2002) that although some herbal medicines have promising potential and are widely used, many of them remain untested and their use are also not monitored. This makes knowledge of their potential adverse effects very limited and identification of the safest and most effective therapies as well as the promotion of their rational use more difficult. Safe medication and traditional remedy can go wrong and, in most cases, do not work faster under the wrong administration.

5.1.3 Pattern of the utilisation of health care services by mothers of under-five

Majority of the respondent did not use the N. O. Idowu Primary healthcare centre during pregnancy, which is in line with the findings from Singh (2019) in a study in India which reported that use of maternal health services was low. Majority of the respondents used traditional birth attendants as their source of care during pregnancy. This is similar to the

finding from central statistics study ministry of health (2009) in Zambia which showed a large percentage of women would prefer to give birth with the assistance of a traditional birth attendant. Majority of the respondents who use the health care prefer to use the health centre at the second trimester, which is in line with the findings from Chitimbe (2006) in a study in Malawi where it was reported that pregnant women started antenatal services late in the second trimester and it was associated with cultural practices such as belief in witchcraft, long-distance and need for support from family members. Many of the respondents reported cost (finance) as their reason for preferring home delivery; this is similar with the finding of Sialubanje et al. (2014) in a study Zambia which reported that the low social status of women and their dependence on their husbands for financial resources and support might be causing a delay in decision-making about the place of delivery which often resulted in most women giving birth at home. A few of the respondent utilize care after miscarriage services which is in line with the findings from Bardos et al. (2015), in a study on a national survey on perceptions of miscarriage which reported that a few women reported to the hospital after a miscarriage because they felt bad about the situation and preferred help of family and friends. Some of the respondents reported using minor illness treatment, this is in line with the findings of Rennie et al. (2012), who reported that though people prefer self-care, seem to be an increase in general practice consultation. This could be so because people are beginning to place priority over their health, also there is a slight increase in services currently being utilised over services ever used, and this is in line with the finding of Ksiazek et al. (2008), which explained that health education could improve utilisation of health care and bring to awareness the environmental factors affecting health increase. This is not surprising since a lot of health education and Programmemes are organised in the study setting to increase health utilisation.

5.1.4 Pattern of the utilisation of health care services by mothers of under-five

Majority of the respondents utilise immunisation and growth monitoring services of the under-five which is in line with the finding of Adefolalu, Adetola, Kanma-Okafor, Oluchi, and Balogun (2019) in Lagos state where the majority of the respondents had immunized their under-five, and still follow up in growth monitoring. These two services go hand in hand since growth monitoring (chatting) must take place before the administration of vaccines on the under-five children. A few of the respondents carry out ear piercing for female children and circumcision of the male child in N. O. Idowu Primary healthcare centre which is similar to the finding of Abdur-Raman et al. (2012) in Ilorin which explained that

most of the circumcision practices were done outside the hospital, circumcision and ear piercing are seen as traditional activities that could be done by family, community healers, traditional circumcisionist (Ben Chaim et al., 2005). Also, the case of ear piercing, family members usually attend such activities because they are seen as household duties. Some of the respondents see teething as a natural situation and so do not bother taking the child to the health care centre instead they use home remedies to address teething problems (Nsirimobu et al., 2014). Majority of the respondents treat under-five diarrhoea in the N. O. Idowu Primary healthcare centre which is in line with the findings of Merga et al. (2015) which reported that majority of the respondents sought treatment from licensed medical practitioners. Majority of the under-five children have been to N. O. Idowu Primary healthcare centre which is in line with the findings of the international institute for population science (2006) which reported that majority of the childhood illness was taken to a health facility. A few of the respondents preferred chemist as their source of care which was as a result of financial implications, which is in line with the findings of Awoke (2013) that explained that the main reason for inappropriate treatment-seeking behaviour was majorly financial.

Majority of the respondents reported that their under-five receives their immunisation in the community which is in line with the findings of Mishra, Mohapatra and Kumar (2019) distance could influence the choice to seek immunisation. Majority of the under-five receive their immunisation because this was the only health set up for immunisation in the community. Some of the respondents think it is best to seek health care when there is no improvement from self-medication which is in line with the findings of Mishra et al. (2019) which reported that some of the women use herbal remedies from neighbours and family as the first option of care and only use health care when the herbal has failed. Some of the respondents prefer the option of both parents seeking for health care which is in line with the findings of Rasha et al. (2007) which identified women's level of autonomy in making a health decision. This decision about health care must be taken with their husband.

5.1.5 Awareness of health services provided for mothers of under-five

Majority of the respondents are aware of antenatal services which are carried out at N. O. Idowu Primary healthcare centre which is similar to the findings of Adewoye et al. (2014) in a study in Ilorin who observed that majority of the respondents are aware of antenatal services. Some of the respondents are aware of health education which is line with the findings of Emmanuel et al. (2013) in Southern Nigeria which stated that women are aware of

health education on different aspects, including breastfeeding styles and proper posture, nutrition during and after pregnancy, proper introduction to complementary feeding, and promoting physical activities in health centres since it is in line with the antenatal services and it is part of the requirements of a standard primary health centre activity for nursing and pregnant mothers. Some of the respondents are aware of vaccination during pregnancy which is in line with the findings of Adeofolalu, Kanma-Okafor, and Balogun (2019) in Lagos state reported that some of the respondents are aware of vaccination during pregnancy.

5.1.6 Awareness of health services provided for under-five children

Majority of the respondents are aware of immunisation services carried out at N. O. Idowu Primary healthcare centre for under-five which is similar to the findings of Adefolalu et al. (2019) in Lagos state in a study that stated that mothers are aware and have good knowledge of immunisation services. Majority of the respondents are aware of growth monitoring which is at variance with the findings of Feleke and Bezabih (2017) in Southern Ethiopia which reported that majority of the respondents were not aware of growth monitoring. This variance might be because of constant health education and promotion in the study setting. Some of the respondents are aware of the treatment of teething problems in N. O. Idowu Primary healthcare centre which is at variance with the findings of Getaneh, Derseh, and Abreha (2018) in Southern Ethiopia where few respondents were aware of teething health services in health care centres. This variance might be as a result of the different study setting and constant health education.

