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PERCEPTION AND UTILISATION OF FREE HEALTH SERVICES BY NURSING MOTHERS IN IGBO-ORA, OYO STATE NIGERIA

BY

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College of Medicine

University of Ibadan

Ibadan, Nigeria.

July, 2004.

DEDICATION

This dissertation is dedicated to Almighty God. Other people I am dedicating it to, are my wife Tolulope, my mother and father, Deacon and Mrs S.A. Awolola.

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ABSTRACT

A policy of free health services at Primary Health Care was introduced in Oyo State in 1999. The policy covers the following services: Antenatal Care (ANC), normal delivery, immunization, essential drugs, some curative services (minor trauma, malaria, acute infections, and diarrhea), consultation, admission (excluding feeding) and treatment of disease in children. Laboratory and X-ray services are subsidized. This study assessed the experiences of nursing mothers on this set of free and subsided services in Igbo-Ora, Oyo State, Nigeria.

The study was descriptive and cross-sectional in design. The target population consisted of women who had delivered babies in years 2000 and 2001, after the introduction of free Health Care Policy. A list of family compounds in Igbo-Ora was compiled. Each family compound was visited to identify all women who had delivered babies in the years 2000 and 2001. The women with the most recent delivery were then selected to arrive at a sample of 351 women. Perceptions and experiences of factors that influence utilization of health facility such as cost, quality of services at health facility were obtained through four focus group discussions, and these were used to develop a

semi-structured questionnaire. The instrument was pretested and administered by trained interviewers. A total of 351 questionnaires were administered by 5 Research Assistants.

The ages of 351 respondents ranged from 18 – 50 years with a mean of 27.4 (SD ± 6.38). A majority 241, (68.7%), were Muslims and 75 (21.4%) had no formal education. Two hundred and sixty-one (74.4%) had heard about free health services either on radio, television, churches, mosques or from health workers. Two hundred and sixty-six (75.8%) had used local or state government facility, 66(18.8) used private clinics and 12(3.4%) had used other services including Traditional Birth Attendants. Two hundred and forty-five (69.8%) women with primary or no formal education had used government facility as compared with 106(30.2%) women with secondary or higher education (P = 0.02). This shows that utilization of government facility was positively associated with lower education levels. Among the 266 who had used government facility, 251 (94.4%) paid money for free heath services, the amount paid ranged from N5 to N700, with a mean of N242. On a 5-point rating scale on the quality of free health care, those who attended public health facilities had a mean score of 3.8. A good proportion of women that utilized government facility, 115 (43.2%), identified problems

associated with the free health services scheme to include inadequate drug supply and frequent absence from duty by the health workers.

In conclusion, the study shows that government services are utilized mostly by low-income earners who still pay for services that are supposed to be free most especially drugs. There is therefore a gap between government policy of free health services and its implementation. This point to the need for the government to properly monitor the implementation of the free health policy in Ibarapa Central LGA.

Key Words: Free Health Services, Service Implementation, Policy, Health Services, Utilisation.

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CERTIFICATION

I certify that this study was carried out by AWOLOLA Adeyemi in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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CHAPTER ONE

INTRODUCTION

Background

In keeping with a campaign promise, the Government of Oyo State (GOS) led by Governor Lam Adesina adopted a policy of free health care services and began implementing it in 1999. Policies aimed at promoting public health services especially those relating to primary health care, have constituted a feature of most civilian administrations in Oyo State (GOS, 1999). Since 1999, Oyo State health policy, to a large extent, focuses more on the primary health care which involves the provision of totally free health services. The free health care policy also seeks to establish an efficient referral system from primary through secondary to the tertiary level. People thus referred, would receive some subsidized service at the secondary health care level. The policy stipulates that a health insurance scheme would be integrated into the State's health care delivery system (GOS, 1999).

The specific components of the Free Primary Health Care (PHC) programme include the following: immunization, micronutrient supplementation for

children aged 0-5 and pregnant women; curative services for minor trauma, malaria, acute infections and diarrhea diseases. (GOS, 1999).

Constitutionally, local government authorities (LGAs) are responsible for the provision of PHC services (FGON, 1988). In Oyo state, they are also obliged to be providing free PHC at the grassroots level. The LGAs, under the supervision and technical assistance of the State and Federal Ministry of Health, are expected to be carrying out a number of key services. Four of them will be highlighted. One of the major services is the provision of health services of preventive, curative, promotion and rehabilitative services as the entry point into the health care system at the community, district and local government levels.

Another responsibility is the promotion of primary health care services through Village Health Workers (VHWs), Community Health Extension Workers (CHEWs), Community Health Officers (CHOs), Environmental Health Officers (EHOs) and Nurses /Midwives. This is done under the supervision of a LGA Medical Officer of Health. The LGAs in Oyo State are expected to be providing funds and mobilizing other resources

for the implementation of PHC activities through the full logistical and financial support of the LGA chairman.

Lastly, it is the duty of LGAs to be collecting, maintaining and submitting health and related data to the State Ministry of Health (MOH) and other designated authorities, on a regular basis. This way, LGAs contribute to the promotion of the National Health Information System. Oyo State is not alone in Nigeria, and in fact in Africa, in having a history of free health services. Many other African countries have experimented with the scheme or policy at one time or the other.

A study conducted in Johannesburg, South Africa by Power, Eis, Zwarenstein, Lewin, Vundule and Mosteri, (1997) on the introduction of free health care in Red Cross War Memorial Children's Hospital revealed that there was an increase in the utilization of health services by the children. This adversely affected the services that were provided at the hospital. The free services increased the number of children that were attending the health facilities and they out-numbered the facilities and services provided by the authority. On the long run, children were unable to receive quality health services. Introduction of free health services in Tanzania led to inadequate supplies of drugs and food in hospitals. Therefore,

patients preferred to pay to private clinics to obtain qualitative health services (Abel – Smith and Rawal, 1992).

Another study conducted in Tanzania by Abel – Smith et al, (1992) on the effect of free health services on the population has revealed that free health services was placed an unaffordable financial burden on the poor. This is because the 'poor' tend to seek for qualitative health services in private clinics since the public health centers could not provide quality health services. Recent surveys have indicated that many African countries have introduced some form of free health services. Fourteen out of 15 African countries surveyed by Russell and Gilson, (1995) and 28 out of the 37 African countries surveyed by Nolan and Turbat, (1995), have introduced some form of free health services.

Currently, African Nations are moving away from free services towards a system that stresses cost recovery such as the UNICEF's supported Bamako Initiative in 1987. The Bamako Initiative (BI) (1987) sponsored by UNICEF, the World Bank and WHO is aimed at providing essential drugs at Primary Health Care level. By the introduction of drug charges at the primary health centers, it is hoped that whole community programmes on drug policies may be funded directly or

indirectly by community members that patronize public health services. Since the inauguration of B1, introduction of user fees has gained patient acceptance in Kenya (Collins, Quick, Musau, Kraushaar and Hussein, 1996). Gilson, (1997) has observed that user's fee should be seen as a health care risk sharing and financing package that should include some form of risk sharing.

A study conducted by Akin, Birdsall and de Ferranti, (1987) on health care financing in developing countries revealed that revenue generated through user fees can be used to extend appropriate facilities for the underserved, thus providing a more equitable services. Gilson, (1997) observed in separate studies that for there to be sustainability in the delivery of qualitative health system at primary, secondary and tertiary levels, the role of external support in terms of introduction of user fees, cannot be ruled out.

Financial, logistical and political constraints have prevented free health services from serving everyone (Drennan, 1991). Such negative effects led Got, (1988) to question the motives behind free health services. These motives often include economic or political consideration or mere need for publicity. The economic consideration comes in when majority of the populace cannot afford basic

health care services. The political basis of free health care services may have stems from the need by government organizations to win the populace to their side. This is done with the hope that beneficiaries would applaude the free health care providers, thereby making them (i.e. the providers) popular.

Research conducted to determine the effect of user fee in remote areas of Uganda showed that the scheme resulted in an increase in utilization of health facilities. The user fee was used to pay health workers' incentives thereby encouraging them to offer improved services. The improved services encouraged community members to patronize health facilities (Kipp, Kamngish, Jacobs, Bumham, Rubaale, 2001).

The Oyo State new free health scheme has been implemented for over four years. There is dearth of information regarding peoples' perception of the scheme and pattern of utilization of free health services. This constitutes the focus of this study.

Statement of the problem

The implementation of free or highly subsidized health services is not a novelty in South Western Nigeria. In Oyo State for instance, successive governments have been alternating the implementation of free health services and cost recovery health programmes. Most civilian governments in the state, operate the free health policy while military governments often implement the cost recovery health care services.

Nursing mothers and their children constitute the major beneficiaries of the Oyo State free primary health care and subsidized secondary health care programmes. No attempt has however been made to systematically determine nursing mothers perceptions and pattern of utilization of free health services especially in rural areas where most nursing mothers rely on primary health care services. This study is therefore designed to address this problem in Igbo-Ora, a rural community in Ibarapa Central LGA, Oyo State.

Research Question

The research questions formulated to guide the study are as follow:

1. What is the level of knowledge of nursing mothers regarding the components of the free health services programme of Oyo State?

2. What are the health care facilities patronized by nursing mothers and which of them render free health services?

3. What is the pattern of use of health facilities among the nursing mothers?

4. What are the factors, which determine nursing mothers' choice of health care facilities?

5. What are the problems which nursing mothers encounter in public and private health care facilities?

6. What are the perceived healths promoting practices or health seeking behaviours of nursing mothers during pregnancy?

Broad Objective

The broad objective of the study is to determine nursing mothers' perceptions and pattern of utilization of health services within the context of a free health services programme of Oyo State.

Specific Objectives

The specific objectives of the study are to:

1. Determine nursing mothers' level of awareness about the components of the free health services programme of Oyo State.

2. Identify nursing mothers' sources(s) of information about free health services.

3. Determine the pattern of utilization of health services among nursing mothers.
4. Determine the factors, which influence nursing mothers' choice of health facilities.
5. Identify the problems perceived by nursing mothers to be associated, with the utilization of public and private health care facilities.
6. Document nursing mothers perceived health promoting and health seeking practices during pregnancy.
7. Make appropriate recommendations for improving the pattern of utilization of health services by nursing mothers based on the findings derived from objectives 1 – 6.

Rationale for the study

The rationale behind the conduct of this study lies in the need to document the opinions and perception of nursing mothers about free health services. In addition, the study has potential for yielding information relating to the pattern of utilization of free health services by nursing mothers. The findings of the study will assist in guiding the formulation of policies relating to the implementation and sustainability of the free health services scheme of Oyo State.

Operational Definition of Terms

Attitude:

An attitude is a disposition towards an object, person or situation. This disposition may be favourable or unfavourable. An attitude may develop from personal experiences or through interaction and learning from other people's experiences.

Free Health Services:

These are health services that are rendered free. The beneficiaries pay no money to receive them. The financial implication of the health services is usually borne by stakeholders including government organizations in most cases (Federal, State or Local) and Non Governmental Organizations (NGO).

Subsidized Health Services:

In cases where the financial implications of health services cannot be borne alone by governmental organizations and non-governmental organizations, the subsidized health services are introduced. In this case, the beneficiaries and the providers of the health services contribute to the financing of the health services. These contributions depend on the policy of individual organization or government of the day.

Organization of the Text:

This dissertation is organized into five chapters. The general introduction to the research topic constitutes the first chapter. Chapter two focuses on the review of relevant literature relating to policy and concepts of users fees as well as free health services. A conceptual framework, which guides the study, concludes the chapter. Chapter three explains the methodology employed for the study, the study design scope, study variables, description of the study area, study population, sampling procedures, data collection process, data analysis, reliability and validity and limitation of the study.

The ethical guidelines that were followed in the conduct of the study are also contained in chapter three. The results of the study are presented in chapter four. They include the key socio- demographic variables; level of awareness about free health services; health promoting and health seeking behaviors; perceptions and experiences with health facility; social support to receive health care; and comparison of health care facilities used. Chapter five discusses the implications of the results, compared with other studies and ends with appropriate recommendations.

CHAPTER - TWO

REVIEW OF LITERATURE

This review of the literature related to the study dwells to a large extent on the pattern of utilization of health services provided by the government and factors affecting it. It also points to the introduction of users' fee in health services as a means of fuiding health system and introduction of free health services as a means of increasing utilization of health facilities for people that cannot afford quality health care at any cost. Other related policy issues on health services discussed included health insurance and health assistance as a means of providing qualitative health as well as sustaining health services. This chapter is organized into four sections. The first section deals with the review of the factors, which affect the utilization of health services generally. The introduction of users' fees into health facilities is reviewed and presented in the second section. The third section presents other policy issues and health services while the fourth section focuses on free health care policy in Africa.

Factors Affecting Utilization of Health Services:

Health services researches have focused on health care services affects the choice of health facilities, frequency of use and mode of their use (Metzner, 1969; Weiss and Greenlick, 1970; Weiss, Greenlick and Jones, 1970; Shannon, Bashshur & Metzner, 1969; Bashshur, Shannon and Metzner, 1971). Other different patterns of utilization of health services among populations. Individuals in many countries choose between western and alternative care services in an attempt to seek for quality health services. Many factors are responsible for choosing the types of health facilities utilized by the population. Various studies have indicated that distance from factors that determine choice of health facilities are; demographic characteristics (Bice and Eichchor, 1971; Kalimo, 1969; Reinke and Baker, 1967), organization of health services (Atkinson and Ngenda, 1996), socio-medical variation (Nyamongo, 2002), quality of health services (Calnan, 1988; Slim, Pierre, Nima and Fassinet, 1998; Sauerborn, Ngoutara and Diesfeld, 1989; Forsbery, Barros, Victoria, 1992; Thomason and Edward, 1991; Mwabu, 1986; Hotchkiss, 1993; Gilson, Alilio, Heggenhougen, 1994), religion (Morrill and Earickson, 1969), fee charging (Morrill and Earickson, 1969), socio-psychological factors such as perceived seriousness of

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the health problem (Coe and Wessen, 1965), community interest or cultural background (Adajuigbe, 1980; Jorge, Helga and Ahmed, 2001).

Majority of consumers take into consideration distance of health facilities to their houses or place of work before choosing what health facilities to be patronizing. The nearer a health facility is to consumers' homes, the greater the choice and frequency of use of such facility. Shannon et al, (1969) stresses the importance of distance in deciding health facility to be utilized. They noted that health facilities that are far from homes are not likely to be considered. Further studies conducted by Weiss & Greenick, (1970) and Weiss, Greenlick and Jones, (1970) on factors that influence utilization of health services, confirmed that proximity of health facility to consumers' homes encouraged patronage. In a study conducted by King, (1973) and Etten, (1972), it was noted that distance alone does not explain everything about decision of consumers to use certain health facilities. Some recent efforts have gone a bit to further identify other factors, which affect health facility utilization.

It has been shown for instance that most patients would choose the health institution which they consider would give them the best services rather than the ones nearest to them which would not (Iyun, 1980). Adajuigbe, (1980) in his study

indicated that patronage of medical establishments is affected by two common factors only, namely "distance" and "community interest". Consumers usually patronize health facilities that are nearer to their homes and facilities where most members of the community patronize which can be regarded as the "norm" of the community.

Slim, Fournier, Machouf and Yatara, (1998) have observed in a study on Community Perception of Primary Health Care Services in Guinea that the lay people's perception of quality of Primary Health Care Services which influences the utilization of health facilities includes the following: technical competency in terms of good clinical examination, good diagnosis, good use of diagnostic equipment, effective communication and interviewing skills, appropriate prescription and referrals, dispensing good drugs, dispensing drugs rapidly, administration of injections, giving good advice and good follow up during patients stay. Others are attitude and conduct of staff, in terms of patient's reception and support by health workers, respect and kindness to patient, availability and adequacy of resources and services, in terms of presence of good doctors, availability of good drugs, availability of diagnostic equipment, availability of hospital beds, running water, washrooms,

in-pattent food and cleaning of bed spread. Additional factors often taken into consideration are accessibility to facility, provision of free drugs and services and delivery of services not conditional upon prior payment. Effectiveness, in terms of reduced waiting time, access to doctors upon arrival and rapid recovery from sickness were also found to influence utilization of health services.

A recent study conducted in Tanzania by Atkinson and Ngenda, (1996) in which 250 women were invited to discuss their previous experiences with public, private and traditional providers revealed that in public health sector, perceived quality of health services are determined by conduct of health staff, convenience of the health facility, organization of health care in the delivery of health services, availability of drugs and prescription pattern in the health facilities. Little attention had therefore been paid to the quality of Primary Health Care (PHC) services in developing countries (Sauerbor, Ngoutara, Diesfeld, 1989, Forsbery, Barros, Victoria, 1992; Haddad and Fournier, 1995). The lack of interest in the utilization of health services can be explained by the priority that has long been placed on improving services in contexts where there have been enormous need of modern health equipments to replace the obsolete ones and qualified health personnel that

have been hardly been met. The evaluation of perceived quality by the public is justified by the desire to meet users' expectation (Calnan, 1988).

Mwabu, (1986); Sauerbor et al, (1989); Hotchkiss, (1993); Gilson, Alilio and Heggenhougen, (1994), as well as Haddad and Fourcir, (1995) have noted in their studies that perceived quality is one of the principal determining factors of utilization and non-utilization of health services. Interest in the quality of health care services in developing countries appears to be on the rise because there has been an increase in the number of actions aimed at maintaining acceptable standards of quality (Thomason and Edwards, 1991). The actions involved the criteria used to judge quality as supported by previous observation on the determination of health services utilization in developing countries.

Close associations have been found between utilization and people's perceptions regarding overall quality in South Nganza, Kenya (Ellis, Kingia and Mwabu, 1970); utilization and facility reputation in Maseru Lesotho (Pepperall, Garner, Foxnushby, Moji and Harpham, 1995); utilization and accessibility of health facilities in rural Nigeria (Stock, 1985) and utilization and availability of drugs (Unger, Mbaye and Diao, 1990; Waddington and Enymayckwa, 1990, Litvack and

Bodart, 1993; Gilson et al, 1994). In as much as users' fee has been argued out to facilitate the delivery of qualitative health care in developing countries, payment procedure should therefore be systematically integrated into the health facility and user fee introduction should not impose economic hardship on consumers (Haddad and Fournier, 1995). Time spent by patients in waiting for consultation, has also been found to influence utilization of public health facilities. Waiting time should be reduced to encourage patients to visit public health facilities. (Kloos, Etea, Degefa, Aga, Solomon, Abera, Abegaz and Belcmo, 1987; Tsongo, Willis, Ded, Wong, 1993; Pepperall et al, 1995; Atkinson and Ngenda, 1996).