5.1.7 Factors influencing utilisation of health services (Barrier factors)

Majority of the respondents identify the cost of services as a barrier factor that influences utilisation of the N. O. Idowu Primary healthcare centre which is similar to the findings of Mohammadbeigi, Hassanzadeh, Eshrati, and Rezaianzadeh (2013) which reported that utilisation of health is associated with socioeconomic status. This simply means that the cost of services could discourage respondents from utilising health care.

5.1.8 Factors influencing utilisation of health services (Facilitating factors)

Majority of the respondents identified distance to the health centre as a facilitating factor while it is at variance with the findings of Nongdhar, Vyas, Narayanan, and Pala (2018) which stated distance as a barrier to accessing health care. This difference in finding may be because of study setting as the study was carried out in India. Majority of the respondents

identified attitude of a health worker as a facilitating factor which is in line with the findings from WHO (2005) which explained that attitude of health workers might directly affect the relationship between patients and provider either negatively or positively, as it is positive in this study. Majority of the respondents identified the provision of free or subsided health care and health insurance plan as a facilitating factor that would promote utilisation of the health centre which is similar to the findings of Feijen-de jong, Jansen, and Baarveld (2012) which explained that absence of health insurance could negatively affect health utilisation.

5.1.9 Quality of health services

Majority of the respondents are being attended to quickly which is in line with the finding of Lubbock and Stephenson (2008), which reported that respondents were satisfied with the waiting time of service. Majority of the respondent's reports that the N. O. Idowu Primary healthcare centre has modern equipment which is at variance with the finding of Omuluabi (2016) who emphasized medical equipment as a major problem affecting Nigeria health sector. Majority of the respondents agree that health workers are confidential with information which is in line with the findings of Moskop, Marco, Larkin, Geiderman, and Derse (2005) which reported a high level of privacy in the health setting.

Public Enlightenment

This can take the form of campaigns which could be used to increase awareness and utilisation of the N. O. Idowu Primary healthcare centre. Furthermore, the messages should be designed to suit the comprehensive level of respondents, especially in this case where the majority of the respondents had secondary school education and below. The flyers should contain messages encouraging the use of the N. O. Idowu Primary healthcare centre.

Availability of drugs

Some of the respondents stated that drugs are never available at the health centre, it is a barrier and serves as a discouraging factor to utilisation to the utilisation of care at the N. O. Idowu Primary healthcare centre.

5.2 Conclusion

This study assessed the perception and utilisation of N. O. Idowu Primary healthcare centre among mothers of under-five in Eniosa. It can be concluded that the respondents had a good perception of the health centre. They also had a poor utilisation pattern. This finding suggests

that socio-economic factor remain the reason for the poor utilisation. Age and marital status were not significant to utilisation of N. O. Idowu Primary healthcare centre. The occupation was significant to the utilisation of the health centre. Factors such as cost of services, lack of basic work equipment can negatively influence utilisation. However, there is a need to continue advocating for cost-effective health treatment, provision of drugs and lab services and also health insurance to increase utilisation. The respondents still have a duty of imparting their community with the good perception and knowledge they possess thereby improving the perception and utilisation towards the N. O. Idowu Primary healthcare centre.

5.3 Recommendations

1. Health educators should sensitize the general public of Eniosa community about the need and benefits of utilising N. O. Idowu Primary healthcare centre with special attention given to pregnant women and children. This can be done by adopting a community directed intervention approach where the community is saddled with the responsibility of ensuring the residents utilize the services of the health centre.
2. Health workers in the facility should be trained and retrained periodically with special attention given to improving their skills and attitude to the patients. The nurses should be encouraged to take their roles in teaching and keeping an interactive relationship with the women seriously to promote utilisation of the health care services.
3. Cost of services should be reconsidered and more funding should be provided for health at the health centre. Fundraising activities should be carried out by the community members targeted at wealthy individuals from the Eniosa community, even if they do not reside there, to raise alternative funds to improve the facility.
4. Community leaders should work with the local government council and advocate for rehabilitation of the facility and provision of basic amenities such as light, water, and so on. They should also further liaise with other relevant organisations such as nongovernmental organisations, private and public agencies who may be willing to contribute to ensuring provision of adequate health care services in the facility.
5. A logistic management unit that will monitor and ensure proper inventory and supply chain management should be created in the facility as a strategy to reduce the chronic stock out drugs and other commodities. The unit should liaise with the pharmacy unit and the local government to ensure consistent supply of essential medicines to the facility.
6. Public awareness has the capacity of reaching out to a larger number of people including women, husbands, mothers in- law, and other population groups in the community.

Campaigns involving different groups should be Organised with an emphasis on maternal and child health care. Adverts, television, radio, jingles and other public relation Programmes should be sponsored. Handbills, pamphlets and poster should be distributed strategically around the community.

7. All available resources for effective care should be supplied or provided in partnership with community members who are willing to help. Health workers should be friendly and show a positive attitude to their clients

5.4 Implication of findings for Health Promotion and Education

The findings of this study have several implications for planning, development and implementation for health promotion and education on the perception, pattern of utilisation and factors that influence utilisation of N. O. Idowu Primary healthcare centre. It has been deduced from this study that, although the respondent's perception was good, the utilisation was poor. Therefore, to increase the level of utilisation associated with N. O. Idowu Primary healthcare centre which would reduce maternal mortality and improve the overall health of the under-five, the following should be put in place.

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APPENDICES

APPENDIX I

Informed consent

My name is EGWU, Jennifer Ifeanyichukwu, I am a postgraduate student of the University of Ibadan presently conducting a study on **Perception and pattern of utilisation of N. O. Idowu Primary healthcare centre among mother of under-five in Eniosa community, Akinyele local government Area, Ibadan, Oyo State.** You do not have to write your name and identification, so the result is anonymous, confidential and for this study only. You have the right to withdraw at any time if you choose to. I will be grateful if you could take a few minutes to fill out this questionnaire and take part in the study.

Thank you.

Consent: Now that the study has been well explained to me and I fully understand the content of the process, I will be willing to take part in the study

Signature _____

Date: _____

APPENDIX II

APPENDIX II (ENGLISH)

Focus Group Discussion Guide for mother's under-five

My name is Egwu Jennifer. I am a post graduate student of public health in the Department of health promotion and education, University of Ibadan. I am carrying out a research on ***PERCEPTION AND PATTERN OF UTILISATION OF N. O. IDOWU PRIMARY HEALTHCARE CENTRE HEALTH CENTRE AMONG MOTHERS OF UNDER-FIVE IN ENIOSA-COMMUNITY, AKINYELE LOCAL GOVERNMENT AREA, OYO STATE.*** The outcome of the study will provide useful information in addressing factors that are responsible for poor utilisation of the health centre by mothers of under five.