Utilization has also been related to health workers' qualification. Consumers tend to seek health services where there are qualified health workers like doctors and nurses (Abosede, 1984; Berman, 1984; Saucrbor et al., 1989). Good technical competence in terms of diagnostic process, and treatment process increases utilization of health facilities (Egunjobi, 1983; Tsongo et al 1993; Gilson et al., 1994; Haddad and Fournier, 1995). Honesty by health workers also increases utilization pattern. This implies that consumers will receive qualitative health care where there are honest and diligent health workers (Bruce, 1990; Gilson et al; 1994; Haddad and

Fournier, 1995). Good conduct of health workers also increases utilization pattern of health facility (Bichman, Diesfeld, Agboton, Gbaguindi and Simhauser, 1991; Gilson et al., 1994; Haddad and Fournier, 1995; Pepperall et al., 1995).

A study conducted by Bice and Eichhor (1971); Kalimo (1969); Reinke and Baker, (1967) revealed that demographic characteristics of consumers determine pattern of utilization of health services. Variables such as sex, age, educational status, religion, place of residents, occupation and marital status, are among the demographic characteristics that either increase or decrease the utilization of health services by consumers. The most important of the variable is the socio-economic status of the consumers. Socio-economic status (SES) has a positive association with the health service utilization. The SES either has positive or negative association with such factors as disposable income, educational status, and job status (Tramaria, Campostrini, Tolley and De Lalla, 1977; Myriantophulos and French, 1968).

On the influence of socio-economic factors in determining consumers' utilization pattern of health services, Nyamong, (2002) has observed that patients of lower socio-economic status are more likely to start to treat themselves at home as they wait for a time during which they observe their progress. This allows them to

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minimize expenditure incurred as a result of the sickness and the anticipated cost of treatment. Patients' judgments of the intensity of sickness, therefore determine their choice of treatment. Poor health services utilization is usually associated with lower socio-economic status.

The trends of health service utilization in eight provinces in China revealed that there is no evidence that health care utilization is decreasing as a result of the more market economy policy, which brought China to a period of economic reform. Rather, for people in a community survey reporting mainly mild or moderate illness, have increased health care utilization since health facilities are accessible to them (Henderson, Akin, Hutchinson, Jin, Wong, Dietrich and Mao, 1998). Yu, (1992) reported that series of surveys in China prior to 1989 have demonstrated a slight decrease in the percentage of people who did not seek care when ill and cited economic difficulty as the main reason for not seeking needed care.

Studies conducted by Wirick, (1966); Anderson, (1968); Anderson, (1973); Bice and White, (1969) have revealed that availability of health services affect utilization pattern of health facility. If health services are available and rendered at health facilities, consumers will be encouraged to use them. They may on the other

hand be discouraged if health services are not available during any of their visits to health centers.

The perceived seriousness of a health problem is a socio- psychological factor, which affects the pattern of utilization of health services. The pattern of choosing health care services in Nigeria is similar to the patterns of choosing health care in most developing nations because most often the perceived seriousness of the health problem and the effectiveness of the heath facility in dealing with the health problem are important factors in selecting health care services (Euchana, Hugh Nnadi and Kabat, 1984).

People tend to seek for health services when they perceive a specific circumstance that arises as harmful or life threatening. The degree of perceived harmfulness of a diseased state differs from one person to another. When a diseased state is harmful or life threatening there are possibilities the subject would take prompt actions to seek for health services in appropriate places that he or she terms as "effective health facility" (Brieger, 2000). Perceptions concerning the seriousness of a health problem vary from person to person. This includes perceptions of illness outcome such as death, reduced physical or social function, stigmatization, and

disability and reduced social relations (Eucharia et al. 1984). Young. (1981) in his study in Mexico also found that seriousness of illness is the most important factor in choice of health care provider. The pereeived severity of an illness and benefits from the health care provider is of primary importance in choosing a health care provider for a specific health problem (Eucharia et al. 1984).

Patients' level of satisfaction with health facilities influences pattern of use of such health facilities. A study carried out in Trinidad and Tobago clearly showed this. It was observed that approximately 74% of the interviewees numbering 1451 were satisfied with the performances of the doctors in health centers. This led to an increase in the use of the health facilities. The interviewees also mentioned that they were satisfied with the services rendered by the nurses and that the greatest need for improvement were perceived to be in pharmacists' and doctors' services with particular references to waiting time with the doctors (Singh, Haqq, Mustapha, 1999).

The cultural background of people determines clients' utilization of health services. Though optimal care should be capable of meeting both medical and psychosocial need of health consumers, it may fail to meet the client's emotional or

social needs. The care that meets psychological needs may leave the clients medically at risk (Mendoza, Piechulek and Al- Sabir, 2001). It therefore, means that developing countries promoting client – orientated health services should carry out more in-depth research on the determinants of clients' satisfaction (Mendoza et al, 2001). A study on low use of rural maternity services in Uganda revealed that lack of skilled staff at PHC, complaints of abuse, neglect and poor treatment in hospitals and poorly understood reasons for procedures are factor responsible for unwillingness of women to deliver in health facilities (Kyomuhendo, 2003). Other factors included adherence to traditional birthing practices and belief that pregnancy is a test of endurance (kyomuhendo, 2003).

A study has been conducted to identify factors responsible for poor utilization of PHC services in a rural community in Nigeria. The major factors that cause non ascendance of the available services included high cost to drugs and other service charges, easy access to traditional healers, difficulty in getting transport to a health facility, the unfriendly attitude of the health workers and wasting of patients' time at the health facilities. Recommendations suggested for corrective measures included raising the standard of practice of health workers through training, provision of

integrated services at PHC facilities, introduction and sustenance of Revolving Drug Fund Scheme at PHC level (Katung, 2001). In another study in Ouagadougou, Burkina-Faso, the curative care (self care) of minor ailments provided by family members decreased their utilization pattern of health facilities. People therefore decided not to attend modern health facilities and traditional healers in order to seek for care since they can manage most ailments in their homes and at the barest cost. (Develay, Sauerborn and Diesfeld, 1996).

Users Fee, Its Rationale and Effect on Health Service Provision and Utilization:

Users' fee is defined as means of generating sufficient reliable resources for continued and improved provision of health care for the growing population (Leighton, 1995). Although never explicitly identified as an objective of user fees, the desire to raise revenue and improve services can be related to concern to tackle problem of sustainability in health systems. The role of external support of health systems suggests that, system sustainability is the capacity of the health system to function effectively over time within a minimum of external support (Lafond, 1995; Gilson, 1997). User fee is a component of public health financing (Fabricant,

Kamara and Mill, 1999). User fees for health care were permitted in all sections as a means of using private funds to improve the quality and availability of government health services. Supporters of user fee argue that the private sector would ensure that resources are used efficiently (Fabricant, Kamara, and Mills, 1999).

Critics counter that user fees are detrimental to household budgets and will cause poor people to make less use of quality health care services (Fabricant et al, 1999). A study conducted in Zambia by Bennett and Musambo, (1990) on the effect of the introduction of user fee for curative care in clinics and hospitals showed that a charge of four Kwacha (US $10) for a patient reduced the visit of health consumers to hospitals to about half because they could not afford the financial implication of the increase in user fee. Users fee for health services are not new in Africa. A few countries in Anglophone Africa had had national user fee system for years. Ethiopia, Namibia and South Africa are good examples (Nolan and Turbat, 1995; Russell and Gilson, 1995).

In many other countries, charges have historically been applied in both governmental and non-governmental health facilities. Since the 1980s, there has been considerable growth in the number of Africa countries implementing some

form of user fee system (Nolan et al 1995; Russell at al, 1995). Newbrander, Collins and Gilson, (2001) have revealed that the introduction of user fee in Kenya, Guinea, Tanzania, Ecuador and Indonesia have reduced the access of the poor to health service utilization since they could not afford the cost of the user fee. After user fees were implemented in Kenya's government health facilities in the early 1990, the revenue generated was earmarked for the facility improvement fund (FIF). By 1996, fees had not increased for two years and cost recovery rates were decreasing due to the effect of inflation in the country. Therefore, as a result of the unaffordable cost imposed by inflation, two new strategies formulated included: possible changes in category of persons exempted from fee and implementation of new fee structure that favored the low-income earner as well as the poor (Musau, Kilonzo and Newbrander 1996).

On the contrary, introduction of user fee in government health facilities in Kabarole district in Kenya, increased utilization of facilities located in remote areas while it decreased in those urban or semi-urban areas (Kipp, Kamugisha, Jacobs, Burnham and Rubasale, 2001). The increase utilization of health facilities in remote areas was considered to be largely attributed to health workers incentive payments

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derived from cost charging revenue. The incentive payments to health workers encouraged them to offer improved services to patients since patients' turnout did not outnumber the health facilities and personnels provided. Other factors might include; improve drugs supply to health facilities and increased public identification with community projects in remote areas (Kipp, et al, 2001).

Apart from the introduction of users' fee, a cost-sharing programme was introduced by Kenya Ministry of Health in December 1989. Early implementation of the outpatient registration fee, led to the suspension of this major source of revenue in September 1990. In 1991, the Ministry initiated a programme of management for improvement and gradual re-introduction of an out-patient fee, but this time as a treatment fee. It is suggested that implementation of user fee in phases at the PHC level of health facility is important to gain patients' acceptance, to develop the requisite management systems, and to orientate ministry staff to the new system (Collins, Quick, Musau, Kraushaar, Hussein, 1996).

At several periods, policy makers usually have to take decisions without adequate information on the costs and benefits of health programme. It is this information that economic evaluation seeks to provide. Economic evaluations

techniques have important role in decision-making (Anne and Drummond, 1987). Fees should therefore be seen as a health care financing package that should include some form of risk sharing. Within this package, fees have greater potential role within secondary and tertiary care levels rather than the primary care level in raising revenues to improve services provided at public health facilities. Such fee is essential in secondary and tertiary care levels to provide quality health care for consumers. Policy makers can judge whether or not, when and how to implement the fee policy so it would not affect the poor who could not afford such fee in the utilization of health care services (Gilson, 1997). Their judgment and leadership remains the most critical elements in effective implementation of the policy (Gilson, 1997).

It is the belief that the user charges for health services in developing countries are likely to improve welfare (Akin, Birdsall and deFormanti, 1987). The World Bank sometimes finances health services in developing countries. It stresses the importance of user fee, insurance and private sector as tools for strengthening health sector (Akin et al, 1987). Griffin, (1992) revealed that the introduction of users' fee as a policy emphasizes the potential welfare costs of higher medical services imposed on consumers, which might not be affordable for the poor. Laugeri, (1987)

has observed that the question of who should pay and how much, depends on the scarcity of the commodity, considerations of equity and investment plans. Everyone therefore should contribute to the cost, but not necessarily in the same proportion, in the same way or at the same time.

User fee have come to be seen as a critical important alternative to tax payment in some countries like Kenya and Tanzania, where governments had previously provided government care in health facilities free at the point of use (Russell et, al, 1995). Recent surveys have indicated that most African countries have now introduced some form of fee in government health care facilities (Russell et al. 1995; Nolan et al, 1995).

The rationale behind the introduction and implementation of user fee for health care in Africa was to support sustainable health care financing and implementation. But it has been found that many of the benefits of user fees which are to raise revenue needed to improve services have not been realized because of implementation difficulties (Nolan et al, 1995; Russell et al. 1995). According to Henderson et al. (1998), these difficulties included technical incompetence; poor diagnostic process, inappropriate prescription, inappropriate referrals and

inappropriate treatment process, bad attitudes of health workers to consumers, non availability and inadequacy of both human and material resources and services such as non- availability of drugs, hospital beds, running water, washrooms workers).

Other constraints which undermine the effective implementation of fee systems are; poor design of fee systems which include difficulty to administer complex fee structure, lack of financial management throughout the health system especially at district or community level, lack of information with which to target the poorest effectively through exemptions, limited funding for the supervision and support needed by primary level, the population's lack of experience in paying for public health service, which generate an unwillingness to pay for them, a variety of socio-cultural and political constraints at both local and national level.(Collins et al, 1996; Gilson et al, 1995; Nolan and Turbat, 1995).

Recent initiative to strengthen primary health care through user charges included the provision that improved quality care through introduction of cost recovery measures (Lerberghe, Telfer, Van Dormeal, 1993; Hanson and Mepake, 1993). It is argued that these interventions may actually increase utilization and improve access to care, thereby promoting more equitable health care delivery

services (Litvack and Bodart, 1993). Gilson's recent review of the impact of user fee and access for the poor in a variety of settings, suggests that effort to safeguard the poor has had limited success (Gilson, Alilio and Heggenhougen. 1994).

Policy Issues and Health Services:

The health sector of many countries of the developing world is in a particular situation of weakness with little room to manoeuvre. Having suffered a disproportionate cut-back in funding, they have to face the pressure from such powerful aid donors' groupings as the World Bank. UNICEF and bilateral donors who attempt to address the severe social effects of adjustment policies (Lob-Levyt, 1990). Is it right that in the developing world, fundamental changes in the nature of funding and supply of health programme should be allowed to be dictated by the aid donors? (Lob-Levyt, 1990). Various efforts have been initiated in Ecuador to extend primary health care coverage, particularly to the rural area (Karen, Mangeldorf, Jorge and Howard, 1988). Some community health workers have been trained but they have often been poorly supervised and inadequately supplied with medicines and equipment.

Severe economic difficulties have aided the rural community to disintegrate, as peasants seek work in urban areas. Maintenance of quality primary health care is therefore a developmental strategy to meet the needs of both rural and urban people (Kanra et al. 1988). In a research conducted by Lincoln, (1987) in China and India, economic crisis presents an opportunity for a structural review of society's health system. If it is true that "good health is within the reach of all" what are the priorities for policy-makers who hoped to achieve improvements in health status despite the need for economic stringency like the implementation of Structural Adjustment Programme under the auspices of World Bank in Zimbabwe (Government of Zimbabwe, 1990). The programme consisted of economic reforms, which included reduction in social expenditure, currency devaluation and trade liberalization.

In the health sector, collections of user fees initially were enforced in Zimbabwe in 1993-1994, (Bijlmaker, Bossert and Sanen, 1995). Perhaps the most significant function of health policy is to ensure that health and nutrition in addition to economics, command the highest priority in development and economic adjustment (Lincoln, 1987). The successful implementation of a PHC policy in the world will be a long-term programme. It requires a sustained effort of planning and

ensuring that the plans are translated into a new pattern of health activities. A coordinated approach to planning and management of resources allocation is essential for successful implementation. Within the Ministry of Health, this will require the strengthening of the capacity to influence the use of resources and to direct them to meet PHC policy priorities (Gerald, 1988).

Health insurance has evolved to pool the risk of incurring high health care across individuals. The evaluation of insurance arrangements in many postcolonial countries particularly in Africa and Asia has been slightly different (Shaw and Griffin, 1995). Upon gaining independence, most government intervened directly in the financing and provision of health care (Shaw and Griffin, 1995). In poorer countries or states, health initiatives have floundered because of low levels of funding, inequitable distribution and inappropriate services.

Governments have encouraged insurance- based funding organizations to relieve the burden on public finances and improve the quality of health care provided. The approach is supported by organizations such as the World Bank (Shaw and Griffin, 1995). A statement of the national health care financing made by The Federal Government of Nigeria states that "within available resources high priorities

shall be accorded to PHC with particular reference to underserved areas and groups". It was also emphasized that community resources shall be mobilized in the spirit of self-help and self-reliance (FGON, 1988).

In order to improve health service delivery to the grass-root in Nigeria, the Federal Government emphasizes the importance of health in socio-economic development of a nation, and mandates all governments of the federation in Nigeria review their financial allocations to health in relation to the requirements of other sectors of the economy. High priority programmes for Primary Health Care shall have first consideration of any additional resources that may be available (FGON, 1988).

Clinical researches in China have shown that patients without insurance have much shorter hospital stays and receive fewer and sometimes inappropriate medications and treatment than those who have insurance (Phillips, 1997). In developing countries mutual and state- sponsored social health insurance arrangements have risen to supplement the basic cover provided by public institutions (Neil and Solann, 1997). Health sector aid policies have changed over the past decades with the development of primary health care (PHC) concepts. In a

research conducted by Lob-Levyt (1990), a vital question was asked which probed into the motives behind health-sector aid.

Various questions had been asked for reasons for giving health-sector aids. Mentioned included compassion, economic or politics. There are reasons, for giving health-sector aids by the providers in most nations. In most poor nations, health aids has long been seen as a political issue (Lob- Levyt, 1990). During the 1936 Spanish civil war, most western governments displayed an ambivalent or a "neutral hostility" to the democratically elected Republican Government in Spain. They therefore gave health aids to them through fund-raising activities from numerous sympathetic organizations in the United Kingdom, United States of America and Canada (Shapiro, 1983).

The public perception of health aids is strongly shaped by the media either in the powerful television images of a helpless, starving Africans receiving famine relief, or in the traditional views of the "charity" of health care (Patton, 1988). Health aid has a low priority in the domestic political agenda of the donor countries. It is rare that a government fears the loss of power or votes through its health policies. The current climate in the West (in terms of majority of governments in power) is

one of disinterest in aid. Many in positions of aid decision –making openly express doubts as to whether aid "works" despite good evidence to the contrary (Patton, 1988).

Throughout the world, bilateral agencies usually contribute 30% of health sector aid and this represents government-to-government aid, while multilateral agencies contributes 24% health sector aid (Howard, 1986). NGOS contributed 18% and UN organization a further 18% (Howard, 1986). In September 1987 in Bamako Mali, African health ministers adopted what has become known as the Bamako Initiative (BI), sponsored by UNICEF, The World Bank and WHO. The aim of the project is essentially to provide drugs as aid. By the implementation of drug charges at the primary level, it is hoped that operational costs and in time, whole community health programme, may be funded. For sometimes, the World Bank has been an active component of user charges for health services. Revenue generated through users fees can be used to extend appropriate facilities for the underserved, thus providing a more equitable service (Akin, 1987).

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up for the provision of water supplies and the improvement of health. It is intended that responsibility for bringing the project schemes to fruition will be shared by individual consumer. This is a form of cost sharing technique (Sanoussi, 1988).

The free health policy in most cases usually encourages wasteful prescribing by doctors and excessive demands by patients. Therefore, to avoid wastage, medicinal drugs of proven effectiveness should be made available to all those who need them at a reasonable price. At the same time, many who are poor or not working cannot afford the medicine, so medicine should be provided free for these set of people (Bidwell, 1988). In every system of health care, it must be decided on how medicines are to be paid for. At one extreme, the health care budgets bear the whole cost of all medicines (as in free health services), at the other, the individual consumer pay the full price of any medicine he needs when he does so (Bidwell, 1988). For these reasons, most governments and private health services impose some limit on the supply of free medicine. Free supplies are restricted to certain categories of person e.g. dependent children, pregnant women, pensioners and those in receipt of social security benefits. Free supplies are also restricted to certain categories of drugs (Bidwell, 1988).

Finally, the attainment of health for all required that a complex range of political, social, managerial and technical problems need to be overcome. To this end, it is necessary to produce a sufficient number of health-for-all leaders throughout the world, that will possess the convincing knowledge that will allow them to galvanize the masses into taking action on their own behalf (Bidwell, 1988).

Free Health Care Policy in Africa:

Should the government provide health services as a basic human right, free to all regardless of income? (Drennan, 1991). For years, many developing countries tried to provide free health services to all, considering it a basic human right. Financial, logistic and political constraints have prevented them from serving everyone however (Drennan, 1991). Furthermore, like the demand for family planning, the demand for health care is increasing, and government has not kept pace. Thus, government along with donor agencies and private voluntary organizations are searching for new ways to pay for health services (Drennan, 1991).

Researches on the willingness of people to pay for preventive health services such as family planning, have shown that people are willing to pay for curative

services more than preventive services because the benefits in curative services are clear and immediate (DeFerranti, 1985; Lewis, and Kenny, 1988; Stinson, 1982; and Zschock, 1982). In many cases, free health services are synonyms with the provision of free family planning. Free or partially subsidized family planning supplies and services may draw customers away from private health providers. But the question of importance is that could people who benefit from family planning as well as free health services contribute to the services received? (Drennan, 1991).

Family planning users in the developing countries now pay an estimated 10% of total planning cost. Could some family planning users who now rely on free supplies and services pay something for family planning and could employers and insurers, who save money when their employee or clients use family planning, help to pay for family planning also? (Drennan, 1991). Paying for family planning is part of the larger problem for paying for health care in developing countries, in which economics, politics and publicity usually have profound influence on people's health. Advertising the provision of free health services, which are inadequately provided by the government for example. is often in conflict with the interests of good health through the reliance that politicians place on it for their own

advancement (Got, 1988). Adverse influence on people's health should be vigorously exposed by all concerned with people's well being.

Tanzania is one of the Africa counuies that have implemented free health services. The provision of free health services in Tanzania since independent has been an integral part of her overall development. It has thus become difficult in recent years to maintain adequate government health services (Abel-Smith and Rawaj, 1992). The reason can be related primarily to the under financing of the health sector due to the present econonic crisis and Structural Adjustment Programme. The level of financing which the Ministry of Finance in Tanzania is able to provide for the public health sector is not, however, not sufficient to maintain this expanded service effectively. The proportion of the budget devoted to social sector has been falling and the government is under pressure to cut public expenditure (Abel-Smith and Rawaj, 1992).

A case study of Tanzania revealed the effect of free health services on the population. Information was collected on travel time, travel cost and waiting time, which health facilities were chosen and why, the cost of using them and difficulty in finding the money to pay and willingness to pay user charges. The most important

conclusion was that because of inadequate supplies of drugs and of food at health facilities, many patients had to incur substantial costs to use "free" services in addition to travel costs. It was found that if patients could pay for traditional mode of care and care provided in mission health services, there were justifications for charging at government services. It was concluded that "free" services in Tanzania are placing unaffordable burden on the poor (Abel-Smith and Rawaj, 1992).

To measure the effect of the introduction of free health care, a research was conducted by Power, Zwarestein, Lewin, Vundule and Mostert, (1997) at Red Cross War Memorial Children's hospital in South Africa among children less than 6years on requirement for levels of care ranging from home to super-specialist. It was found that the hospital provided care to a large number of children 48% of who were unreferred. On the introduction of free health care, the number of unreffered children increased to 83% and consequently the number of children that attended health facility out-numbered the free health services provided.

In 1980, the Zimbabwean government inherited at independence, fragmented health services, which was urban-centered and focused on curative services. This led them to adopt a free health policy that ensures greater equity in access to health

services (Chinemana and Sanders 1993; Loewenson, Sanders, and Davies, 1991). The Zimbabwean health was free for 90% of the population based on an income cut-off of Z $ 150 (Bassett, Bijlmakers and Sanders, 1997).

The South African Government (SAG, 1996) free health policy states thus:

> *"Free health will be provided in the public sector for children under six years, pregnant and nursing mothers, the elders, the disabled and certain categories of the chronically ill. Preventive and promotive activities, school health services, antenatal and delivery services, contraceptive services, nutrition support, curative care for public health problems and community based, care will also be provided free of charge in the public sector. User fee for insured patients using public hospitals will be increased to ensure full cost recovery".*

Another study conducted in Soweto, South Africa, in a dental clinic, compared patients' attendance rates one year before and after the introduction of free primary dental health services. The study revealed a statistically significant increase in casual patient attendance in the year after free primary dental health care was introduced (Bhayat and Cleaton-Jones, 2003). The impact of free maternal health care on South

Africa was also studied by Schneider and Gilson, (2000). In their study there was an increase in the utilization of government health services due to the introduction of free maternal health care (Schneider and Gilson, 2000).

On the 19th of May 1997, in Johannesburg, President Nelson Mandela visited Kathleong Nori Clinic. He asked a nurse about free health care services (Simon, 1997). Her first reaction was to point at the crowded wooden benches of the hospital waiting room. She said.

"There are lots of patients"

When users' fees were scrapped, more patients turned up for care. The South African Health Review in 1996 said the rise in attendance figures confirmed that users' fees in states sector had been a barrier to health (Simon, 1997). In an interview conducted in a study by Schneider and Gilson, (2000) a professional nurse in Northern Cape, she said: .

"Patients in this place are abusing free health care service, and we don't have control over it. A patient will come on Monday with a headache, on Wednesday with stomach-ache and on Friday will remember an old sprain he got when he was

young and come complaining of knee pain. We have to provide them with service and we can't chase them. How do we control this?"

Government health policy in Nigeria increasingly had become an issue of public debate and public contention in the late 1980s. The issue emerged during the Constituent Assembly meeting held in 1989. The draft reported by the assembly included a clause specifying that free and adequate health care was to be available as a matter of right to all Nigerians within certain categories. The categories included all children younger than eighteen; all people sixty-five and older; and all those physically disabled or handicapped (FOS, 1991). The provision was however, deleted by the president and the governing council when they reviewed the draft constitution (FOS, 1991).

It will be recalled that free health policy has been the policy of past civilian administrations in Oyo State since independence, with the exception of the 29 years of military regimes (GOS, 1999). However, it was not until the civilian administration of 1979-1983 that the free health policy was given full implementation (GOS, 1999). The free health policy is therefore termed a "social

heritage". The free health policy under the manifesto of the defunct Unity Party of Nigeria (UPN) was given full implementation in 1979. It pointed out that health care delivery should be totally free at all levels in all state owned health facilities. As a result of the economic situation in Nigeria including Oyo State, and the ever-increasing population, the provision of health has become an expensive social contract, the financial implications of which could not be borne alone by the state government. The Oyo State new free health policy was then formulated (GOS, 1999).

The Oyo State new free health policy contains to a large extent, some subsidies. This implies that health delivery in its entire ramification in the State would not be totally free. (GOS, 1999). The high points of operation of the new health care policy in Oyo State under the leadership of the Alliance for Democracy included:

Free primary health care, subsidized secondary health care, and establishment of efficient referral system and integration of health insurance scheme into the free health care policy.

Total free primary health care included:

Free ante-natal and normal delivery, free immunization (NPI) services, free consultation and examination, free micro- nutrient supplements for children 0-5 years and pregnant women, free curative services – minor trauma, malaria, acute infections, diarrhea diseases, health education and school health programme (GOS, 1999).

Conceptual Framework:

Theories and models are very important tools in health education. They provide information about strategies and methods for understanding individual's behaviour before planning and implementing health intervention programmes. A combination of models and theories is often recommended since no one theory can capture all aspects of behaviours (Igun, 1988). Thus, there is strength in using more than one model/theory (Tanner and Cockerham, 1983). A model is a visual construct of the causal linkages among a set of concepts believed to be related to a particular public health problem (Earp and Ennett, 1991). In planning health education research and intervention programmes, it is important to consider the individual and

his micro-level factors that influence him/her as well as other influential environmental and social forces that are involved in generating the individual's behavior. In this study, a model was adopted, and it provided clearer explanation of how factors such as beliefs, attitudes, knowledge and social supports may be associated with pattern of utilization of health services. The model is Health Belief Model (HBM).

Health Belief Model:

The HBM was developed by Rosenstock and Becker during the 1950s to explain preventive health behavior, particularly regarding the relationship of health behavior to utilization of health services such as screening and immunization programme (Ross and Mico, 1980). The HBM has been applied to many other aspects of health behaviours as well (Hubbley, 1993). The model explains preventive or curative health behaviour by examining the extent to which an individual perceives a problem to be serious and has high probability of occurrence. The model considers motivation as a necessary condition for health action since motives

selectively determine one's perception of the environment. The key components of the model are as follow:

Perceived susceptibility, which refers to the subjective perception of risk or vulnerability to a health problem.

Perceived severity, which consists of ones' perception of the seriousness of the health problem.

Perceived benefit, which involves the efficacy of an action, designed to prevent or reduce the threat of an illness.

A "recommended" health action aimed at preventing or ameliorating a given disease threat.

Perceived barriers, which refers to the negative consequences that might be associated with the preventive behaviour.

Modifying factors, which refer to the socio-demographic characteristics of the person and the knowledge they possess about the health issues.

Cue to actions, which are the stimuli that increase threat perception and therefore promote action.

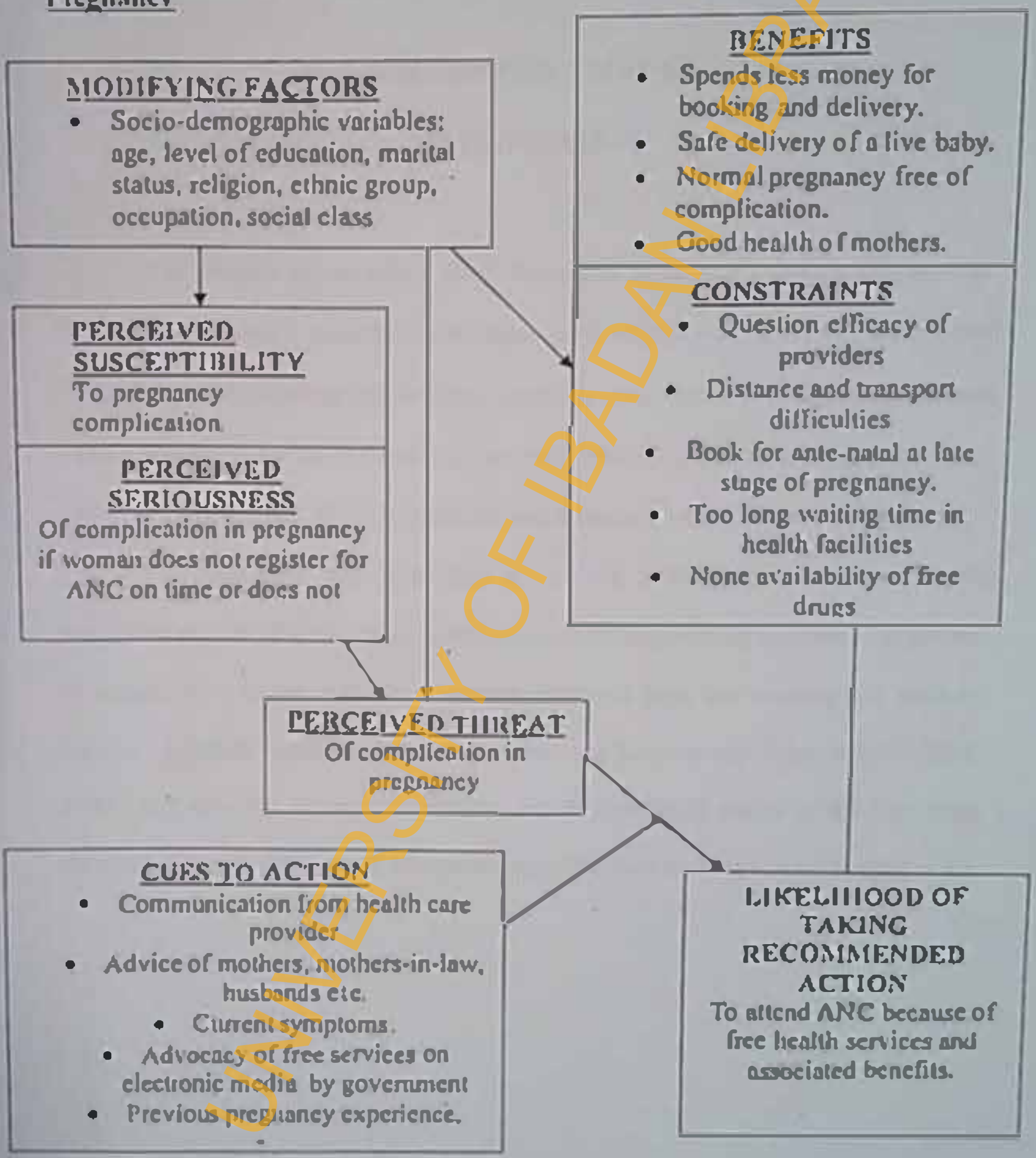
The aforementioned components of HBM are shown in figure 1. The susceptibility and severity in combination mobilize the individual to act, whereas the cost-benefit analysis provides the person with a preferred course of action. Although the individual is energized to act, the desired action may not occur unless a cue is present. Such cues may be internal (e.g. diseases symptoms) or external (e.g. mass media message, influence of others). Modifying factors are variables that may indirectly affect the likelihood of a self-protective act through their influence on one or more of the model component (Pretice-Dunn and Roger, 1986). The HBM provides a useful guide for choosing the points to emphasize in any communication process relating to the importance of perceived seriousness, susceptibility and preventability. It has some weaknesses in the sense that it does not consider social pressures from others in the family or community and ignores enabling factors (Hubley, 1993).

This model has been applied in this study to explain pregnant women's health promotive and preventive behaviours within the context of free health services. Their perceived susceptibility to complications in pregnancy and perceived seriousness of

complication has potential for enabling to take actions relating to visiting health care facilities for ANC. These behaviours could be reinforced by the influence of promotion of free health services by government on electronic media like radio and television to stimulate the utilization pattern of health services. Mothers usually evaluate the benefits and constraints of utilization and non-utilization of government free health services during pregnancy. They are therefore likely to choose whether to go to government health facilities or not, if they believe that the benefit of doing so outweighs the constraints. It is important that the mothers' perception and judgments on utilization of free health services be determined. The HBM was used as a guide for formulating questions in the instrument relating to the demographic characteristics of nursing mothers, their health seeking and health promoting activities during pregnancy, facilities respondents used during and after delivery and what services they received.

Figure I

Health Belief Model Applied to the Utilization of Health Services in Pregnancy



CHARPTER THREE

METHODOLOGY

The chapter begins with a brief description of the study design, followed by the scope of the study, variables in the study and description of the study area. It also includes study population and samples, sampling procedure and sample size, method and instruments for data collection, data collection process, data management and analysis, validity and reliability, ethical consideration and limitations of the study.

The researcher was interested in gaining a broad understanding of the perception and utilization of free health services among nursing mothers. The pattern of utilization of government facilities was obtained from the booking and delivery data in all public health centers in Igbo-Ora and Idere towns from 1996 to 2001, before and after the commencement of the new free health policy of the Oyo State Government (see tables 1 and 2 respectively). The data enabled the researcher to see

the trend of utilization pattern of the public health facilities before and after the commencement of the new free health policy i.e. whether the utilization pattern increased or decreased with the introduction of the health policy.

Description Of The Study Area

Igbo-Ora, the headquarters of Ibarapa Central Local Government Area (LGA) in Oyo State Nigeria, is situated on Longitude 71° 2' N and Latitude 30°4' E (Watson and Warcham, 1963). The community is located about 130km southwest of Ibadan, the Oyo State Capital and about 40km northwest of Abeokuta, the Ogun State Capital.

The type of soil in the area is lateritic, with cassava, maize and melon being the commonest food crops grown (Phelan, 1993). The community usually passes through three distinct seasons. These include a period of major rains from April through August, a season of minor rains from August through October, and a period of dry season, from November through March

The people of Ibarapa Central Local LGA belong primarily to the Yoruba ethnic group. They speak *Onko* dialect of Yoruba language Igbo-Ora consists of six cultural/historical wards with each having its traditional ruler known as *Baale*. The

Baale or Chief of Igbo-Ora is the officially recognized head of the entire community. Most of the community traditional chieftaincy titleholders and heads of extended families are elders. While a *'Baale'* is the head of the community and the trustee of the community lands the *'Bale'* is the head of the extended family compound *(Ile)* From east to west, these wards are: Igbole, Pako, Iberekodo, Idofin, Sagaun and Igbo-Ora. Two of them have further subdivisions, i.e Iberekodo ward has Ago-Oro, Ita-Baale and Pataoju as its subdivisions, while Igbo-Ora is subdivided into Oke-Iseri, Isale Oba, Isale Ogede and Oke Odo. The settlement pattern of Igbo-Ora is made up of 339 extended family housing clusters called compounds or *Agbole* in the local language (Adebayo, 1996) The whole LGA is comprised of 10 political wards of which Igbo-Ora town has seven. A sketch map of the town is seen in figure 2.

The predominant occupation of the people is peasant farming although artisans and petty traders also abound. Being a local government headquarters, Igbo-Ora offers its residents numerous public service employment opportunities such as teaching and health care. Igbo-Ora has 20 public primary schools, 4 private nursery/primary schools, 6 public secondary schools and one government technical college.

A variety of health care options are available. The local government runs three maternity centre/dispensary units located at Igbole and Sagamu. The Oyo State Ministry of Health, in collaboration with the College of Medicine, University of Ibadan, operates a general hospital at the western edge of the town. There are four private health care facilities, two of which offer in-patient care. Nearly 50 patent medicine shops are scattered throughout the community, as there are numerous indigenous health care providers.

Intra-town transportation is mainly by foot but there are motorcycle taxis, locally called *nibo-nibo*. Occasionally taxicabs are available for long distances across town. The distance from the new motor park at Igbole to the general hospital is 7km. Motorcars, buses and Lorries are used for inter-town transportation of goods and persons. Newspapers are occasionally circulated in the community, but the people rely mostly on battery operated radio sets for external news.

Electricity and pipe-borne water supply were installed in the community nearly 35 years ago. Pipe borne water supply has since stop while electricity supply is epileptic; the people therefore use kerosene lanterns for light, and firewood and kerosene stoves for cooking. Water is fetched from brooks and shallow wells many

of which go dry during the dry season. For this reason, guinea worm disease remains endemic in the area.