You are invited to participate in this focus group discussion, which involves providing answers to the questions relating to the utilisation of the health centre. The interview will last for 45 minutes. There is no right or wrong answers. We are only interested in your views on what you think about the health centre. We assure you that all the information you provide will be kept strictly confidential and used for research purposes only.

In order for us to better capture your views, the following will be done during the interview:

- Audio taping of whatever is been said for accountability
- Reporting; handwriting of all discussions
- Time keeping; to keep track of time by time keeper

Procedures/ Ground rules

There is no right or wrong answer(s); we only want to know your personal opinions on the issue.

It is important that you respond to the questions honestly.

Everyone would be given an opportunity to share their views.

No need to raise your hand, only one person will be permitted to talk at a time.

No official breaks but going to washroom is allowed.

Now that you fully understand the research process, I would like to obtain a voluntary decision before we proceed.

YES ( ) NO ( ) Thumb print …….

Demographic data of participants

First name

Age

Mother's occupation

Ethnicity

Religion

Educational level

Family type

Husband's occupation

Focus Group Discussion Guide for mothers of under-five

S/N	QUESTIONS	PROBING QUESTION
1	Where do women (mothers of under-five) usually seek heath services within the community?	Chemist Traditional homes Churches Hospital (N. O Idowu health centre) Home management with herbs
2	What are the health problems that would make nursing mothers or pregnant women go to the health centre? What are the health problems that would make under-five visit the health centre?	For mothers of under-five
3	What factors encourage women (mothers of under-five) to visit the health centre in the community?	Friendly nurses, health workers and environment Kindness Attention Urgent response
4	What are the factors that discourage women (mothers of under-five) from going to the health centre?	Cost of service Distance to the health centre Attitude of health worker Availability of health staff

		Services provided Availability of drugs Waiting time
5	How satisfied are you, with maternal care services been provided by the health centre in the community?	For mother of under-five For children
6	What is the general perception of the community about the health facility?	Is a good place to receive health care Is a place that is too expensive Is it the last option if all other places fail
7	What challenges do you encounter when you visit the health centre?	For mothers of under-five For children
8	What are the perceived opinions or views about the services provided at the health centre in the community?	
9	Do you think there are certain traditional beliefs in the community that affect patients use of the clinic	If so what are they?
10	How would rate the quality of care at the health What do you think the government can do to improve patronage	Was it pleasant Was she unpleasant Tell me more about

APPENDIX II1 (YORUBA)

ATONA FUN AJOROPO LORI AWON MOMO OMO TI ODUN WON KERE SI MARUN

Oruko mi ni Egwu Jennifer. Mo je akekogboye lati eka Ipolongo Ilera ati Eko, ti Ekun Ilera-Ilu, Eko-isegun, Unifasiti Ibadan. Mo nse iwadi-ijinle lori *ERO ATI ONA TI AWON MOMO TI OMO WON KERE SI ODUN-MARUN MA FI NLO ILE IGBATOJU-ALABODE TI N. O. IDOWU PRIMARY HEALTHCARE CENTRE TI AGBEGBE ENIOSA NI IJOBA-IBILE AKINYELE NI IPINLE OYO.*

Abajade iwadi yi yio pese awon igbamun to dara lati wa ojutu si awon ipenija to ro mo ile igbatoju yi ni iposin larin awon momo awon omo ti won kere si odun-marun. Mo si nroyin lati kopa ninu ajoropo yi, ti o si da le pipese awon idahun si awon ibeere nipa awon ona ibaje to ro mo lilo ile igbalera naa.Ti ajoropo yi yio si je sise fun iseju marun-din-ni-adota, si mo daju pe ko si awon idahun ti o tona abi ko tona, sugbon a kan nilo awon ohun ti ero nipa ile-igbalera naa. A si nmun da yin loju pe awon gbogbo idahun ti e ba si fun wan i yio wan i idakonko ti a o si lo fun iwadi nikan.

Ki a le gbo gbogbo ero ti e fe ba wa so yi, awon nkan wonyi ni yio je sise nigba ajosopo yi:

Igbigba ohun yin sile fun idaniloju awon nkan ti o ba so fun wa.

Kikosile, fifi owo ko awon nkan ti a ba ngbeyewo.

Wiwo ago funwa, lati ma le lo ju akoko ti a da lo pelu alaago.

Awon liana/Awon ofin toromo

Ko si si awon idahun ti o tona abi ko tona, sugbon ka le mo ero yin ni kan lori ijiroro yin i.

Ọ si se Pataki ki o dahun awon ibeere wonyi pelu otito.

Okokan yin ni a si ma fun ni aye lati wi tire.

Ko pan dandan ki eni kanakan naa owo re, ti eyo enikan soso ni yio ni anfani lati soro ni asiko sisoro.

Kosi ni si anfani fun aye-isimi ayafi latilo si yara ifo nkan.

Ni bayi ti eti mo gbogbo nkan toye ki o mo nipa iwadi yi, ma wa fe ifinufindo iyonda lati kopa ki a to te siwaju.

BEENI ( ) BEEKO ( )

Iteka……

Awon nkan toromo olukopa

Oruko akoko yin

Odun melo ni eto bayi

Eya wo ni yi

Iru esin wo ni e nsin

Iwe wo ni ogaju ti eka

Iru ebi wo ni ebi yin

Iru ise ti oko yin nse

ASAFIYEWO SI ATONA LORI AWON IBEERE FUN ISAJOROPO LORI AWON MOMO AWON OMO TI OKERE SI ODUN MARUN

NOOMBA	IBEERE	IBEERE FUN TITOPINPIN
1	Nibo ni awon obinrin (awon momo omo ti kere si odun marun) ma nje ki won wa si ile igbatoju ti agbebe yi?	Ile-ita oogun Awon ile igbatoju ri ibile Awon ile-ijosin Ile-iwosan (N. O. Idowu Primary healthcare centre)
2	Kinni iru awon ipenija ilera ti o ma nmun awon momo olom ti okere si odun marun ma fi nlo ile-igbatoju? Kinni awon ipenija ilera ti ole ki awon omo ti okere si odun marin ma nfi wa si ile iwosan yi.	Fun awon momo ti omo won kere si odun marin
3	Kinni awon nkan ti o ma nmun ori awon obinrin (awon momo omo ti kere si odun marun) ma nje ki won wa si ile igbatoju ti agbebe yi?	Nitori awon ore won olusetoju, awon osise-ilera ati ayika ile-iwosan.
4	Kinni awon nkan ti o ma nje idiwo fun awon fun awon obinrin(awon momo omo ti kere si odun marun) lati mo fe wa gba itoju ni ile igbeto yi?	Owo igbatoju. Jijina si ile-igbatoju. Iwuwasi awon eleto ilera. Wiwasi awon osise ibe. Iru awon iwosan-ilera ti won nfunni. Wiwasi awon orisirisi awon oogun.

		Asiko iduro ki won to da awon towa loun.
5	Bawo ni o se ma nte yin lorun si nipa awon itoju awon momoni ile igbatoju yi?	Fun awon momo awon omode ti okere si odun marun. Fun awon omode.
6	Kinni akotan ero abi igun ti agbegbe ko si lilo ile-igbatoju yi?	Nje ohun ni ireti ti o kan ihin, nigba ti awon ireti gbogbo yoku ba kuna.
7	Kinni awon ipenija ti e ma nkoju ti e ba lo si ile ibatoju?	Fun awon momo ti okere si odun-marun. Fun awon omode.
8	Kinni awon ero yin si awon itoju ti won npesi ni ile igbatoju agbegbe yi?	
9	Nje ero boya ikankan nipa igbagbo kan ni agbegbe ma nje ki awon eniyan sa seyin fun lilo ile igbawosan yi?	Ti o ba je bee, kinni won?
10	Kinni ipo ti e le fi didangajia si nipa gbigbatoju si ni ile iwosan yi Kinni ero ti ijoba le se lati se irugogo si wiwa gba itojusi ni ile igbatoju ti N. O. Idowu Primary healthcare centre Yi?	Se o dun moni Nje ko dun mo obinrin So fun mi si.

APPENDIX IV

QUESTIONAIRE

PERCEPTION AND PATTERN OF UTILISATION OF N.O. IDOWU PRIMARY HEALTHCARECENTRE AMONG MOTHERS OF UNDER-FIVE IN ENIOSA-COMMUNITY, AKINYELE LOCAL GOVERNMENT AREA, OYO STATE

Dear respondent,

I am Egwu Jennifer Ifeanyichukwu, a postgraduate student of the Department of Health promotion and Education in the faculty of public health, college of medicine, University of Ibadan; the purpose of this research is to gather information on Perception and pattern of utilisation of N. O. Idowu Primary healthcare centre health centre among under-five mothers in Eniosa community, Lagelu local government Area, Ibadan. This research is part of the requirement for the award of Master of Public Health in Health promotion and Education and findings from this study will help in the adoption of measures that will help in revising existing health policies, please note that your participation in the study will help to better understand the utilisation of the health centre and factors influencing utilisation. The survey is not interested in identifying any individual response, but group response. YOU SHOULD NOT WRITE YOUR NAME, ADDRESS AND TELEPHONE NUMBER on the questionnaire. All information that would be collected during this study will be treated with utmost confidentiality and there are no risks associated with this study and please note that there is no right or wrong answer to the questions asked or the statements made. Kindly feel free to express your view and be assured that your responses will be kept confidential.

I anticipate your honest and sincere response to the following questions.

Thank you for your co-operation.

SECTION A: Socio-Demographic Characteristics of Respondents

In this section, please tick (√) any of the responses that apply to you in the boxes provided or complete the blank space provided as applicable

1. Age: _____(Years)
2. Ethnic group: 1 Yoruba [ ]2 Hausa [ ] 3 Igbo [ ] others specify……
3. Religion: 1Christianity [ ] 2 Islam [ ]3 Traditional [ ] - others specify……
4. Level of education: 1 Non formal education [ ] 2. Primary [ ]3 Secondary[ ] 4 Tertiary [ ]
5. Level of education of husband 1 Non formal education [ ] 2 Primary [ ] 3 Secondary [ ] 4) Tertiary [ ]
6. Marital status 1 Single [ ] 2 Married [ ] 3 Separated [ ] 4Divorced [ ] 5. Widow [ ] 6. Others specify……..
7. Occupation: 1) Farmer [ ] 2 Trader [ ] 3 Civil servant [ ] 4 House wife [ ] 5. Others specify……..

8. Have u ever visited the N. O. Idowu Primary healthcare centre Yes [ ] No [ ] if NO. Stop interview

SECTION B: PERCEPTION OF MOTHERS OF UNDER-FIVE TOWARDS UTILISATION OF THE HEALTHCARE CENTRE

Instruction: Table contains a list of statement, for each tick *(√) what you agree or disagree with. If you are not certain tick Not sure/undecided*

Table 1

SN	Statement	Agree	Disagree	Undecided\ Not sure
9.1	Traditional herbal homes are safer than the N. O. Idowu Primary healthcare centre primary health care centre			
9.2	Patent medicine vendors and more reliable compared to the N. O. Idowu Primary healthcare centre primary health care centre			
9.3	Those who use herbal remedies do not fall sick frequently compared with those who use the N. O. Idowu Primary healthcare centre primary health care centre			
9.4	Using herbal medication or traditional herbal home is more affordable than the N. O. Idowu Primary healthcare centre health care centre			
9.5	I think the N. O. Idowu Primary healthcare centre do not have plenty of health workers			
9.6	I think the N. O. Idowu Primary healthcare centre is not reliable			
9.7	Health workers at the N. O. Idowu Primary healthcare centre abuse patients			
9.8	The health workers at N. O. Idowu Primary healthcare centre are hostile and not supportive			
9.9	Traditional remedy or self medication works faster than going to the N. O. Idowu Primary healthcare centre			

SECTION C: UTILISATION OF HEALTH CARE SERVICES

10 Have you ever visited the N.O. Idowu primary health centre when pregnant?
1Yes [ ]2 No [ ]

11 If NO what was your source of care? 1.Traditional birth attendants [ ]
2) Family members [ ] 3) Friends [ ] 4) co-wives [ ] 5 hospital outside community [ ]

12 If yes at what trimester of the pregnancy did you visit N.O. Idowu primary health centre?
1 First trimester [ ] 2 Second trimester [ ] 3 Third trimester [ ] 4 All through pregnancy[ ]

13 Which place of delivery do you prefer?

1) Home delivery [ ] 2) N. O. Idowu Primary healthcare centre health centre delivery [ ]

3 hospital outside community [ ]

14) If home delivery, why?
1) It is comfortable [ ] 2) For privacy reasons [ ] 3) Against the local customs [ ]
4) It is safer [ ] 5) No permission from husband [ ] 6) cost less [ ]
7) Attitude of health workers in health centres [ ] 8) Others specify…….