Most homes have no toilets and baths. Generally, bath stalls are constructed of corrugated iron sheets adjacent to the homes. Very few homes have flush water toilets, some use pit latrines, and while most dispose of human waste in unoccupied bushy plots of land within or surrounding the town.

Mosques, churches and shrines are located throughout the community as residents consist of Muslims, Christians and traditional African worshippers. Within the community, people of different faiths usually live in harmony. An extended family usually consists of members who belong to a variety of religious groups. Although there have been clashes over the years among adherents of different beliefs, the community elders and leaders usually take strong role in resolving such disputes.

Study Design

From the data collected, it was noted that the introduction of the new free health policy in 1999, has not significantly changed the pattern of utilization of

government health centers. It was then decided to undertake a cross-sectional descriptive study in the rural town of Igbo-Ora in Oyo State using a survey research approach to learn about perception and pattern of utilization of free health services.

Significance of the Study

This study is unique in that it identified those factors that promotes or inhibits the utilization of free health services in a totally free primary health care and subsidized secondary health care system. These findings will be communicated to the policy makers in the State Ministry of Health with a view to empowering them to appropriately channel their energy and resources to strengthening the free health initiative. The findings of this study will also serve as baseline information for designing advocacy interventions geared towards the formulation of policies for promoting the health of nursing mothers and their babies within the context of the free health programme of Oyo State.

Variables

The independent variables included age, religion, marital status, whether registered for ANC, educational status and occupation. The major dependent variables of interest were utilization of free primary health services including antenatal care, delivery and regular care. Other dependent variables included, where mothers registered for ANC, place of delivery, which advised mothers to use health facility and reasons for using such facility.

Intermediate factors that might influence utilization include level of knowledge about free health services, awareness of the services, perceptions of free health services and amount paid in health centers. Perceptions in this case include attitudes towards the services, beliefs about the quality of the services and perceived problems in utilizing the services.

Hypothesis

A number of hypotheses were formulated to facilitate a greater understanding of the pattern of utilization of health services among the mothers. These were that:

1. There will be no significant relationship between the type of health care facility used and stage of pregnancy.
2. There will be no significant relationship between the type of health care facility used and amount paid for ANC.
3. There will be no significant relationship between the health care facility where delivery took place and perceived health status.
4. There will be no significant relationship between health care facility used for ANC and social support received.
5. There will be no significant relationship between health care facility used for childbirth and social support received.
6. There will be no significant relationship between level of awareness of free health services and type of facility used for booking.
7. There will be no significant relationship between awareness of free health services and type of facility used for delivery.
8. There will be no significant relationship between type of facility used for ANC and respondents' socio-demographic characteristics.

Study Population And Sample

The target population consisted of women who had delivered babies in the years 2000 and 2001, after the introduction of the Free Health Care Policy of the Oyo State government. Nursing mothers were targeted because in any community, mothers and children constitute a priority group. The study covered nursing mothers who had been residing in the town since year 1999. Researchers have pegged the population of Igbo-Ora itself at 60,000 (Ososanya, 1993) and 65,917 (Adebayo, 1996). While there is much mobility among the general population between Igbo-Ora and nearby large cities (Brieger, 1984, Ososanya and Brieger, 1994) and between the town and surrounding farm hamlets (Brieger, Akpovi, Johnson and Adeniyi, 1982), it is likely that the people found at home are representative of the nursing mothers' population in town. The study relied on the abilities of nursing mothers to recall experiences relating to the utilization of services in the public health centers during ANC and delivery.

By virtue of their numbers and relative vulnerability to health problems, mothers and children constitute the major consumers of health services, of whatever form. From commonly accepted indices, it is evident that infant, child and maternal

mortality rates are high in many developing countries. Furthermore, much of the sicknesses and deaths among mothers and children are largely preventable. By improving the health of mothers and children, we will be contributing to the health of the general population. These considerations have led to the formulation of special health services for mothers and children all over the world including the study area.

The health of mothers and children still remains one of the most serious health problems affecting the community, particularly in the developing countries. The present strategy is to provide mother and child health services as an integrated package of "essential health care" also known as primary health care which is based on the principles of equity, intersectional coordination and community participation (Park, 1997; WHO/UNICEF, 1978)

Sampling Procedure and Sample Size

Igbo-Ora town has a total number of six wards namely: Igbole, which has 35 compounds, Pako, which has 43 compounds, Iberekodo, which is further subdivided into Ago- oro, which has 8 compounds, Ita Baale, which has 31 compounds and Patoo-oju, which has 51 compounds, Idofin has 26 compounds, Sagaun; 12

compounds and Igbo-Ora which is also subdivided into Oke Iseri; 62 compounds, Isale Obu; 31 compounds, Isale Ogede; 18 compounds and Oke odo; 22 compounds. The total number of compounds was 339. Effort was made to ensure representativeness of the whole town. Extended family compounds, which are 339 in number, served as sampling units. This implied that at least one woman was interviewed per extended family. In any large compound, two women were interviewed. One large compound each, was identified in Igbole, Pako, Idofin and Okeodo, and two large compounds were identified in Ita Baale,, Pata- oju, Oke Iseii and Isale Oba, so two women were interviewed in each of the houses.

Each family house was visited to identify all women who had delivered within the last two years preceding the study. The woman with the most recent baby was selected. This meant that a sample size of 351 respondents (women) was obtained as shown in table 3.

Methods and Instruments for Data Collection

Combinations of two methods (one qualitative and the other quantitative) were used to facilitate data collection. These were focus group discussions and semi-

structured interview. The instruments will be described in greater detail; one after the other.

FGD Guide:

A focus group discussion (FGD) guide was developed after a review of literature related to pattern of utilization of health services and factors influencing it. The FGD guide consisted of open-ended questions. The questions were used to probe into issues relating mothers practices during pregnancy, opinion about public health facilities, factors influencing utilization of health facilities, perception of nursing mothers about health facilities, opinion about free health services and recommendation on how to improve free health services.

The researcher followed guidelines requiring that the respondents must be demographically homogenous but must not be known to each other prior to the interview to allow free flow of information (Krueger, 1988). The guide was pretested through a FGD session in a neighboring town, Idere. This helped to familiarize the researcher, the observer and two recorders with their expected roles.

The FGD questions were translated into Yoruba, the language of the subjects. Back translation was done with a view to determining the accuracy of translation using translators who are fluent in both English and Yoruba. There was need to use the FGD to develop the semi-structured questionnaire for the survey compounds.

Questionnaire

The questionnaire was the quantitative instrument for this study. It was initially prepared in English language using local issues and concerns that emerged from the FGDs. It was later translated into Yoruba, after a review for content validity by the researcher's supervisor and experienced research assistants. The questionnaire was later back translated to English by another Yoruba language expert.

The questionnaire had a brief introduction wherein the interviewer sought to establish rapport with the interviewees, sought their consent, explained the purpose of the research and solicited for their support. The women were also screened to determine who was qualified to respond, as mothers of babies delivered in years 2000 and 2001 were required.

The questionnaire consisted of three sections namely Sections A, B, C. The first section (A) of the questionnaire consists of questions relating to the demographic characteristic of the respondents. Section B elicited information about the following, from the respondents; personal hygiene, what food they eat, routine drugs taken during ANC, immunization taken during ANC, exercise, social meetings attended, environmental hygiene, booking for ANC, use of concoction during pregnancy and so on. In Section B, questions were asked about the role played by the significant others. E.g. husbands, grandmothers, mother–in- laws, and sister etc in encouraging or discouraging the utilization of government free health service. Section C sought information on respondents' level of awareness of health services encountered in the utilization of government health facilities and suggestions to improve the free health policy.

Ten copies of the questionnaire were pre-tested on nursing mothers in Idere, a town about five kilometers from Igbo-Ora. Thus, the investigator had the opportunity of correcting any procedural problems that arose in the field.

Validity and Reliability

Validity is the extent to which an instrument actually measures what its suppose to measure (Davitz and Davits, 1997). Making sure that the variables generated from the FGD sessions were reflected during the development of the questionnaire ensured the validity of the items in the questionnaire. The validity of the questionnaire was also ensured by pretesting the instrument before final data administration in a different place from the study area.

Reliability is the degree to which an instrument yields consistent responses (Davitz and Davits, 1997). To achieve this, the researcher recruited experienced research assistants who had participated in this kind of survey previously and trained them specifically on both the FGD and questionnaire administration. Training of the interviewers was aimed at reducing inter-observer bias. FGD sessions helped provide more insight into the important issues of this research and to monitor the internal validity of the data generated through the questionnaire. The FGD guide was pre-tested in Idere. Necessary deletion, addition and corrections were made before the final guides used for the study were produced. Pre-testing of the questionnaire

assisted the researcher to make necessary modifications in terms of content and the time frame for completing an interview before the final production.

The researcher himself did conduct a number of interviews, and was therefore, in a good position when reviewing the questionnaires of others each day to detect anomalies and inconsistencies.

The interviewers, including the researcher, used the local language (Yoruba) throughout to ensure consistency and full understanding of the respondents, many of who were illiterate or semi-illiterate.

Data Collection Process

The qualitative and quantitative data collection processes will be described. The focus group discussion components of the study will be described first. The conduct of the focus group discussion preceded the survey. A team of four people consisting of the investigator who served as the moderator and three Research Assistants (RAS) conducted the discussions. The RAS were indigenes of Igbo- Ora community who have been involved in several research projects. They were all trained on the roles they were expected to play during the discussions. One of the

assistants served as the observer while the other two served as recorders. A tape recorder was used to complement the efforts of the recorders who were involved in writing down the proceedings. The discussants were recruited with the assistance of the community leaders who were properly briefed about the purpose of the study. Dates, time and venue for the conduct of the FGDs were agreed upon after consulting the women in the community. The FGDs were conducted in places, which were free of distractions. There were between 5 and 7 participants in each of the groups.

The moderator started by introducing himself and the RAS, made the purpose of the FGD known to the women, assured them of confidentiality of their responses and encouraged them to be free, well relaxed and ready to express their opinions. The importance and need to use a tape recorder was also explained to them. It was only used after approval by the discussants. Four FGDs were conducted at different locations in the town in the early evenings and an appropriate time was chosen for each session. Each discussion lasted between 30 and 45 minutes. Refreshments were served in accordance to the wishes of the women during the discussions to ensure free flow of conversation and relaxation.

After each FGD, the notes taken by the recorders were merged with a view to coming up with one report. The recorded tapes were played back and the investigator carefully wrote down their contents. The transcribing of each FGD was done the day it was conducted. The notes taken by the research assistants and information obtained from the tapes were merged with a view to coming up with one FGD report.

A description of the data collection process regarding the survey component of the study now follows: Five trained RAS and the investigator himself, making a total number of 6, administered the questionnaires. The investigator acted as the supervisor while one person was chosen among the RAS to act as Assistant Supervisor. A local community resident was recruited to act as scout in the community. The research team then moved from compound to compound interviewing identified eligible respondents who were women who had delivered babies in the years 2000 and 2001. The women with the most recent delivery were then selected until the required number of respondents was reached. Informed consent was obtained from the interviewees after proper explanation of the purpose of the interview. Interviewer-administered questionnaires were used. The women

were interviewed in their homes. Each RA completed an average of 5 questionnaires a day and the exercise lasted a period of 12 days. The researcher made sure that all the questions were well answered and submitted to him on daily basis. A total of 351 respondents were interviewed across the whole.

Data Management and Analysis

At the end of each FGD, the two recorders compared their notes and produced one transcript of the session. The moderator who is the researcher ensured that they faithfully reflected the proceedings of the discussions. The researcher then reviewed the four transcripts for similarities and differences in content among nursing mothers. Text Base Beta was used to code and sort the FGD transcript.

The administered questionnaire were sorted and coded manually by the researcher. They were then entered into the computer using the EPI INFO 6.1 software package developed by the U.S. Centre for Diseases Control and Prevention (CDCP). Basic frequencies were first generated, from which frequency tables and charts were developed. EPI INFO was also used for data analysis using primarily Analysis of Variance.

Ethical Consideration

On reaching any house selected during data collection, the interviewers introduced themselves and stated the purpose of the study. Consent of all women to participate in the study was sought. Any one who was not interested in the research work was left alone. Participants were assured that information volunteered by them would be kept secret. Their consent was also obtained before a tape recorder was used. Only verbal consent was sought.

Limitations Of The Study

Surveys are usually characterized with limitations. This study was limited by the high mobility of the Igbo-Ora people especially women (Brieger, 1984; Ososanya and Brieger, 1994). This fact was verified during pretesting. The women left at home, in all likelihood, represented the relatively stable residents of the community who could provide needed valid information about health services utilization patterns in Igbo-Ora.

Similarly, response bias associated with under-rating or over-rating of perception of free health services may pose a risk to the quality of the data in terms of their generalizability. Recall bias is another potential source of error. Fortunately, most of the items focused on current knowledge about free health services, problems faced during utilization of free health serviees, and assessments of free health services. It is not unlikely for some of the respondents to deliberately provide incorrect information about themselves. There was no way of verifying the authenticity of information volunteered by the respondents. So the investigator had to rely only on whatever the subjects reported. This is usually a major limitation of most survey researches involving interviews.

Table 1

Booking Pattern in Primary Health Centers before and after the Commencement of Free Health Services in 1999

Facilities	Before FHS				After FHS	
	1996	1997	1998	1999	2000	2001
Igbole MC	240	261	220	88	203	195
Oke Agogo MC	527	718	527	546	246	543
Idere HC	178	304	301	310	264	246
Igbo-Ora GH	67	99	129	133	109	196
Oke-Odo MC	0	0	80	191	198	13
Total	1012	1382	1257	1268	1020	1193

FHS - Free Health Services

MC - Maternity Centres

HC - Health Centres

GH - General Hospitals

Table 2

Delivery Pattern in PHC before and after the commencement of FHS in 1999

Facilities	Before FHS				After FHS	
	1996	1997	1998	1999	2000	2001
Igbole MC	196	232	190	178	152	147
Oke Agogo MC	449	566	405	468	397	404
Idere HC	209	227	221	244	201	174
Igbo-Ora GH	96	72	125	123	107	127
Oke-Odo MC	176	183	136	147	156	158
Total	1126	1280	1077	1160	1013	1010

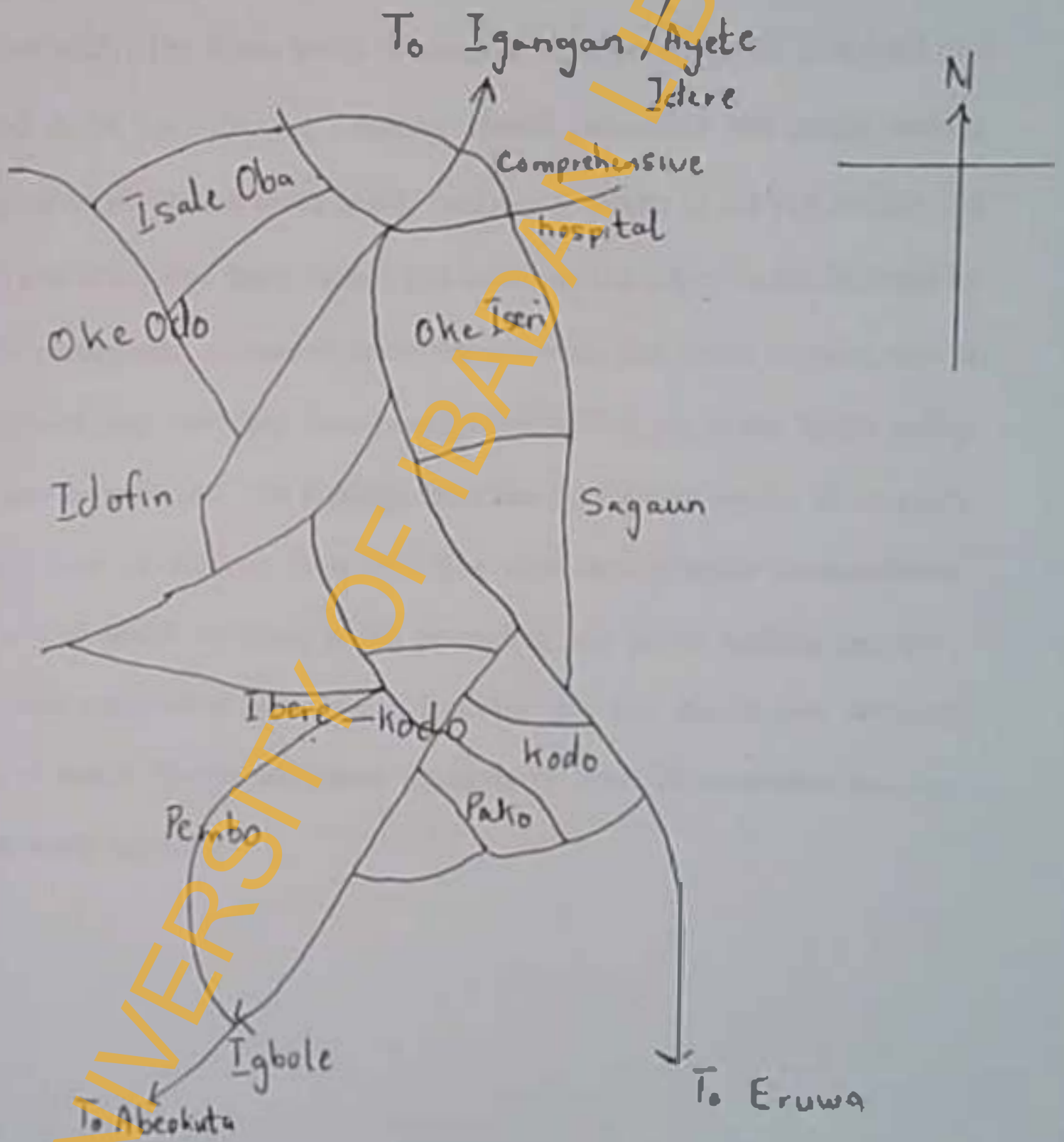
FHS - Free Health Services
MC - Maternity Centres
HC - Health Centres
GH - General Hospitals

Table 3

The Summary of the Sampling Process

Ward/Subdivision	No of compounds	No of women selected
Igbole	35	36
Pako	43	44
Iberekodo		
Ago-oro	8	8
Ita Baale	31	33
Pata- Oju	51	53
Idofin	26	27
Sagaun	12	12
Igbo-Ora		
Oke Iseri	62	64
Isale Oba	31	33
Isale Ogede	18	18
Oke Odo	22	23
Total	339	351

Figure 2: Sketch Map of Igbo-Ora Town



CHAPTER FOUR

RESULTS

This chapter presents the qualitative (FGD) and quantitative (Survey) findings of the study. The focus group discussion findings which are presented first are organized under the following sections: Health promoting and health seeking practices; opinions of women about health facilities available in the community and types of services obtainable there; factors that influence the use of health facilities by women in the community; awareness of women about the free health services, how it is being practiced and what they have benefited; effectiveness of the health policy and how it can be modified. The findings from the quantitative aspect of the study are organized into six sections as follow. The socio-demographic characteristics; awareness of free health services; health promoting and health seeking practices; perceptions and experiences with health facilities and free health care services; comparison of health facility utilization practices by level of awareness and key socio-demographic variables.