15) Which place would you prefer to have your baby in the community?

1)N. O Idowu health care centre [ ] 2) prayer house [ ] 3) traditional home [ ]
4) A chemist who is a nurse [ ]

Health care seeking path way for under-five children:

16) Have you taken your under- five child (ren) to N. O. Idowu Primary healthcare centre for care before? 1Yes [ ] 2No [ ]

17)) If No where do your under-five child(ren) receive health care?
1) Traditional herbal homes [ ] 2) prayer houses [ ] 3) chemist [] 4) self medication from mother [ ] 5 hospital outside the community [ ]

18) Did your under-five child(ren) receive his/ her immunisation in the community?
1) Yes [ ] 2) No [ ]

19) If yes where did your under-five child receive the immunisation services?
1) Chemist [ ] 2) N. O. Idowu Primary healthcare centre [ ]
3) outreach for immunisation [ ] 4) Other specify……..

20) What time will be right to seek health care for your under-five at the N. O. Idowu Primary healthcare centre?
1) The moment you notice the child is sick [ ]2) when herbal traditional remedies fail [ ]
3) when there is no improvement from self medication [ ]
4) When there is no other option of care [ ]

21) Who decides where help should be sought from when child is sick 1) father [ ]
2) mother [ ] 3) both parents [ ] 4) others specify……..

22. AWARENESS OF HEALTH CARE SERVICES PROVIDED FOR PREGNANT AND NURSING MOTHERS

Instruction*: Table contains a list of statement, for each tick (√) what you aware or not aware of.*

Table 2

SN	Health care services provided for pregnant and nursing mothers	Tick (√)	
		Aware	Not Aware
22.1	Antenatal services		
22.2	Health education throughout pregnancy i. Nutrition during pregnancy ii. Breastfeeding styles and proper posture iii. Proper introduction to complementary feeding for under-five children		
22.3	Vaccination during pregnancy		
22.4	Diagnosis, treatment and care during pregnancy		
22.5	Promoting physical activity		
22.6	Provision of safe and effective drugs during pregnancy		
22.7	Checkup monitoring of health during pregnancy		
22.8	Delivery		

22.9	Post natal services (care of mother after delivery)		
22.10	Care after miscarriage		
22.11	Advice on different family planning methods		
22.12	Treatment of minor illness during pregnancy and after delivery		

23: AWARENESS OF HEALTH SERVICES PROVIDED FOR UNDER-FIVE CHILDREN AT THE N. O. IDOWU PRIMARY HEALTHCARE CENTRE HEALTH CENTRE

Instruction*: Table contains a list of statement, for each tick (√) what you are aware or not aware of*

Table 3

SN	**Health care services provided for under-five**	**Tick (√)**	
		Aware	**Not Aware**
23.1	Immunisation		
23.2	Growth monitoring		
23.3	Treatment of teething problems in children of under five		
23.4	Treatment of minor illness		
23.5	Piercing of female ear hole		
23.6	Circumcision of the male child		
23.7	Treatment of diarrhea		
23.8	Tepid sponging (The process of using cold water to reduce extreme fever)		

SECTION D: PERCEIVED FACTORS INFLUENCING UTILISATION OF THE HEALTH CARE CENTRE

Instruction*: Table contains a list of statement, for each tick (√) what you consider to be a facilating or barrier factor. Yes or no for each factor*

Table 4

24) What are the factors that you perceive will affect the utilisation of the N. O. Idowu Primary healthcare centre

S/NO	Factors	BARRIER FACTORS		FACILATING FACTORS	
		YES	NO	YES	NO
24.1	• Cost of services				
24.2	• Distance to the health centre				
24.3	• Attitude of health worker				
24.4	• Non- availability of health staff				
24.5	• Services not well provided				
24.6	• Non availability of drugs				
24.7	• Long waiting time				
24.8	• Rude nurses and all health workers				
24.9	• Lack of empathy and referral from				

	health workers				
24.10	• Provision of free or subsided health care				
24.11	• Health education for mothers of under-five				
24.12	• Health insurance plan for mothers of under-five				

Instruction*: Table contains a list of statement, for each tick (√) yes or no for each service used or currently using*

Table 5

25. Utilisation of health care services provided at the N. O. Idowu Primary healthcare centre for nursing and pregnant mothers

SN	**Health care service for pregnant and nursing mothers**	**Services ever used**		**Services currently using**	
		Yes	No	Yes	No
25.1	Antenatal services				
25.2	Delivery service				
25.3	Family planning consultation				
25.4	Health education I. breast feeding methods and styles ii. proper nutrition				
25.5	Vaccination during and after pregnancy				
25.6	Post natal services				
25.7	Care after miscarriage				
25.8	Minor illness treatment				

Instruction*: Table contains a list of statement, for each tick (√) Yes or no for each service used or currently using*

Table 6

Utilisation of health care services provided at the N. O. Idowu Primary healthcare centre for under-five children

SN	Health care services for under five children	Services ever used for under five		Service currently using for under five	
25.9	Immunisation	Yes	No	Yes	No
25.10	Growth monitoring				
25.11	Ear piercing for female children				
25.12	Circumcision for the male child				
25.13	Treatment of teething problems				
25.14	Treatment of Diarrhea				
25.15	Treatment of minor illness				
25.16	Tepid sponging (The process of using cold water to reduce extreme fever)				

SECTION E: QUALITY OF HEALTH CARE SERVICES AND PERSONNELS

26. What kind of activity takes place when you visit the health care centre?

1) Your weight is recorded [ ] 2) Your blood pressure was measured [ ]

3) You received breastfeeding counseling [ ] 4) You received new born counseling [ ]

5) You received immunisation counseling [ ] 6) You received anti-malaria treatment [ ]

27. Is the N. O. Idowu Primary healthcare centre open 24 hours daily? 1. Yes [ ] 2. No [ ]

3. I don't know [ ]

28) Are you attended to quickly or you spend much time during visits? 1) I spend much time [ ]

2) I am being attended to quickly [ ] 3) I am not always attended to quickly [ ]

29. Do they have qualified personnel? 1) Yes [ ]2) No [ ]

30 Is the N. O. Idowu Primary healthcare centre always open in time 1.Yes [ ] 2). NO [ ]

3). I don't know [ ]

31. Does N. O. Idowu Primary healthcare centre have modern equipment 1. Yes [ ] 2.No [ ]

3. I don't know [ ]

32. Are the health workers in N. O. Idowu Primary healthcare centre confidential with information

1. yes [ ] 2. No [ ] 3 .I don't know [ ]

APPENDIX V

AFIKUN KINNI A

IWE IBEERE YORUBA

ERO ATI ONA TI AWON MOMO TI OMO WON KERE SI ODUN-MARUN MA FI NLO ILE IGBATOJU-ALABODE TI N. O. IDOWU PRIMARY HEALTHCARE CENTRE TI AGBEGBE ENIOSA NI IJOBA-IBILE AKINYELE NI ILU IBADAN.

Oruko mi ni Egwu Jennifer. Mo je akekogboye lati eka Ipolongo Ilera ati Eko, ti Ekun Ilera-Ilu, Eko-isegun, Unifasiti Ibadan. Idi gbogi fun iwadi yi ni lati sakojo awon ero ati ona ti awon momo ti omo won kere si odun-marun ma fi nlo ile igbatoju-alabode ti N. O. Idowu Primary healthcare centre ti agbegbe eniosa ni ijoba-ibile Akinyele ni ilu Ibadan.Iwadi yi je okan gbogi latigba oye keji ni eka Ipolongo Ilera ati Eko, ti Eku Ilera-Ilu, Eko-isegun, atipe awon arigbamun lori iwadi yi yio je iranwo fun atunse awon ilana towa fun ilera, si je ko ye o pe kikopa re yio fun o ekunrere oye nipa lilo ile igbatoju ilera ati awon awon nkan to le ran awon to ban lo lowo. Iwadi yi sise ki se la ti mo olukopa ni idahun eni kokan, sugbon ni idahun gbogbo olukopa ni apapo. Fun idi eyi, MA SE KO ORUKO RE, IBI TI ONGBE ATI NOOBER ERO-ALAGBEKA RE si ori iwe-ibeere yi. Oniruru gbogbo imoran ti e ba funwa ni yio wa ni yio wa ni idaabobo, atipe ko si ni si ewu kankan ti yio ro mo kikopa re ninu sise iwadi yi. Si tun mo daju pe ko si si idahun ti otona abi kotona si awon ibeere abi awon gbolohun ti a pese sile yi. Jowo turaka lati so ero okan re, ki o si ni idaniloju pe awon idahun re si ma wa ni ipamo.

Mo nwo ona fun idahun otito ati eyi ti oti okan wa si okokan awon ibeere wonyi.

Nje o ti de ile-igbatoju N. O. IDOWU PRIMARY HEALTHCARE CENTRE ri bi? Beeni [ ] Beeko [ ]

Tobaje BEEKO. Jowo, ma te siwaju mo.

Mo dupe pupo.

Eka A: Awon ohun idamo nipa awon olukopa

Ni eka yi, jowo maaki (√) eyi keyi ninu awon toba je mo o ninu okokan awon iho ti a pese sile abi ki o ko idahun si okokan alafo naa ni sise ntele.

1. Ojo ori? _____ (Ni odun)

2. Eya ti e je? 1. Yoruba [ ] 2. Hausa [ ] 3. Igbo [ ] 4. Omiran, salaye……

3. Esin ti e nsin? 1. Igbagbo [ ] 2. Musulumi [ ] 3. Isese [ ] 4. Omiran, salaye……..…

4. Iwe ti e ka? 1. Nkolo ile-iwe [ ] 2. Alakobere [ ] 3.Girama [ ] 4. Iwe-giga [ ]

5. Iwe-togaju ti oko yin ka? 1. Nkolo ile-iwe [ ] 2. Alakobere [ ] 3. Girama [ ] 4. Iwe-giga [ ]

6. Igbeposi yin? 1. Apon [ ] 2. Tiloko [ ] 3.Tituka [ ] 4. Tikora [ ] 5. Opo-binrin [ ] Omiran, salaye…….……

7. Ise ti e nse? 1. Agbe [ ] 2. Ntaja [ ] 3.Osise-ijoba [ ] 4. Iyawo-ile nikan [ ]

5. Omiran, salaye…….……

Eka B: Ero awon momo omo ti okere si odun-marun si lilo ile-igbatoju

Atona: Tabili isale yi ni awon eto okankan gbolohun, fun okokan,maaki (√) eyi ti o faramo abi oofaramo. Ti ko ba si da e loju maaki (√) kodamiloju/nkoleso:

Tabili kinni

Nooma	**Gbolohun**	**Mofaramo**	**Nkofaramo**	**Nkosetan/ Kodamiloju**
8	Awon ile igbatoju ti lewe-legbo ni aabo ju ti itoju-ilera onipo kinni ti lo.			
8.1	Awon ile-ita oogun je eyi ti o fi okan bale si ibi itoju-ilera onipo kinn N. O. Idowu Primary healthcare centre i ti lo.			
8.2	Awon ti won nlo awon lewe-legbo ki se aisan ni lemolemo si awon ti won ma nlo ti itoju-ilera onipo kinni ti. N. O. Idowu Primary healthcare centre			
8.3	Lilo oogun iloju ibile abi ilo ile lewe-legbo deni lorun ju gbigba itoju-ilera ti lo.			

8.4	Mo nro pe ile igbatoju-ilera ti N. O. Idowu Primary healthcare centre ko ni anito olusise eleto ilera.			
8.5	Mo nro pe ile igbatoju-ilera ti N. O. Idowu Primary healthcare centre kose gbe okan le/darade.			
8.6	Awon olusise eleto-ilera ni ile igbatojuti N. O. Idowu Primary healthcare centre ki se aponle olugbatoju.			
8.7	Awon olutoju eleto-ilerani ile igbatoju ti N. O. Idowu Primary healthcare centre je alaini oyayaati alaini iranwo.			
8.8	Nje o dara lati mo lo awon ona miran bi lewe-legbo Ni ibere, sugbon leyin oreyin ti ko ba si ayipada, ki eniyan to kori si ile igbatoju ti N. O. Idowu Primary healthcare centre.			
8.9	Itoju ti ibile abi adalo oogun ti Dokita ko ko ma nsise kanman kanman yatosi ki alaisan lo si ile igbatoju ti N. O. Idowu Primary healthcare centre lo.			