Findings from the Focus Group Discussion

Health Promoting and Health seeking practices:

During the FGD, discussants mentioned lots of activities they engaged in so as to stay healthy during pregnancy. They reportedly ate nutritious food and fruits that will make the fetus develop. Such food and fruits are *beans, fish, amala, egg, meat, snail, vegetables, pap, moin-moin, plantain, ekara oranges, paw-paw, banana and mangoes*. Most of the discussants also reported that they went to health facilities during pregnancy for medical examination, received drugs, injections and vaccines. Few of the discussants disclosed that they took *agunmu, agbo* and any other concoction with the routine drugs given to them in hospitals in order to stay healthy. Very few said they did not take routine drugs at all but *agunmu, agbo* and native rings given to them by their father-in-laws. Majority of them reported that they had stopped taking *agbo* and *agunmu* but only took routine drugs given in hospitals. Very few also took routine drugs with *agbo* and *agunmu*. Discussants also mentioned that they did lots of exercises to keep their "babies kicking".The exercises they participated in included, sweeping their houses and the immediate environment.

washing clothes, fetching water from borehole, pounding "*eluba*", singing and dancing to keep the foetus kicking in the stomach, tidying up the house, sale of petty things or hawk around the neighborhood in other to keep their babies alive.

Opinion of Women about Health Facilities in the Community and types of services obtainable:

Discussants mentioned that they visited maternity centers, private clinics, traditional healers, traditional birth attendants and faith healers during pregnancy. Majority of the discussants reported that they had decided not to go to TBAs and traditional healers again because every woman was becoming enlightened and educated in the community. Many said, "The *ogbo* or *agunmu* from traditional healers would give problems to our babies". Very few of the discussants still insisted on the use of *agunmu ooyi*, which was given to them by their father-in-laws. Very few reported the wearing of native rings, which they claimed, made women strong. Few mentioned the use of *agbo irobi agbo kokoro*, and black soap for bathing so as to stay healthy. Majority of the discussants believed that women that went to traditional healers during pregnancy were the ones with serious deadly diseases

Majority of discussant went to government health facilities during pregnancy. Majority also went for booking at the seventh month, because they 'believed' they were healthy and there was no problem with their fetus. Many mentioned that it is people that had one problem or the other that would go earlier to book for ANC.

Many respondents reported that during their visits to health facilities, health workers gave routine drugs like vitamin B-Complex tablets, Sunday-Sunday tablets (a malaria chemoprophylactic), ferrous tablets, Chloroquine tablets and Paracetamol tablets. They mentioned that they paid an average of ₦300 for drugs and injections in public health facilities. Few of the discussants preferred the use of private clinics to government hospitals because they were not satisfied with the services rendered at the government hospitals. They disclosed that at the private clinics, health workers attended to them on time but fees paid in private clinics were more. Very few of the discussants who used private clinic before stated that private clinics rendered better quality health services than government health facilities.

Very few respondents visited only churches for prayers for divine intervention during delivery. Majority of discussants maintained that staying healthy during pregnancy was important to them regardless of where they sought it. Majority

of them disclosed that they sought divine intervention from the faith healers and at the same time attended government hospitals. Majority reported, "Prayers work with drugs."

Factors that influence the use of health facilities:

Many discussants mentioned that they decided on what facility to attend during pregnancy by listening to advise given to them by husbands, father-in-law, mother-in-law, neighbours, friends and by attending what facility majority of community members attended. Other factors reported by many discussants included: nearness to their homes, nearness to their places of work, cost of receiving the services, relationship of health workers with patients, presence of qualified personnel at health facilities, presence of health workers at their duty post. Majority of the discussants disclosed that they visited a particular health facility because of the availability of drugs at pharmacy department, availability of vaccines, availability of cards for consultation and writing materials. Very few discussants reported that they utilized the public health facilities because of the free health services provided by the

state government. Very few discussants disclosed that they had never visited either public or private clinics. They gave no reasons for this.

Awareness About Free Health Services:

Majority of respondents reported they heard about Oyo State Free Health Services on radio, public address system, from husbands, neighbours and friends. Very few heard it from health workers and their children. Respondents remarked that despite the free primary health care, they paid money at the public health facilities for services received. Services they paid for included ANC, delivery, immunization and booking. The amount of money they paid varies in different facilities. Very few respondents disclosed that they received routine drugs and immunization free on very rare occasions. They explained further that free drugs and free immunization were not always available at health facilities because health workers were not allowed to collect unofficial fee at government health facilities as they used to do before the commencement of the free health policy. Many also reported that since no money was collected in the public health facilities, there were no drugs or vaccines available. In addition to the money paid for services that were supposed to be free at the public health facilities, respondents mentioned that health workers requested for some items for delivery before admission was made. The items listed are contained in table 4.

Table 4: Items usually submitted by expectant mothers to health facilities before admission for delivery

Items	Quantity
Dettol	1 bottle
Kerosine	1 bottle
Cotton wool	Sufficient quantity
Detergent	1 packet
Razor blade	1
Spirit	1 bottle
Surgical glove	2 pairs
Needle and syringes	2
Olive oil	1 bottle

Respondents also reported the drugs that they had ever received free in public health facilities. The drugs included the tablets form of the following: paracetamol, chloroquine, ferrous sulphate, mullivitamins, folic acid, sunday-sunday medicine and vitamin C.

Many respondents disclosed that drugs and vaccines were not always available at the pharmacy department of public health facilities. A majority also reported that there were availability of drugs during the early period of implementation of the programme but were not always available during the later period.

Effectiveness of the Free Health Policy:

Discussants were asked how effective the free health policy was. Majority mentioned that the programme was not a success at all while very few reported it was a success. All discussants disclosed that the programme was not properly implemented because health workers still demanded for money to be paid at health facilities before patients could receive adequate treatment and there was no adequate

supply of drugs to government health facility. Very few mentioned that the programme was good and very few also reported that they could not assess the effectiveness of the programme.

Respondents were asked if the free health services motivated their use of public health facilities. Many respondents reported that the policy did not change their frequency of use of the public health facilities. Majority of the discussants mentioned that despite the free health policy, the utilization pattern of public health facilities did not increase at all, compared with when no service was free in health facilities.

Opinion of discussants was sought on the aspect of the programme that needed modification. Majority suggested that the supply of drugs and vaccines should be increased and that there should be no payment made at all if health services at the PHC are indeed totally free. Few discussants suggested that government should stop false propaganda relating to the provision of free health care whereas it is not being implemented to the last letter. Few discussants suggested the

supply of drugs to government health facility. Very few mentioned that the programme was good and very few also reported that they could not assess the effectiveness of the programme.

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recruitment of qualified and enough number of health workers. Few discussants also wanted improved remuneration and conditions of service for health workers. Very few discussant wanted government to adequately maintain clean and conducive environment.

The Survey Results

The survey component of this study involves a total of 351 nursing mothers who had delivered babies in the years 2000 and 2001.

The Socio – Demographic Characteristics of Respondents

Table 5 shows the socio-demographic characteristics of the respondents. The ages of respandents ranged from 18-50years with a mean of 27.5 (SD+ 6.38). Majority of the women, 197(56.1%), were engaged in petty trading as a primary means of livelihood. Other occupations the women engaged in were artisan, 87(24.8%); farming, 15(4.3%); ward aids, 10(2.8%); professional (teachers), 8(2.3%); clerical duties, 2(0.6%); and students, 1 (0.3%). Only 31 (8.8%) of the mothers were full time housewives.

The husbands of 232 (66.1%) of the women were married to only one wife, while the husbands of 105(29.9%) women were married to other wife/wives. Seven (2.0%) of the women were single; 5(1.4%) were divorced and only 2(0.6%) were widowed. Slightly less than 170 (48.4%) of the mothers had primary school education; 75 (21.4%) had no education; 50 (14.2%) of the women had junior secondary education; 46(13.1%) had senior secondary education; 9(2.6%) had post secondary education which included University and Polytechnic and one (0.3%) had a post graduate degree.

The religions commonly practiced by respondents are Islam, 241(68.7%) and Christianity, 107 (30.5%). Only 3 (0.9%) respondents were adherents of traditional African religion. Three hundred and forty-one (97.2%) of the respondents were Yorubas; 3(0.9%) were Fulanis; 2(0.6%) were Igbos; 2(0.6%) were Sabes; 2(0.9%) were Togolese (Non Nigerians) and one (0.3%) respondent was a Hausa woman.

Awareness of Free Health Service

Information was sought from the respondents on whether they were aware that services were totally free at the PHC. Three hundred and twenty (91.2%) of the

respondents mentioned that they knew immunization was free; 16(4.6%) said they were not aware and 15(4.3%) reported that they were not sure immunization was free. Two hundred and thirty two (66.1%) disclosed that they knew examination by doctors was free; 63(17.9%) responded they never knew and 56(16.0%) were not sure it was free. A total number 230 (65.5%) knew ANC was free; 79 (22.5%) were not aware it was free and 42(12.0%) were not sure. Two hundred and seventeen (61.8%) knew cards collection was free; 90(25.6%) never knew and 44 (12.5%) were not sure. One hundred and ninety (54.1%) knew there were free drugs in health centers; 115(32.8%) never knew and 46(13.1%) were not sure. (See table 6 for details).

Table 7 shows that a majority, 159 (60.9%) of the respondents had heard about free health services from health workers and 69(26.4%) heard about it on radio. Twenty nine (11.1%) heard of it on public address system, 23(8.8%) respondents heard about it from friends and 20(7.7%) from neighbours. Twelve (4.6%) respondents reported they heard from husbands. 5(1.9%) on televisions, 4(1.5%) respondents mentioned they heard from churches and town criers

respectively, 2(0.8%) heard about it from politicians, 2 (0.8%) heard from community members and 1(0.4%) respondent heard about it from school children.

Table 4: Socio-Demographic Characteristics of Respondents. N=351

Age group	
15 -19	12 (3.4)
20 – 24	101 (28.8)
25 – 29	106 (30.2)
30 – 34	87 (24.9)
35 – 39	31 (8.8)
40 – 44	11 (3.2)
45 – 50	3 (0.9)
Occupation	
Petty trading	197 (56.1)
Artisan	87 (24.8)
Full House Wife	31 (8.8)
Farmer	15 (4.3)
Ward aid	10 (2.8)
Professional	8 (2.3)
Clerical	2 (0.6)
Students	1 (0.3)
Marital Status and type of marriage	
Husband married to me alone	232 (66.1)
Husband married to me and other wife/wives	105 (29.9)
Not married	7 (2.0)
Divorced	5 (1.4)
Widowed	2 (0.6)
Level of Education	
Primary	170 (48.4)
None	75 (21.4)
JSS/Modern	50 (14.2)
SSS	46 (13.1)
Post Secondary	9(2.6)
Post graduate	1 (0.3)
Religion	
Islam	241 (68.7)
Christianity	107 (30.5)
Traditional religion	3 (0.9)
Ethnic Group/Nationality	
Yoruba	341 (97.2)
Fulani	3 (0.9)
Igbo	2 (0.6)
Sabe	2 (0.6)
Togolese	2 (0.6)
Hausa	2 (0.6)
Mean age = 27.464years	Age range = 18-50years

Table 6: Respondents level of awareness about health services that were free:

N=351

Services	Aware No (%)	Not Aware No (%)	Unsure No (%)
Antenatal Clinic (ANC)	230 (65.5)	79 (22.5)	42 (12.0)
Delivery	80 (22.8)	220 (62.7)	51 (14.5)
Drugs	190 (54.1)	115 (32.8)	46 (13.1)
Treatment of minor ailment	140 (39.9)	119 (33.9)	92 (26.2)
Examination by doctors	232(66.1)	63 (17.9)	56 (16.0)
Admission of pregnant women for delivery	109 (31.1)	118 (33.6)	124 (35.3)
Immunization	320 (91.1)	16 (4.6)	15 (4.3)
Card	217 (61.8)	90 (25.6)	44 (12.5)

Table 7: Sources of Information about Free Health Services

N=261

Sources of Information	No* (%)
Health Workers	159 (60.9)
Radio	69 (26.4)
Public address system	29 (11.1)
Friends	23 (8.8)
Neighbours	20 (7.7)
Husbands	12 (4.6)
Televisions	5 (1.9)
Churches	4 (1.5)
Town crier	4 (1.5)
Politicians	2 (0.8)
In the town	2 (0.8)
School Children	1 (0.4)

- Multiple responses included

Health Promoting and Health Seeking Practices

The reported health promoting practices among respondent are shown in table 8. Three hundred and thirty two respondents (94.6%) mentioned that they ate nutritious food to stay healthy during pregnancy. Other health promoting and health seeking activities they reported included taking routine drugs and vaccines, 313 (89.1%); observation of good food hygiene, 291 (82.9%); going for booking and ANC, 284 (80.9%); relaxation, 282 (80.3%); doing domestic works, 264 (75.2%); have romantic play with husbands, 245(69.8%); took herbal concoction, 209(59.6%); keep body clean, 195(55.5%); and attending association's meetings and social functions, 156(44.5%). Only 40(11.4%) respondents disclosed they wore native rings during pregnancy to stay healthy.

In order to stay healthy during pregnancy, respondents were requested to use a particular facility or might decide on their own to use a particular facility. Majority of respondents, 158(45.0%), decided to go to maternity centers on their own; 104 (29.6%) respondents reported that their husbands mandated them to use government health facility they visited during pregnancy. Eighteen (5.1%) women took to the instruction of their mother-in-laws; 15(4.3%) were advised by their father-in-law.

11(3.1%) respondents mentioned that their neighbours introduced them to the maternity center they used and 23(6.6%) could not decide who advised them to use maternity center.

For Igbo-Ora General Hospital (IGH), 169 (48.1%) of the respondents decided they could use the facility on their own; 77(21.9%) were instructed to use IGH by their husbands and 12(3.4%) respondents were introduced to it by their mother-in-laws. Fourteen (4.0%) women were advised to use IGH by their father-in-laws; 7(2.0%) were requested by their mothers; 6(1.7%) were advised by their fathers and 4(1.1%) by their neighbours. Six (1.7%) respondents could not decide who requested them to use IGH (See table 9 for details).

Information was sought on reported reasons why respondents used the free health services during previous pregnancy. Their responses are presented in table 10. One hundred and twenty seven (54.3%) respondents disclosed that they used the services because it was nearer to their homes; 41(7.5%) reported that drugs were purchased at reduced cost at government health facilities; 32(13.7%) said the health workers' cordial relationship and services with patients made them go there; 18(7.7%) acted on the advice of others; 12(5.1%) reported that their husbands or

relatives could not afford the cost of using private health facilities and 4(1.7%) mentioned they went to public health facilities because of government's campaign on radio and television on the need to use free health services.

Respondents were interviewed on the types of health facilities they patronized and the type of health services received during ANC. Majority of the respondents went to maternity homes and received services such as; booking, 250(71.2%); ANC, 249 (70.9%); immunization, 250 (71.2%); collection of cards, 248 (70.7%); medical examination, 247 (70.4%); blood/urine test, 245(69.8%) and delivery, 206(58.7%). Those who patronised IGH received the following services: ANC, 24(6.8%) respondents; booking, 24(6.8%); immunization, 24(6.8%); routine drugs, 24(6.8%); collection of cards, 25(7.1%); medical examination, 24(6.8%); blood/urine test, 24(6.8%); and delivery, 17(4.8%). Other health facilities patronized included private clinics and the services received at the private clinics were: booking 64(18.2%); ANC, 61(17.4%) TBAs: booking, 7(2.0%); ANC, 5(1.4%); delivery, 4(1.1%); spiritualist: booking, 9(2.6%); delivery, 13(3.7%); others: delivery, 17(4.8%). (See table 11 for details).

Respondents were asked about the set of free health services they had benefited from (See table 12). The services listed included: Immunization, 261 (74.4%); treatment of minor ailment and diseases, 125(35.6%); free drugs including routine drugs, 93(26.5%); examination by doctors, 77(21.9%); collection of cards, 71(20.3%); ANC, 61 (17.4%); delivery, 15(4.3%) and admission for delivery, 12(3.4%).

It was found that there was a significant relationship between the types of facility used and period they went for booking. The result of the testing of the hypothesis that states that 'there will be no significant relationship between the type of health care facility used and stage of pregnancy' are presented in table 13.

Information about respondents' places of last delivery was obtained. More than half, 206 (58.7%) reportedly gave birth in maternity homes. Other places of delivery were private hospitals, 90(25.6%); IGH, 17(4.8%); home, 17(4.8%); churches, 13(3.7%); TBAhome, 4(1.1%); herbalist home, 4(1.1%). (See figure 3).