Eka D: Lilo awon nkan Igbatoju

9. Nje e ti lo ile igbatoju onipo kinni ti N. O. Idowu Primary healthcare centre nigba ti eni oyun ri?.1.Beeni [ ] 2.Beeko [ ]

10. Tobaje BEEKO, ki ni o ko yin ni eyi? 1. Awon onugbebi tibile [ ] 2. Awon ara ile [ ] 3. Awon ore [ ] 4. Awon iyawo yoku [ ]

11. Tobeje BEENI nigba sise-ntele nigba ti e ni oyun, nje e lo ile igbatoju ti N. O. Idowu Primary Healthcare Centre bi?

1. Nigba ipele oyun nini kinni [ ] 2.Nigba ipele oyun nini keji [ ] 3.Nigba ipele oyun nini keta [ ] 4. Titi igba ti e fi ni oyun pata [ ]

12. Ibi won tin bi omo wo ni o yan ni aayo/feran? 1. Ile ni [ ] 2. Ile isetoju ti N. O. Idowu Primary Healthcare Centre [ ]

13. Tobaje ti ile ni, kin ni idi eyi? 1. O ma nrorun [ ] 2. Fun awon idi toye mi nikan [ ]
3.Yatosi ti awon ona ibile [ ] 4.O rorun [ ] 5.Kosi iyonda lati odo oko [ ] 6.Owo re kopo [ ]
7. Iwuwasi awon osise eleto ilera ni ile-igbatoju [ ] 8. Omiran, se alaye……
14. Ni ibo ni yo wuyin lati bi omo yin si ni agbegbe yi? 1. Ile igbatoju-ilera ti N.O. Idowu [ ]
2.Ile-Adura [ ] 3. Ile-ibimo tibile/Abiwere [ ] 4. Ile ita-oogun ti o je Noosi [ ]

Ona bi a ti ma nwa itoju-ilera fun awon ti odun won kere si marun:

15. Nje e ti mun omo yin to kere si odun marun lo si ile igbatoju-ilera ti N.O. Idowu health centre Eri bi? 1.Beeni [ ] 2.Beeko [ ]
16. Tobaje BEEKO, nibo ni awon omo yin ti ko to odun-marun ti gba itoju-ilera?
3. Ile-ibimo tibile/Abiwere [ ] 2.Ile-Adura [ ] 3. Ile-ita oogun [ ] 4.Ile ita-oogun [ ]
5. Ibi adafuni ni oogun fun awon momo [ ]
17. Nje awon omo yin ti ko to odun marun gba awon abere-ajesara re ni agbegbe yi bi?
1.Beeni [ ] 2.Beeko [ ]
18. Tobaje BEENI, nibo ni won ti gba awon abere ajesara yi? 1. Ile-igboogun [ ]
2. Ile igbatoju-ilera ti N. O. Idowu Primary healthcare centre [ ] 3Ibi ipolong abere-ajesara [ ]
4.Omiran, se alaye……
19. Igbawo ni yio dara lati wa itoju fun omo re ti ko ti pe odun-marun?
1.Logan ti e ba ko firi pe omo naa nse aisan [ ] 2. Nigba ti itoju tewe-tegbo ba kuna [ ]
3.Ti ko bas i ayipada si oogun adalo [ ] 4. Ti ko ba si ona miran fun itoju mo [ ]
20. Ta ni o ma nso ibi ti iranlowo fun itoju yio ti je gbigba nigba ti omo ba nse aisan?
1.Baba [ ] 2. Momo [ ] 3.Baba ati Momo [ ] 4.Omiran, se alaye……
21. **Ijekamosilori ipese iseto itoju-ilera fun awon oloyun ati momo ti won nto omo lowo**

Atona: Tabili isale yi ni awon eto okankan gbolohun, fun okokan, maaki (√) eyi ti o ba tiso-telefunabi kotiso-telefun

Tabili-keji

Noomba	**Ipese iseto itoju-ilera fun awon oloyun ati momo ti won nto omo lowo**	**Maaki (√)**	
		Timotele	**Nkotimotele**
21.1	Igbatoju nipa oyun nini		
21.2	Ifuni ni eko todale ilera nipa oyun i.Oje jije nigba oyun nini ii.Owa ona ti afifun omo ni oyan ati gbigbe lowo		

	iii.Lilani loye lori bi ase nfun ikoko ni afimo ounje omo fun awon ti okere si odun-marun		
21.3	Igbabere nigba iloyun		
21.4	Sisewadi, sisetoju ati itoju nigba oyun nini		
21.5	Sise agbende nipa ise ere idaraya		
21.6	Sise ipolongo aabo ati didangajiya si awon oogun lilo nigba oyun nini		
21.7	Sise ayewo amojuto ilera nigba oyun nini		
21.8	Ibimo		
21.9	Awon itoju leyin ibimo (itoju momo olomo leyin ibimo)		
21.10	Itoju leyin oyun bibaje		
21.11	Igbani-niyanju nipa oniruru eto ifetosi-omobibi		
21.12	Itoju awon aisan kekeke nigba oyun ati leyin oyun nini		

22.**Ijekamosi lori ipese iseto itoju-ilera fun awon omo ti wonkere si odun-marun ni Ile-Igbatoju-ilera N. O. Idowu Primary healthcare centre** Atona: Tabili isale yi ni awon eto okankan gbolohun, fun okokan, maaki (√) eyi ti o ba tiso-
telefun abi kotiso-telefun

Tabili-keta

Noomba	**Ipese iseto itoju-ilera fun awon omo ti okere si odun-marun**	**Maaki (√)**	
		Timotele	**Nkotimotele**
22.1	Abere-ajesara		
22.2	Didagbasoke si		
22.3	Sise itoju awon ntoromo ipenija eyin fun awon omo tokere si odun-marun		
22.4	Sise itoju awon aisan kekeke		
22.5	Lilu iho eti omo obinrin		
22.6	Sise idabe fun omo okunrin		
22.7	Sise itojuaisan igbe-guuru		
22.8	Iwe sisadinku fun ogbonrangandan ara gbigbona (lilo omo tutu latifise adinku iba ologbonrangandan)		