Table 8: Health Promoting Practices among Respondents

N=351

Health Promoting Practices	Spontaneous No (%)	After Probe No (%)	Total No (%)
Eat nutritious food	212 (60.4)	120 (34.2)	332 (94.6)
Take routine drugs and vaccines	136 (38.7)	177 (50.4)	313 (89.1)
Observe good food hygiene	168 (47.9)	123 (35.0)	291 (82.9)
Go for booking and ANC	99 (28.2)	185 (52.7)	284 (80.9)
Rest/Relax	59 (16.8)	223 (63.5)	282 (80.3)
Do domestic work	80 (22.8)	184 (52.4)	264 (75.2)
Have romantic play with husbands	41 (11.7)	204 (58.1)	245 (69.8)
Took herbal concoction	61 (17.4)	148 (42.2)	209 (59.6)
Keep my body clean	63 (17.9)	132 (37.6)	195 (55.5)
Attend organization meeting /social functions	15 (4.3)	141 (40.1)	156 (44.4)
Use black soap to bath	31 (8.8)	120 (34.2)	151 (43.0)
Carry out environmental hygiene and related activities	30 (8.5)	103 (29.3)	133 (37.8)
Exercise	18 (5.1)	99 (28.2)	117 (33.3)
Attend religious meetings	10 (2.8)	81 (23.1)	91 (25.9)
Wear native rings	3 (0.9)	37 (10.5)	40 (11.4)

Table 9: Health Facilities Respondents were requested to be using

N=351

Adviser	Facilities advised to be using**					
	Maternity center No (%)	IGH* No (%)	Private clinics No (%)	Herbalist house No (%)	Spiritualist House No (%)	*** TBAs House No (%)
Self	158 (45.0)	169(48.1)	176 (50.1)	145 (47.0)	165 (47.0)	178 (50.7)
Husband	104 (29.6)	77 (21.9)	88 (25.1)	95 (27.1)	95 (27.1)	82 (23.4)
Mother-in-law	18 (5.1)	12 (3.4)	15 (4.3)	12 (3.4)	11 (3.1)	10 (2.8)
Father-in-law	15 (4.3)	14 (4.0)	8 (2.3)	26 (7.4)	9 (2.6)	9 (2.6)
Health workers	3 (0.9)	2 (0.6)	3 (0.9)	1 (0.3)	0	0
Neighbours	11 (3.1)	4 (1.1)	2 (0.6)	2 (0.6)	2 (0.6)	2 (0.6)
Brothers/sisters	0	1 (0.3)	2 (0.6)	2 (0.6)	4 (1.1)	1 (0.3)
Mother	9 (2.9)	7 (2.0)	7 (2.0)	7 (2.0)	5 (1.4)	5 (1.4)
Father	6 (1.7)	6 (1.7)	2 (0.6)	4 (1.1)	2 (0.6)	2 (0.6)
Sister-in-law	1 (0.3)	2 (0.6)	2 (0.6)	2 (0.6)	1 (0.3)	1 (0.3)
Family choice	0	1 (0.3)	1 (0.3)	0	0	0
Elder/eldest wife	3 (0.9)	0	1 (0.3)	0	0	0
Undecided who requested	23 (6.6)	6 (1.7)	44 (12.5)	55 (15.7)	57 (16.2)	16 (4.6)

- Igbo Ora General Hospital
- Multiple responses
- Traditional Birth Attendants

Table 10: Reported Reasons for using Free Health Facilities during previous Pregnancy

N=234

Reported Reasons	No (%)
Proximity to my home	127 (54.3)
Reduced cost of drugs	41 (17.5)
Health workers' cordial relationship	32 (13.7)
Advice of others	18 (7.7)
My husband/relatives cannot afford other private health facilities	12 (5.1)
I heard it on radio/television	4 (1.7)

Table 11: Types of health Facilities patronized and services received during ANC

N=351

Type of health facilities	Services received							
	Booking	ANC	Immunization	**Routine drugs	Collection of cards	Medical Examination	Blood/urine test	Delivery
Maternity homes	250 (71.2)	249 (70.9)	250 (71.2)	247(70.4)	248 (70.7)	247 (70.4)	245 (69.8)	206 (58.7)
IGH*	24 (6.8)	24 (6.8)	24 (6.8)	24 (6.8)	25 (7.1)	24 (6.8)	24 (6.8)	17(4.8)
Private clinics	64 (18.2)	61 (17.4)	57 (16.2)	60 (17.1)	61 (17.4)	63 (17.9)	59 (16.8)	90(25.6)
TBAs	7 (2.0)	5 (1.4)	3 (0.6)	2 (0.6)	5 (1.4)	3 (0.9)	3 (0.9)	4 (1.1)
Spiritualist	9 (2.6)	7 (2.0)	5 (1.4)	5 (1.4)	4 (1.1)	7 (2.0)	7 (2.0)	13 (3.7)
Others***	1 (0.3)	0	1(0.3)	0	0	0	0	17 (4.8)

* Igbo Ora General Hospital

** B. Complex tablet, Folic acid tablet, Multivitamin tablet, Darapsim tablets, Paracetamol tablets, Ferrous sulphate tablet

*** Homes

Table 12: Free Health Services Respondents received

N=351

Services*	No (%)
Immunization	261(74.4)
Treatment	125(35.6)
Free drugs	93(26.5)
Examination by doctors	77(21.9)
Cards	71 (20.3)
Antenatal clinics (ANC)	61(17.4)
Delivery	15 (4.3)
Admission for delivery	12 (3.4)

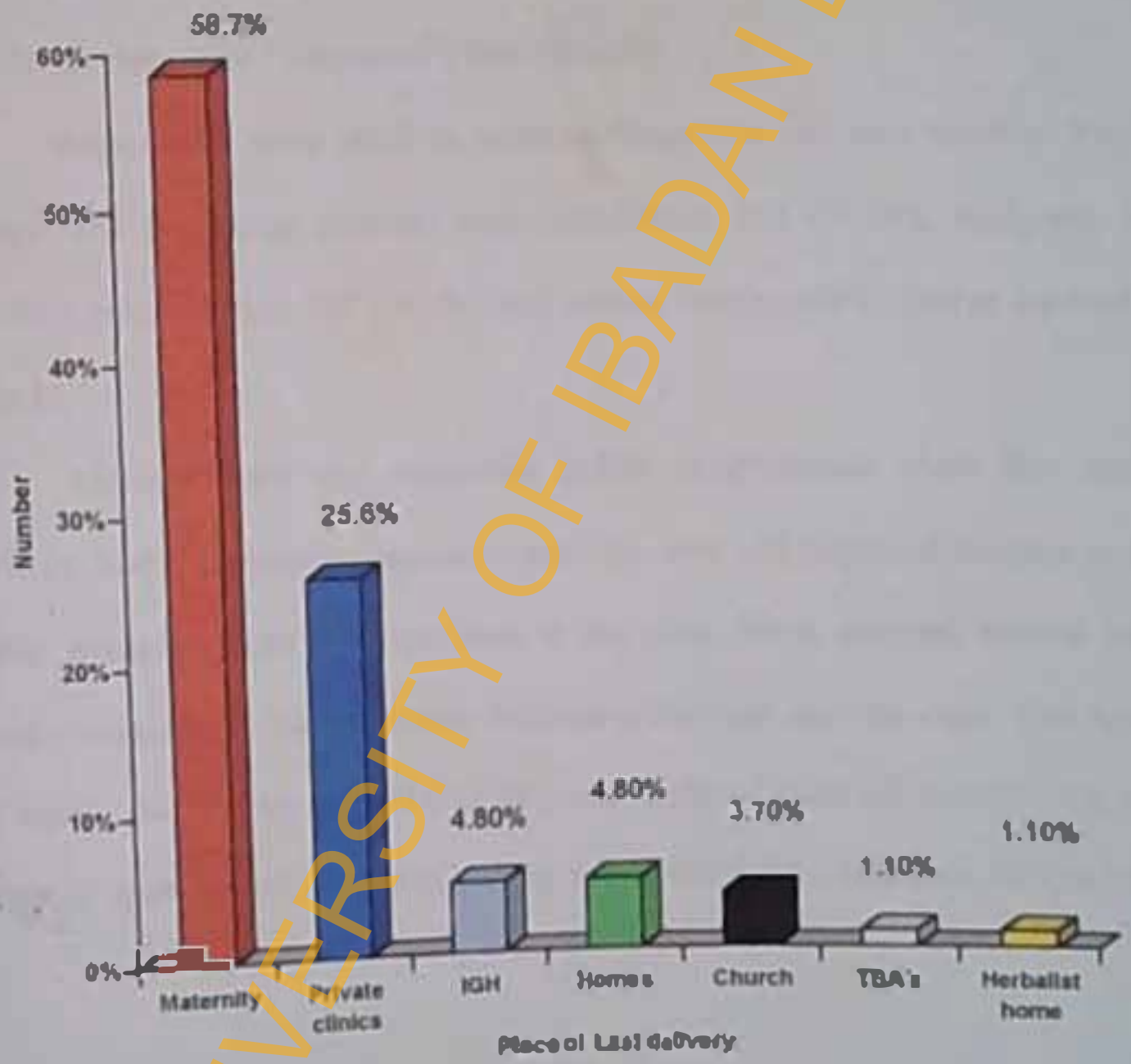
- Multiple responses included

Table 13: Health Facilities used by Stage of Pregnancy

	Stage of Pregnancy			
Type of facility used	1st trimester No (%)	2nd trimester No (%)	3rd trimester No (%)	Total
Public health facility	6 (2.3)	131 (49.2)	129 (48.5)	266
Other Facilities	7 (9.0)	44 (56.4)	27 (34.6)	78

X2 = 10.38 df = 2, p-value= 0.005

Figure 3: Health facilities reportedly used for delivery during previous pregnancy



Perceptions and Experiences with Health Facilities and Free Health Care Services

The respondents were requested to comment on the quality of free health services received by them. Slightly more than half, 182 (51.9%) rated the free health care services as "not good"; 94(26.8%) stated that the services were "good"; 12(3.4%) reported they did not know how to assess it and only three (0.9%) reported that the services were "very good"; (See table 14).

Respondents were asked to mention drugs they had ever received free of charge. The free drugs received were haematinics, 202 (57.5%); analgesic, 192 (54.7%); multivitamins, 190 (54.1%); and malaria tablets, 145(41.3%) as reported in table 15.

Although there was aggressive public enlightenment about free health services, health consumers (expectant mothers) were still requested to come to the public health facilities with one item or the other. Items pregnant women were usually requested to bring to health facilities to facilitate delivery were: One bottle of dettol, 254(72.3%); pad, 254(72.3%); one bottle of olive oil, 253(71.1%); one bottle of spirit, 248(70.7%); one bathing soap, 244(69.5%); detergent, 227(64.7%);

one bottle of kerosene, 218 (62.1%) and needle and syringe, 65(18.5%). (See details in table 16).

Information was sought about the opinion of respondents about the free health services. A majority of respondents. 218(62.1%) disclosed that health workers performed their duties very well. Forty-one (11.7%) reported that the services rendered before the commencement of the free health services and during the implementation of the policy programme were not remarkably different while only 34(9.6%) mentioned that the services rendered were well organized. Another thing reported by the respondents was that they received free drugs and vaccines, 12(3.4%). Ten (2.9%) respondents acknowledged that health facilities were dirty and needed repair. Other details about the opinions of respondents are contained in table 17.

Problems respondents encountered during their last visit to the public health facilities were mentioned (see table 18). Some of the respondents, 43(25.6%) stated that free drugs were not enough at health facilities; Thirty-nine (23.2%) responded that health workers were not always on duty; 24(14.3%) reported the too long waiting time of patients and 18(10.7%) disclosed there were inadequacy of health

equipments and personnels. Fourteen (8.3%) mentioned that health centers were dirty and in a state of collapse and only one (0.6%) respondent responded that there were no writing materials to be used by health workers in hospitals.

Information was sought from respondents on the amount of money paid for receiving different services at different health facilities. The average amount paid in government maternity center for delivery was N 499.40; N 220.78 for booking; N 12.06 for routine drugs; N 7.39 for obtaining a card and N 7.07 for ANC. Other amount paid for different services were urine/blood test, N 6.93; immunization, N 3.38; and medical examination, N 1.84.

In IGH, the mean amount paid for booking was N 187.50; N 162.35 for delivery; N 32.08 for urine/blood test; N 11.66 for immunization and N 7.91 for ANC. The mean amount paid in private hospitals was N 1400.53 for delivery, N 366.8 for booking and N 31.80 for ANC (Details are shown in table 19).

A comparison of the mean amount paid for ANC with type of facility used indicated no significant relationship was established. The results of the testing of the hypothesis which states that "there will be no significant relationship between the type of health care facility used and amount paid for ANC are prescated in table 20

Table 21 shows that no significant relationship was established between problems perceived by respondents with type of health facility used for delivery. The results of the testing of the hypothesis which states that "there will be no significant relationship between the type of health care facility used for delivery and perceived health status showed this.

Table 14: Respondents Perception of Quality of Free Health Services

N=351

Perception of Quality	No (%)
Not good	182 (51.9)
Not good at all	94 (26.8)
Good	60 (17.0)
Don't know	12 (3.4)
Very Good	3 (0.9)
Total	351 (100)

Table 15: Drugs Received free of Charge at Health Facilities

N=351

Types of Drug*****	No (%)
Haematinics*	202 (57.5)
Analgesics**	192 (54.7)
Multivitamins***	190 (54.1)
Malaria tablets******	145 (41.3)
Others****	121 (34.4)

* Folic acid, ferrous sulphate tablets

** Paracetamol tablets

*** Multivite, B complex tablets

**** Mist expectorant syrup, ketrax tablet, Antacids, Immunization

***** Multiple responses

****** Choloquine tablets

Table 16: Items Requested to be brought to Free Public Health Facilities for Delivery

N=351

Items	Spontaneous response No (%)	After Probe No (%)	Total No (%)
Dettol	170 (48.4)	84 (23.9)	254 (72.3)
Pad	130 (37.0)	124 (35.3)	254 (72.3)
Olive Oil	138 (39.3)	115 (32.8)	253 (71.1)
Spirit	121 (34.5)	127 (36.2)	248 (70.7)
Soap	158 (45.0)	86 (24.5)	244 (69.5)
Detergent	109 (31.1)	118 (33.6)	227 (64.7)
Kerosine	119 (33.9)	99 (28.2)	218 (62.1)
Cotton wool	73 (20.8)	128 (36.5)	201 (57.3)
Blade	54 (15.4)	137 (39.0)	191 (54.4)
Matches	57 (16.2)	126 (35.9)	183 (52.1)
Gloves	19 (5.4)	48 (13.7)	67 (19.1)
Needle & Syringe	6 (1.7)	59 (16.8)	65 (18.5)
Drugs/Injections	3 (0.9)	16 (4.6)	19 (5.5)

Table 17: Respondents' General Perceptions about the Free Health Services

N=351

Expenses	No (%)
Health workers performed their duties very well	218 (62.1)
Services rendered before the commencement of the free health services and during were not remarkably different	41 (11.7)
The services rendered were well organized	34 (9.6)
We were given free drugs and vaccines	12 (3.4)
Health facilities were dirty and needed repair	10 (2.9)
No qualified health workers in health facilities	9 (2.6)
Too long waiting time	7 (2.0)
We were referred to private hospital	7 (2.0)
No sufficient free drugs	5 (1.5)
Government does not take care of health workers well	4 (1.2)
Health workers went on strike	3 (0.9)
There were qualified health workers at health facilities	1 (0.3)

Table 18: Problems Encountered by Respondents during their last visit to Free Public Health Facilities

N=168

Problems Encountered	No (%)
There was not enough free drugs and vaccines at health centers	43 (25.6)
Health workers were not always at work	39 (23.2)
Waiting time at health facilities is too long	24 (14.3)
Inadequate facilities and personnel	18 (10.7)
Health centers are dirty and dilapidated	14 (8.3)
Health workers' relationship with patient is bad	14 (8.3)
Money is paid for one thing or the other despite the free services	12 (7.1)
Health workers went on strike	3 (1.8)
There were no writing materials to be used by health workers	1 (0.6)

Table 19:Types of Health Services Utilized and Amount (in N) Paid at the Health Facilities

Service(s)	Mean Amount Paid in N		
	Maternity	IGH	Private
Delivery	499.40	162.35	1400.53
Booking	220.78	187.50	366.89
Routine drugs	12.06	11.66	22.10
Card	7.39	6.80	40.82
ANC	7.07	7.91	31.80
Urine/blood test	6.93	32.08	78.30
Immunization	3.38	11.66	22.10
Examination by doctors	1.84	2.40	18.57

Table 20: Comparison of Health Facilities by Amount (in N) Paid for ANC

Facility	Number	Mean	Median		Std. Deviation	
Public health facility	238	6.51	10.000		19.477	
Other facility	11	19.09	0.000		60.076	
Difference		-12.58				
ANOVA						
Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	1663.468	1	1663.468	3.261	0.072162	1.805829
Within	125996.371	247	510.107			
Total	127657.835	248				

Bartlett's Chi Square	=	48.990
Degree of Freedom	=	1
Kruskal-Wallis (equivalent to Chi Square)	=	0.530

No significant relationship between variables

Table 21: Type of health facilities where delivery was made by perceived health status

Perceived health status	Public health facilities	Other health facilities	No
Had no health problem	132 (65.0)	71 (35.0)	203
Had health problem	91 (61.5)	57 (38.5)	148

Marital Discord: $X^2 = 0.46$ P-value = 0.49707721

Social Support For Receiving Health Care Services

Comparison of means of social support received by type of health facility used for ANC showed a significant relationship between the variables. The results of the testing of the hypothesis, which states "there will be no significant relationship between the type of health care facility used for ANC and social support received" are presented in table22.

On comparing mean of social support received by type of facility used for delivery, a significant relationship was established. The result of the testing is also shown in table23.

Table 22: Comparison of Means of Support by Type of Health Facility used for ANC

Facility	Number	Mean	Median	Std. Deviation
Public health facility	266	22.665	25.000	2.519
Other facility	85	22.129	25.000	3.236
Difference		0.536		

ANOVA Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	18.507	1	18.507	2.522	0.113161	1.588137
Within	2560.798	349	7.338			
Total	2579.305	350				

Bartlett's test for homogeneity of variance

Bartlett's Chi Square	=	8.637
Degree of Freedom	=	1
P-value	=	0.003294

Table 23: Comparison of means of support by facility used for Child Birth

Facility	Number	Mean	Median		Std. Deviation	
Public health facility	223	22.744	25.000		2.522	
Other facility	128	22.172	25.000		2.996	
Difference		0.573				
ANOVA						
Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	26.656	1	26.656	3.641	0.057079	1.909024
Within	2552.649	349	7.314			
Total	2579.305	350				

Bartletts Chi Square	=14.905
Degree of Freedom	= 1
P-value	= 0.026775

Comparison of Health facility utilization practices by level of awareness and key socio-demographic variables.

A comparison of means of awareness of free health services by types of facility respondents used for booking showed a significant relationship between the two variables. The results of the testing of the hypothesis, which states "there will be no significant relationship between the type of health care facility used for booking and level of awareness of free health services" is presented in table 24. A comparison of the means of awareness of free health services with the type of facility used for ANC showed a significant relationship between the mentioned variables. The testing of the hypothesis is shown in table 25.

A comparison of means of ages of respondents by types of facility used for ANC was made. Result revealed no significant relationship between the two variables. When the type of facility used for ANC was also compared with the level of education of respondents, a significant relationship was established. The results of the testing of the hypothesis, which states, "there will be no significant relationship between the type of health care facility used for booking for ANC \ delivery and

respondents' socio-demographic characteristics " are presented in tables 26 and 27 respectively.

When the means of awareness of free health services by type of facility used childbirth was compared, result showed that there was a significant relationship between the two variables. The result of the testing of the hypothesis is presented in table 28. Comparing the type of facility used for delivery by religion of respondents indicated a significant relationship between the variables. Result of testing for the hypothesis is shown in table 29.