Eka E: Awon nkan ti o se se lati ran ile igbatoju-ilera lilo lowo

Atona: Tabili isale yi ni awon eto okankan gbolohun, fun okokan, maaki (√) eyi ti o ba ri bee abi ko ri bee nisale yi

Tabili-kerin

23. Kin ni awon nkon ti ero pe o le dena lilo ile igbatoju-ilera N.O Idowu Primary Health centre

Noomba	**Awon okunfa**	**Awon idena**		**Awon nkan iranlowo**	
		Beeni	**beeko**	**Beeni**	**beeko**
23.1	Owo sisan latigba itoju				
23.2	Jijinasi ile-igbatoju				
23.3	Iwuwsi awon osise eleto ilera				
23.4	Aisi awon osise ilera				
23.5	Sisetoju ti komuna doko/dangajia				
23.6	Aisi awon oogun				
23.7	Diduro fun olutoju ologbonrangandan				
23.8	Iyajusi awon Noosi ati awon eleto ilera yoku				
23.9	Aini aanu ati iwe idari si ibomiran ti awon eleto ilera lati lo si ibi ibga itoju tokan				
23.10	Pipese ofe abi edinwo itoju ilera				
23.11	Pipese eko nipa eto ilera fun awon momo ti won ni omo tokere si odun-marun				
23.12	Sise eto ilera-adojutofo fun awon momo ti won toju omo ti ko to odun-marun				

Atona: *Tabili isale yi ni awon eto okankan gbolohun, fun okokan, maaki (√) eyi ti o ba ri bee abi ko ri bee nisale yi*

Tabili-karun

24. Lilo ipese itoju ilera ti o wa ni ile igbatoju-ilera N. O. Idowu Primary healthcare centre fun awon momo ti wontoju omo ati oloyun

oomba	oju ilera fun awon momo ti wontoju omoati oloyun	won itoju ti wontigba niba ri		won itoju ti won ngba lowolowo	
		Beeni	Beeko	Beeni	beeko
24.1	Igbatoju nipa oyun nini				
24.2	Isetoju nipa ibi omo				
24.3	Gbigba idanileko nipa ifeto-somobibi				
24.4	Ifuni ni eko todale eto-ilera i. Owa ona ti afifun omo ni oyan ati gbigbe lowo ii. Oje to sara loore ni jije				
24.5	Igbabere nigba oyun nini ati leyin omo bibi				
24.6	Awon itoju leyin omo bibi				
24.7	Itoju leyin oyun bibaje				
24.8	Sise itoju awon aisan kekeke				

Atona: *Tabili isale yi ni awon eto okankan gbolohun, fun okokan, maaki (√) eyi ti o ba ri bee abi ko ri bee nisale yi*

Tabili-kefa

Lilo ipese itoju ilera ti o wa ni ile igbatoju-ilera N. O. Idowu Primary healthcare centre fun awon omo ti wonkere si odun-marun

Noomba	Itoju ilera fun awon momo ti wontoju omo ati oloyun	Awon itoju ti wontigba niba ri		Awon itoju ti won ngba lowolowo	
		Beeni	Beeko	Beeni	beeko
24.9	Abere-ajesara				
24.10	Didagbasoke si				
24.11	Lilu iho eti omo obinrin				
24.12	Sise idabe fun omo okunrin				
24.13	Sise itoju awon ntoromo ipenija eyin fun awon omo tokere si odun-marun				
24.14	Sise itoju aisan igbe-guuru				
24.15	Sise itoju awon aisan kekeke				
24.16	Iwe sisadinku fun ogbonrangandan ara gbigbona (lilo omo tutu latifise adinku iba ologbonrangandan)				

Eka E: Didangajiyasi eto ilera ni sise ati awon osise

25.Iru awon nkan wo ni won ma nse fun yin nigba ti ebawa si ile-igbatoju?

1. Sise iwon-ilowurasi mi [ ] 2.Sise ayewo ifunpa mi [ ] 3. Ma ngba imoran nipa fifun omo loyan [ ] 4.Ma ngba imoran nipa omo tuntun [ ] 5.Ma ngba imoran nipa abere-ajesara [ ] 6. Ma ngba itoju fun idena arun-iba [ ]

26. Nje ile igbatoju-ilera N. O. Idowu Primary healthcare centre ma nje sisi/sise fun wakati merinle-logun ojokan bi? 1.Beeni [ ] 2.Beeko [ ] 3. Nkomo [ ]

27. Nje won ma nse itoju yin ni kiakia ti e ba de ibe fun itoju yi bi abi e ma nduro pe titi ni? 1.Ma nlo asiko pipenibe [ ] 2.Ma ntete se itoju wa [ ] 3.Won ki tete se itoju mi ni kiakia [ ]

28.Nje won nianito awon osise eleto ilera ni ile igbatoju-ilera N. O. Idowu Primary healthcare centre bi? 1.Beeni [ ] 2.Beeko [ ]

29. Nje won ni awon osise ti won dangajiya bi? 1.Beeni [ ] 2.Beeko [ ]

30. Nje won tete ma nsi ile igbatoju-ilera N. O. Idowu Primary healthcare centre ni asiko bi? 1.Beeni [ ] 2.Beeko [ ] 3. Nkomo [ ]

31.Nje ile igbatoju-ilera N. O. Idowu Primary healthcare centre ni awon ero iwosan igbalode bi? 1.Beeni [ ] 2.Beeko [ ] 3. Nkomo [ ]

32. Nje awon osise eleto-ilera niile igbatoju-ilera N. O. Idowu Primary healthcare centre ma npa asiri nipa ilera yin ma bi? 1.Beeni [ ] 2.Beeko [ ] 3. Nkomo [ ]

33. Nje awon osise eleto-ilera ni ile-igbatoju ilera N. O. Idowu Primary healthcare centre ma nsise fun wakiti merin-le-logun bi? 1.Beeni [ ] 2.Beeko [ ]

APPENDIX VI

ETHICAL APPROVAL LETTER

TELEGRAMS..... TELEPHONE.....

"OYO STATE: THE PACESETTER"

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting

Our Ref. No. AD 13/479/1443

30th September, 2019

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Egwu Jennifer

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Perception and Pattern of Utilization of N.O. Idowu Primary Health Centre among Mothers of Under-Five in Eni-Osa Community, Akinyele Local Government Area, Ibadan, Oyo State." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethics Review Committee