A comparison of mean age of respondents by type of facility used for childbirth showed that no significant relationship was established. . The results of the testing of the hypothesis, which states "there will be no significant relationship between the type of health care facility used for childbirth and respondents' socio-demographic characteristics' is shown in table 30. Respondents were asked to make recommendations for improving the free health services in public health facilities. A majority of the respondents. 255(72.6%), suggested that government should ensure adequate supply of free drugs. Many 148(42.2%) were of the view that government should recruit qualified and more health workers. 134(38.2%) mentioned that

government should ensure that vaccines for immunization are available in all public health facilities, while 132 (37.6%) opined that government should ensure that no money is paid at public health facilities where health is totally free. Other suggestions and recommendations are contained in table 31.

Table 24: Comparison of means of Awareness of Free Health Services by Type of Facility for booking

Facility	Number	Mean	Median	Std. Deviation
Public health facility	250	3.856	5.000	1.071
Other facility	101	3.891	4.000	0.904
Difference		0.035		

ANOVA Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	0.089	1	0.089	0.084	0.771704	0.290372
Within	366.618	349	1.050			
Total	366.707	350				

Bartlets Chi Squre	=	3.797
Degree of Freedom	=	1
p-value	=	0.051337

Table 25: Comparison of means of Awareness of free Health Services by type of Facility used for ANC

Facility	Number	Mean	Median		Std. Deviation	
Public health facility	79	3.620	5.000		1.191	
Other facility	272	3.938	5.000		0.960	
Difference		-0.317				
ANOVA Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	6.161	1	6.161	5.964	0.015095	2.442163
Within	360.545	349	1.033			
Total	366.70700	350				

Barletts Chi Square	=	6.013
Degree of Freedom	=	1
p-value	=	0.014200

Table 26: Comparison of means of Ages of Respondents by Types of Facility used for ANC

Facility	Number	Mean	Median		Std. Deviation	
Public health facility	266	27.72	30.0		5.446	
Other facility	85	26.45	30.0		5.760	
Difference						
ANOVA						
Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	104.674	1	104.674	3.238	0.072816	1.799417
Within	11282.425	349	32.328			
Total	11387.100	350				

Bartletts Chi Square	=	0.392
Degree of Freedom	=	1
p-value	=	0.531359

Table 27: Comparison of type of facility used for ANC by level of education

Type of facility	Educational status						
	No education	Primary	JSS1/* modern	SSS**	Post secondary	***others	No
Public health facilities	60 (22.6)	136 (51.1)	35 (13.2)	29 (10.9)	6 (2.3)	0	266
Other facilities	15 (17.6)	34 (40.0)	15 (17.6)	17 (20.0)	3 (3.5)	1 (1.2)	85

X^2	=	10.89
Df	=	5
P-value	=	0.05360322

P-Value = 0.05

* Junior Secondary School

** Senior Secondary School

*** Postgraduate school

Table 28: Comparison of means of Awareness of free health services by type of facility used for childbirth

Facility	Number	Mean	Median		Std. Deviation	
Public health facility	223	3.933	5.000		1.018	
Other facility	128	3.750	4.000		1.027	
Difference		0.183				
ANOVA						
Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	2.716	1	2.716	2.604	0.107526	1.613593
Within	363.991	349	1.043			
Total	366.707	350				

Bartletts Chi Square	=	0.12.667
Degree of Freedom	=	1
p-value	=	0.000372

Table 29: Comparison of specific place of delivery by religion

Specific Types of facilities	Religions	
	Islam	Christianity
Maternity centres	148 (61.4)	56 (52.3)
Private clinics	60 (24.9)	30 (28.0)
*IGH	15 (6.2)	2 (1.9)
At home	9 (3.7)	8 (7.5)
Church homes	4 (1.7)	9 (8.4)
TBAs home	3 (1.2)	1 (0.9)
Herbalist homes	2 (0.8)	1 (0.9)S

p-value = 0.01711
Chi-Square = 15.44
Df = 6

* IGH Igbo- Ora General Hospital

Table 30: Comparison of mean age of respondents by type of facility used for childbirth

Facility	Number	Mean	Median	Std. Deviation
Public health facility	223	27.64	30.00	5.748
Other facility	128	27.00	30.00	5.625
Difference		064		

ANOVA Variation	SS	Df	MS	F-statistic	P-value	t-value
Between	33.094	1	33.094	1.017	0.313875	1.008587
Within	11354.006	349	32.533			
Total	11387.100	350				

Bartletts Chi Square	=	0.075
Degree of Freedom	=	1
p-value	=	0.784711

Table 31: Respondents' Recommendation for Improving Free Health Services (N=351)

Recommendations	No (%)
Government should ensure adequate supply of free drugs	255 (72.6)
Government should recruit qualified and more health workers	148 (42.2)
Government should ensure that vaccines for immunization is available in all public health facilities	134 (38.2)
Government should ensure that no money is paid at public health facilities where health is totally free	132 (37.6)
Government should ensure good management of health policies and improved services	87 (24.8)
Government should give adequate remuneration to health workers	84 (23.9)
Government should ensure adequate supply of equipment/facilities and renovate dilapidated buildings	81 (23.1)
There should be continued education or seminar to update knowledge of health workers	43 (12.3)
There should be good relationship between patients and health workers and reduce waiting time in hospitals	42 (12.0)
Government should stop false sensitization of free health services when nothing in on ground	32 (9.1)
Government should provide free health services for adults only at old age	13 (3.7
Government should constitute monitoring team to monitor the implementation of free health policy	3 (0.9)
Health workers should be punctual and hard working at work	2 (0.6)
Government should introduce users fee.	2 (0.6)

CHAPTER FIVE

DISCUSSION

The implications of the findings of the study are discussed in this chapter. The major issues discussed included: the socio-demographic information, health promoting and health seeking practices, awarencss, experiences and perceptions of free health services in public health facilities as well as factors influencing pattern of utilization of health facilities in the study area.

Demographic characteristic

The study has revealed that the study population is relatively young. Some of the socio-demographic factors that were significantly associated with the pattern of utilization of the public health services are religion, level of education and period that respondents went to register for ANC. Other variables that have significant association with the pattern of utilization of free health services are; support of influence group and knowledge of provision of free health services.

Researches done by Eucharia et al, (1984) in rural areas of Nigeria revealed that sex, religion, occupation, ethnic group, locus of residence (urban or rural), education, income and age were found to have significant association with the choice of type of health care services used by subjects. Likewise, Hoffman, Pick, Cooper and Meyers, (1997) reported that age, education and marital status have significant association with women's knowledge of services for cervical smear in health clinics in South Africa. A reasonable proportion of the respondents fall into the category of low-income earners. Titiloye documented a similar age and socio-economic profile in the study area among the same population a few years ago (Titiloye, 2001). It could be argued that many of the respondents are influenced to use free health facilities as a result of their low socio-economic status. It should be noted that treatment charges are comparatively higher in private health care facilities than in public health facilities in the community.

A large proportion of the respondents in the study area are adherents of Islamic religion. This is to be expected, as Islam is the most predominant religion in Igbo-Ora (Oshiname, 1990; Brieger and Kendal, 1996; Chirwa, 1987; Titiloye, 2001). The religious leaders in the study area constitute potential sources of

information for the dissemination of information about free health services. A majority of respondents live with their husbands who are married to only one wife. Even moslems in the study area now sticks to only one wife as a result of the prevailing economic depression Their decision to use a particular health facility is greatly influenced by their husbands. Among the Ibampa Yorubas, the advice, choices and preferences of husbands' largely determine women's health seeking behaviour (Titiloye, 2001; Nwankwo, 1998; Ogunlesi, 1989; Salami, 2000)

Majority of the respondents had primary education. This has been the highest level of educational attainment among many residents in the study area (Oshiname, 1990; Nwankwo, 1998; Titiloye, 2001; Salami; 2000). The respondents' level of education is positively associated with the utilization pattern of public health facilities. Respondents with primary or no formal education use the public health facility especially the maternity centres, than respondents with secondary or other higher educational level. Previous researches have suggested that maternal education is one of the strongest determinants of utilization of health care services (Cleland and Van Ginneken, 1988). The respondents' ethnic group was positively associated with the utilization of public health services. The Yorubas especially of

the Ibarapa extraction have been used to the patronage of public health care facilities since the advent of allopathic medical care in South Western Nigeria.

Health promoting and Health Seeking Practices:

The reported activities performed by most respondents in the study area to maintain good health during pregnancy include eating of good food. Good food was explained as nutritious food that would promote the health of the mothers and that of the developing fetus. The subjects ate a variety of food substances. These include; beans, eggs, fruits, vegetables and carbohydrate containing food substances. If they are taken in enough quantity, quality and in right combination, then the available food substances are sources of balanced diet for expectant mothers and the fetus. Balanced diet should be promoted among expectant mothers as it protects and promote their health and the unborn child (Holmboe-olesen, 1995). In view of the fact that many of the subjects have no formal education, the promotion of the concept of balanced diet should be based on culturally appropriate concepts. (Brieger, 1985).

Another health promoting activitiy engaged in by a large majority of women was clinic attendance for ANC. Patronage of health care facilities for ANC is a recommended health seeking behaviour for pregnant women (Kambarani, Chirenje and Rusakaniko, 1999). Most of the women registered for ANC at maternity centers in the sixth and seventh month of pregnancy. This implies that it is at this period that women start to receive professional care including patient education.

During pregnancy, women took routine drugs in order to have adequate vitamins and mineral supplements. The vitamins, which are particularly promoted among pregnant women by health workers are B-complex and multivitamins while iron-containing drugs promoted among them include folic acid and ferrous sulphate.

The subjects cited the receipt of immunization as a health promoting activity. A person is said to be immuned when he possesses "Specific protective antibodies as a result of previous infection or immunization, or is so conditioned by such previous experience as to respond adequately to prevent infection and clinical illness following exposure to a specific infection agent" (Benenson, 1981). In May 1974, the WHO officially launched a global immunization programme, known as

Expanded Programme on Immunization (EPI) to protect all children of the world against six vaccine- preventable diseases, namely: diphtheria, whooping cough, tetanus, polio, tuberculosis and measles by the year 2000. Therefore the six vaccines recommended in childhood by WHO for inclusion in the EPI are BCG, Diphtheria Toxoid, Pertussis vaccine, Tetanus Toxoid, polio vaccines and measles vaccine (WHO, 1978). A study of children with measles seen at the Igbo-Ora Rural Health Care Centre and at an urban Centre in Ibadan during an epidemic revealed that 30% and 57% of the children had received measles vaccine. The most likely causes of immunization failure in these children were inappropriate immunization age and breakdown in the cold chain (Asuzu and Onodeko, 1984).

Simple domestic activities mentioned by the women who are health-promoting measures in pregnancy were sweeping, washing and maintenance of good personal hygiene. These are practices, which should be promoted or encouraged among pregnant women, in addition to the use of safe drinking water, which should be given top priority to maintain good health in pregnancy (Khosla, Dahiya and Dahiya, 2002).

Going to churches, mosques and spiritual homes for prayers was cited as part of the activities performed to ensure health maintenance. Ozturk, Guzet, Gan and Osturk, (2002) have noted the significance of religious institutions in the modification of social attitudes and behaviours of the society including women. These religious institutions should be mobilized for the promotion of the health of women during pregnancy. A combination of orthodox and native medicines was actively used together by few respondents to maintain health during pregnancy. A similar observation has been reported by Damase-Michel, Lapeyre-Mestre, Moly, Fournic and Montastruc, (2000) in Paris. They noted that pregnant women consumed an average of two medicines per week. The attention of pregnant women in the area should be drawn to the harmful consequences of drug use in pregnancy.

Awareness, Experiences and perceptions of Free Health Services

The results showed that a majority of the subjects were aware of the free health services offered in public health facilities in Oyo State. Health workers constituted the source of information about free health services to many of the subjects. This point to the need to prepare health workers adequately to be providing

simple, clear and accurate information about free health services to expectant mothers.

In Oyo State, there are six functioning electronic media. These include three television stations and three radio stations. As at the time this study was conducted, there was no electricity in Igbo-Ora, therefore, most people depended on the use of small transistor radios for news. Media advocacy for the patronage of the Oyo State free health services was largely conducted through the electronic mass media. Only those who have powered radio sets could listen to the Oyo State free health advocacy programme. Public address system in market places is another source of information about free health services. The local health authorities that disseminate health related information to the general populace usually use public address system.

Lastly, friends told few respondents about free health services. Their perception of free health and the quality of services rendered in public health facilities is quite revealing. A majority of the respondents' perceived free health services as not good. The respondents were requested to state whether they were satisfied with the free health services or not. Very few of the women were satisfied with the quality of services provided. Perceived satisfaction could be implicitly or

explicitly defined as an "evaluation based on the fulfillment of expectation" (Williams, 1994).

Respondents also reported that services rendered by health workers before the commencement of the free health services and during the implementation of the free health programme were not remarkably different. This cannot be unconnected with the chronic shortage of drugs in the public care facilities before and during the free health care programme of the state government. For instance, it has been observed prior to the introduction of the Oyo State free health programme, that it is not uncommon for patients to be referred from public health care facilities in the study area to the informal (private) drug stores for their drug needs. Patients get dissatisfied with the quality of health care if drugs are not available (Oshinaeme 1990). This is so because it is drug availability that is perceived to determine the credibility of any health care (Haddad et al, 1998). It is necessary to probe deeper into respondents' other sources of dissatisfaction with the free health services of Oyo State government. This is necessary so as to yield dependable baseline information for appropriate intervention.

Generally, consumers make judgment about quality of health care by assessing factors they can appraise such as courtesy, responsiveness, attentiveness and perceived competence (Calnaan, 1988). Respondents noted that they waited for too long a time on their visits to public health facilities. This phenomenon is not however peculiar to Oyo State health facilities care. It has been noted that people who use public health services often must pay in time (Drennan, 1991). This problem was also reported by Katung, (2001) in Nigeria and Singh et al, (1999) in Trinidad and Tobago in their studies.

Another major problem reported by respondents was the inadequacy of health care equipment and health workers at health centers. There is a linkage between inadequate equipment, health staff and waiting time. Shortage of these resources increases waiting time in health care facilities. Patients in the study area therefore resorted to the procurement of prescribed drugs in pharmacy shops outside the health centers at exorbitant prices. A research conducted by Abel-Smith et al. (1992) in Tanzania has showed that substantial costs were incurred by those using government "Free" services in terms of cost of travelling to receive free consultation and buying

prescribed drugs, which were not available free at government health facilities. Consequently, free health services in Tanzania places great burdens on the poor.

Factors Influencing Pattern of Utilization of Health Facilities

Perception of quality and ability to pay for health services influenced respondents' choice of health facility. Respondents that were not satisfied with the free health services had to go to private clinics for their ANC and delivery. This observation is similar to the result of a study conducted by the Ministry of Health and Family Welfare in Dhaka, Bangladesh where unofficial fee collection had negative influence on patients' satisfaction and perception of quality of health services. Unofficial fee collection reduced utilization of health services by patients (Killingsworth, Hossain, Hedrick-Wong, Thomas, Rahwan and Begum, 1999).

In this study, most respondents had their booking for ANC in their last trimester. When they were asked why they did so, their responses were that 'because we had no problem during our early stage'. The last trimester of pregnancy is regarded as the most serious or important in pregnancy, which requires professional care. In Mexico, Young, (1981) found that the seriousness of illness is

the most important factor in the choice of a health care provider. Another important factor that influences choice of a health facility is the perceived effectiveness of the health care provider in dealing with the health problems presented (Fuchiaria, et al, 1984). They noted that individuals would continue to use the services of any health care provider as long as the individual feels that the health provider will effectively deal with his/her problems. One can therefore conclude that perceived severity of a health condition and benefits from health care provider or health services is of major importance in choosing a health care provider.

Respondents provided information on the reinforcing factors (Green, Kreuter, Deeds and Partidge, 1980) that motivated them to use public health facilities during pregnancy. Of great importance is the influences of others in making them decide on what facility to use. Many women decided to use maternity centers on their own because they observed that friends and relatives went there. Many respondents were advised to use maternity centers by their husbands because most husbands wanted their wives to attend government health facilities where free health services were provided and where most women in the community attended. Maternity centers are the most common health establishments for expectants and nursing mothers in Igbo-

Ora. As at the time of this study, there were two public maternity centers in the community. These are located in Sagaun and Igbole areas of Igbo-Ora. In addition, the comprehensive hospital owned by the Oyo State government provides ANC and postnatal services.

A study by Singh et al (1999) in Trinidad and Tobago revealed that primary care services are fully financed by the state government and the people who use them are mostly poor, uneducated and unemployed. These people have the greatest difficulty in evaluating what is provided because, as a rule, they have no bases for comparison. As for the Igbo-Ora study population, there are private sources of care whose services can be compared with the public health care facilities. Another major factor that was reported by majority of respondents to be influencing their pattern of utilization of health facilities was the proximity of health facilities to their homes. Most women use only the health care facilities closest to them. Of course, this is the rationale behind the establishment of these health facilities in the study area. Egunjobi. (1983) in his study on factors influencing choice of hospitals in Northern part of Oyo state, revealed that nearness is perceived to be the most significant factor that influenced the utilization pattern of the subjects in the area. He

noted that the nearer the respondents' homes to health facilities, the higher the pattern of utilization. Morrill, (1970) also observed that people choose hospitals on the basis of accessibility in the same way they choose supermarkets.

Other documented factors which influence pattern of utilization of health services elsewhere include; high cost of drugs, increase in service charges, easy access to traditional healers, difficulty in getting transport to a health facility, unfriendly attitude of health workers and long waiting time in health facilities (Kanung, 2001).

Despite the implementation of the free health policy in Oyo State, respondents were asked to bring one item or the other for their delivery in maternity centers. Sometimes, clients may pay money "under the table" to get fast services. Paying money "under the table" is a phenomenon of bribing the health workers so as to get good health services. The free health care for all is not totally rendered in most developing countries, concluded Drennan, (1991). Varying amount of money was paid in Naira for various services. The reason for the collection of fees was not clearly stated but some few respondents said they were told it was for the purchase of items respondents needed in health centers, which were not available. This raises

questions about the free health care policy. Bitran, (1989), in his research in Zaire, observed that despite the "free" health services in developing countries, the poor still pay 1% to 8% of their income for health care. A study in Coted' Ivoric and Peru also found that poor families pay 1.6% and 4.5% of their income on health care (Gertler and Vander Gaag, 1990).

Adequate financing of health sector is therefore a task to be accomplished so as to promote increase utilization of the health services (Akin. Birdsall and de Ferrantis, 1987). There have been intensive discussions concerning the need to generate more resources for the heahh sector. The main options are compulsory health insurance (Abel-Smith, 1986), community financing (Stinson. 1982) and user charges (Gilson, 1997). The primary reason has been that most developing countries find themselves no longer able to raise the additional revenue required to finance their health services through taxation. let alone find the extra resources needed to achieve "Health for all and the Free Health Policy" under present economic difficulties. There is an economic theory, which says that most patients should pay at least the marginal cost of what is provided (Akin et al. 1987). They explained that since patients are paying considerable sums to mission hospitals, private hospitals or

even traditional healers, they should be able to pay similar charges to government hospitals.

Akin et al, (1987) reported in their studies that treatment charges were paid in the subsidized health policy and in secondary health care. Therefore, if patients are willing to pay for health services provided by the government, then charges paid for the services should be used to improve health services. Some organizations, for example MEXFAM in Mexico, and PROFAMILIA in Columbia, insist that all clients pay something (Lopez, 1991; Negrette, 1991) for their health care. MEXFAM also extended credit rather than providing free services.

The subsidized Secondary Health Care and total Free Primary Health Care in Oyo State (GOS, 1999) is a good health policy but the government should review the policy to ensure that the prevailing problems associated with the free health care programme are eliminated or reduced to the barest minimum. Moreover, health workers should be taught to screen and access patients who cannot afford charges paid for health services. In Dominican Republic for example, clinic staff can judge people's ability to pay by their addresses (Lewis, 1990). Exemptions for the poor can invite trouble from other clients if they found out that someone else paid less.

Generally, organizations set fee that most of their clients could afford and few clients asked for exemption.

The Planned Parenthood Federation of Nigeria exempts the poor by their physical appearance (Sulaiman, 1991). Most poor patients are usually malnourished, unkempt, dirty, rough and skinny. Another screening procedure can be to conduct interview for the clients. The Family Planning Association of the Philippine interviews clients to ask their monthly family income before they could be excluded from fee payment (Tanedo, 1991). In Niger, clients present proof of poverty and village chief assist the health care provider by issuing card to indigents that are too poor to pay hospital bills. These bills are then paid by the local government (Weaver, 1990). Also, in public hospitals in Jamaica, fees are waived for people who receive subsidies for food (Lewis and parker, 1991). Clients living in poor areas are usually given discounts or exemptions, this they do by asking clients that come to clinics where they live, or clinics in poor areas, may charge less than clinic in wealthier areas (Lewis, 1990).

In Oyo State, this process or procedure for exempting people from paying for health care may be characterised by fraud due to lack of objective indicators for

determining who can or cannot pay. This is more so, as some health workers request for extra -legal fees before providing legitimate services. Respondents proposed recommendations for improving free health services in Oyo State. Most of the recommendations focus on the provision of adequate human and material resources. The respondents observed that since health was totally free at the primary health care level, payment of any form of money at this health care level is illogical.

A study conducted by the Ministry of Health and Family Welfare in Dhaka Bangladesh found that unofficial fee collection when services were supposed to be free has impact on the efficiency of health facility (Killings Worth et al, 2002). The fee imposed unaffordable hardship on consumers thereby reducing their utilization pattern of health facilities. The respondents suggested that government should ensure a formulation of good health policies and provision of improved services. In addition, respondents stated that government should adequately renumerate health workers so that they will be motivated to perform their duty adequately. Inadequate renumeration probably accounts for why health staffs demand for illegal charges or payment before rendering any services in public health facilities. All the recommendations made, point to factors, which may have been adversely affecting

the adequate provision of free health services in the study area. A major concern raised by the women was improvement of patients – health workers relationship. Previous researches done by Gilson, (1991) in Tanzania and Waddington and Enymayeka, (1990) in Ghana showed that most patients complained that nurses treated them harshly and with contempt at their visits to health facilities.

Implications of the findings for health education

Series of health education strategies can be targeted at the nursing mothers, the health workers and the government to ameliorate the problems associated with the implementation of the Oyo State free health policy. Majority of the respondents had primary education and many people had no formal education. Patient education, which is culturally appropriate, should be instituted in public health centers. Deliberate efforts should be made to upgrade expectant mothers' knowledge about the importance of ANC. Market based health education services have been shown to be effective (Akpovi, Johnson and Brieger, 1981). Markets are important places for reaching many women with health education services because most markets are near health facilities. A market-based intervention has been successfully used to facilitate

the reporting of cases of guinea worm in the study area (Brieger and Kendall, 1996). Programmes meant to upgrade women's knowledge should be organized in collaboration with market women associations.

Training is useful for upgrading the knowledge of religions leaders about care of pregnancy and enhancing their capacities to provide education to the followers. Primary Care Training of Patient medicine vendors in Igbo- Ora has yielded a positive result in upgrading their knowledge through appropriate educational strategies (Oshiname and Brieger, 1992). Trained health workers such as nurses could provide patient education services, which include right to good health and right to public health facilities. Training of health workers is a vital issue in health education (Brieger and Akpovi, 1982/83). Health workers should be allowed to benefit from continuing education programme about health care management. This is to improve their knowledge so as to be able to educate patients and other subordinate health workers on the importance of health services. Training of health workers on health care management will enhance the implementation of the free health policy

Public enlightenment programmes which focus on the free health services provided by the government should be organized by the local and state governments to sensitize women on the need to use public health facilities and services provided for them. The public enlightenment programme should however rely on culturally appropriate communication media and methods in line with the principles of primary health care (WHO/UNICEF 1978).

The findings of this study may be explained using the HBM (Ross et al, 1980; Hubbley, 1993). There is likelihood that pregnant women attend health facilities for ANC and delivery because of their perception of seriousness and susceptibility of diseases in pregnancy. Their perception about the disease seriousness motivated women to use public health facilities to seek healthy condition during pregnancy.

Advocacy of the provision of free health services in the public health facilities by Oyo State government may not motivate women to use any facility if their perception about quality of health services provided by the state government is low. Mothers may not use public health facilities if they considered that distance from their homes to health facilities is too far, if there is a transportation difficulty in

the area, too long waiting time spent in the health facilities for consultation and non availability of free drugs. The implication is that if pregnant women perceive the benefit of utilizing a public health facility as outweighing the constraints, there is likelihood they adopt the utilization of such facility irregardless of influence of any reference groups or any other external factors.

CONCLUSION:

This study shows that most of the women who still patronize public health facilities and pay for services that are supposed to be free are low-income earners. As a result of inadequate supply of free drugs, free vaccines and inadequate number of qualified health workers in health facilities, many patients had to incur substantial costs to use "free" services. These they do by paying unofficial fee for drugs and services in government health facilities in an attempt to receive qualitative health services. The new free health policy of Oyo State, which includes free PHC has obvious advantages to patients in that it encourages women to use services as soon as they are needed rather than going to seek for health care in the hands of quacks. The

subsidized SHC also has advantages in that it enables patients to contribute indirectly towards the financing of health care system.

Subsidized users fee in SHC was introduced because of the financial implication of the total free health service in PHC and SHC which cannot be borne by the government alone. The free health care programme is a desirable initiative. However, pregnant women are dissatisfied with it as a result of its mode of implementation. The study points out that there are therefore gaps between government's free health policy and its implementation. Despite the good intention of the policy, health workers have not been implementing the policy as required. Respondents pay different amount of money for different services such as vaccination, routine drugs, normal delivery, antenatal care, treatment of minor trauma, treatment of malaria, treatment of acute infection and diarrhea diseases which are supposed to be free at both PHC and SHC levels. Health workers also request patients to bring various items such as dettol, methylated spirit, cotton wool, surgical gloves, needle and syringe to health facilities during their antenatal visits or during delivery. These practices call to question the type and quality of free health services being provided in the study area. Therefore, there is need for the

government to monitor the implementation of the free health policy in Ibarapa Central Local Government Area and Oyo State in general so as to eliminate the associated abuses and the implementation barriers that are associated with it.

RECOMMENDATIONS:

1. A combination of health education strategies are needed to promote the adoption of free health services among women in the study area. For instance, training geared towards upgrading health providers' knowledge and skills relating to ways of promoting qualitative free health services are recommended. Well-designed appropriate media interventions are needed to create public awareness about the nature and scope of free health services being provided with a view to avoiding false expectations.
2. The credibility of a health care facility is a function of the availability of drugs. To ensure that these resources are always available, a drug revolving fund scheme should be institutionalized in each health care facility in the study community.

3. Government should appoint a monitoring team that will be charged with the responsibility of monitoring the implementation of the free health policy at primary and secondary health care levels. Such a team should

- Ensure regular supply of free essential drugs and vaccines, which are of good quality, at PHC centers.
- Ensure that no money is paid at the PHC centers and no patient is asked to bring anything to the health centers.
- Ensure health workers are constantly at their duty posts.
- Organize stakeholders meetings to create opportunity for people to make meaningful contributions on how the free health programme can be improved upon.

4. Finally, further research is needed to determine aspects of the health service design at primary and secondary care levels, which have potentials for undermining the provision of qualitative free health services to expectant and nursing mothers in the study area. Such a study will lead to the generation of additional baseline information for intervention.

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FGD GUIDE ON THE ASSESSMENT OF PERCEPTION OF QUALITY OF ANTENATAL SERVICES IN OYO STATE FREE HEALTH SERVICES

Introduction:

Good day. I welcome you all to this discussion. I am a student of the College of medicine, University of Ibadan. I am here to share your views on the quality of health services you receive as parts of antenatal care during pregnancy period. I want to implore you that we should all contribute since your contribution would help us in this discussion.

1. What do pregnant women in this community do to stay healthy during pregnancy?
   a. Probe:
   i. What type of food and drug do they take to make them healthy during pregnancy?
   ii. Do they do any exercise or activities at the period to make them healthy?
   iii. Where do they go to receive care and what treatment do they receive from there? Probe:
   (1) What government services do they use?
   (2) What private services do they use?
   (3) What traditional services do they use?
   (4) What faith based services do they use?

2. What are the opinions of women about different health services available in this community
   probe:
   a. What are the different health facilities women use in this community during their pregnancy period. PROBE:
   i. What type of services do pregnant women receive from the government hospital.
   ii. What type of services do pregnant women receive from the private clinic
   iii. What type of services do pregnant women receive from the traditional healer
   iv. What type of services do pregnant women receive from the faith healers
   b. (for each of the facilities ask for their role about: ANC, booking, delivery, immunization, admission, consultation, day meal)

3. How do pregnant women decide on what type of facility to use for their ANC? Probe:

   a. Why do women choose to use or not to use governmental hospital?
   b. Why do women choose to use or not to use private clinic?
   c. Why do women choose to use or not to use traditional healers?
   d. Why do women choose to use or not to use faith healers?
   e. For each of the facilities ask for what they like or dislike about
      i. cost,
      ii. proximity,
      iii. others= influence,
      iv. quality of service, (give examples)
      v. patient-nurse/provider relationships

4. Oyo State embarked on free health services a few years ago.

   a. What have you heard about free health services
   b. How do you hear about this? (e.g radio, TV, significant other, husband, friends, in-laws, town crier)
   c. What aspects of the services are supposed to be free? Probe:
      i. for pregnant women?
      ii for women who are ready to deliver?
      iii for small children?
   d. Which of these services have you or your friends used?
   e. When these services were used -
      i. Were there any products you provided in the hospital
      ii Was there any cost incurred for consultation, admission, immunization, treatment, drugs. day meal

f. How effective is the programme?
   i. Probe in terms of quality, promptness, access - i.e. ask the women to give examples to support their claims.
   ii. Has free health services affected women's use of health services in this community
      1. does it affect their choice between government, private and other services? If yes, how
      2. does it affect when they book for ANC? If yes, how?
   iii. What aspect of the programme needs to be modified?
   iv. (follow-up) We noticed from records that women usually book from their seventh month of pregnancy onwards. Please explain why women wait until this time to start ANC

Thank you for your patience and contribution since the beginning of the discussion

ASSESSMENT OF PERCEPTION OF QUALITY OF ANTENATAL SERVICES IN OYO STATE FREE HEALTH SERVICES

Introducing:

Good day, I am a student of the College of Medicine, University of Ibadan. I am working on the health and social needs of pregnant women in this community, so I am here to share your views on the quality of health services you received as parts of antenatal care during your pregnancy period. I would also like to share the type of support you received and what area you would expect improvement in the future. All your responses will be kept confidential; thus your name is not needed. Are you ready for the interview? If yes please mark (√) the box to the right and continue. However, if the respondent is not ready, please thank the respondent and discontinue.

Date: ____/____/2002 Location: ☐ Igbo-Ora ☐ Idere ID No. ___

SECTION A: DEMOGRAPHIC DATA

1. What is your age? ____ ____

2. What is your religion? ☐ Muslim ☐ Christian
☐ Traditional Religion ☐ None ☐ Others

3. What is your level of education? ☐ None ☐ Primary
☐ JSS/Modern ☐ SSS ☐ Post-secondary ☐ Others (Specify)

4. What is your marital status? ☐ Not married ☐ Married ☐ Divorced
☐ Separated ☐ Husband has more than one wife ☐ Others

5. What is your husband's educational qualification? ☐ None
☐ Primary ☐ JSS/Modern ☐ SSS ☐ Post-secondary
☐ Others (Specify)

6. What is your husband's occupation? ☐ Small trading
☐ Artisan ☐ Large trade ☐ Farmer ☐ Clerical
☐ Professional ☐ Other

7. Do you live together with the following people? ☐ Husband's relatives
☐ Own relative ☐ Unrelated housemates ☐ No others

8. What is your tribe? ☐ Yoruba ☐ Igbo ☐ Hausa ☐ Other

9. What is your occupation?
   - ☐ Small trading ..... ☐ Artisan .....
   - ☐ Large trading ..... ☐ farmer ..... ☐ clerical .....
   - ☐ Professional ..... ☐ full housewife ..... ☐ Other

10. Sex of last child ☐ Male ☐ Female (if twin ..)

11. Age of last child: Month ..... Year .....

12. What is the position of last child?

13. Where did you give birth?
    - ☐ at home ..... ☐ private hospital .....
    - ☐ govt hospital ..... ☐ local govt maternity .....
    - ☐ a church ..... ☐ (TBA) Traditional birth attendance
    - ☐ spiritualist ..... ☐ (farm) ..... ☐ others .....

SECTION B: ACTIVITIES DURING PREGNANCY

14. What were some of the things you did to stay healthy during pregnancy? (Please underline what they mentioned spontaneously and mark it. Ask for the rest and mark their boxed)
    - ☐ go to health facilities ☐ take routine drugs and infections
    - ☐ eat nourishing food ☐ observe personal hygiene
    - ☐ go for booking and ANC ☐ Seek good health care
    - ☐ drink or bath with herbs ☐ used native rings
    - ☐ bathe with black soap ☐ use concoction (aseje)
    - ☐ take agunmu ☐ others ..... specify
    - ☐ relax / rest .....

15. Specifically, did you attend ANC (ipade) when you were pregnant with that child?
    a. (If yes) where? ☐ LGA ☐ IGH ☐ Private ☐ Church ☐ Others .....
    b (If yes) At what month of pregnancy first book? 1 2 3 4 5 6 7 8 9

c. Why did you chose to book at the month?

☐ since nothing is wrong with me ☐ it is a waste of time to go early

☐ if pregnant is not prominent, we don't want to attend you

☐ it is not convenient for me ☐ I know the drugs health workers will give me ☐ my husband cannot afford the cost of drugs

☐ it is not important to go maternity for ANC early

☐ my husband given money late to me

☐ others (specify)

d. (If no) Why not book for ANC?

16. (For those who attended ANC somewhere) Who advised you to go to ANC at (state the place) and what were your reasons for going or not going (to that place)?

A. Facilities	Use/not	B. Who Advise	C. Reasons for use /for not use
LGA Maternity			
Govt hospital			
Private clinic			
Traditional healers			
Faith healers			
TBA			
Others !			

*use = √, not use = x

17. Among the following people, what do you think about your attending the government's 'free' ANC? Also indicate among those people whose opinion you value the most.

Person	What they thought about your attending					Who value most
	Very good idea	Good idea	Not certain	Bad idea	Very bad idea	
Own Mother						
Husband						
Husband's Mother						
Friends						
Neighbours						

18. Have you ever been referred from the health facility/place you went for ANC to another place? ☐ Yes ☐ No (if no, go to number 19)

If referred:

From	To	Month of Preg	Reasons

19. Listed below are the services received from different facilities. Please tell me facilities where you obtained these services and how much paid for any services you received. Please mark (x) if no payment is made

Source / Amount	SERVICES												
	Booking	ANC	Immunization/ injection	Routine Drug	Card	Exam/ Consult	Check Blood/ Urine	Delivery	Connection	Native Ring	Black Soap	Holy Water	Prayer
a. LGA Maternity													
Amount													
b. Govt. Hospital													
c. Private Clinic													
Amount													
d. Traditional													
Amount													
e. Faith Healers													
Amount													
f. Others													
Amount													

SECTION C: KNOWLEDGE ABOUT FREE SERVICES

20. Have you ever heard about free health services in Oyo State

☐ Yes ☐ No (if no, go to number 26)

21. If yes, how did you hear about it

☐ on radio ☐ on TV ☐ from health workers ☐ in mosque
☐ in churches ☐ Husband ☐ Friends ☐ public address system in community ☐ town crier ☐ neighbours ☐ others ..... (specify)

22. Which services do you know is free within the free health programme? Which have you yourself ever received?

Services	Yes – spontaneous	Yes – probe	No	Uncertain	Ever received
Ante Natal Care Services					
Normal delivery system					
Drug use in primary health care					
Curative services provided					
Consultation					
Laboratory					
Admission					
X-ray					
Booking					
Routing drug					
Immunization					
Card					
Treatment					
Others specify					

23 What items did you provide at the government hospital/clinic during ANC, booking and delivery?

	Maternal and Health Serv		Quantity
	Spontaneous	Probe	
Dettol			
Spirit			
Adiagbon			
Blade			
Kerosine			
Omo detergent			
Needle and Syringe			
Lux, Premier toilet soap			
Pad			
Cotton wool			
Gloves			
Match box (isana)			
Injection/drug			
Others specify			

24. Have you ever seen the list of free drugs displayed in pharmacy department since the beginning of free health services in 1999? ☐ Yes ☐ No

a. (If yes) Please what drugs have you received free from the government hospital for your personal use ever and during your last pregnancy (*Interviewers should tick those mentioned spontaneously first and later read out other categories*)

A. List of drugs	Ever received free		During Last pregnancy	
	Spontaneous	Probe	Spontaneous	probe
Blood mcd.....				
Analgesics				
Multivitamins				
Anti malarial				
Others 1.....				
Others 2.....				

25. (For those who used free services last pregnancy) Which of these factors influence your utilization of free health services?

☐ Nearness to home ☐ influence of health workers
☐ cost of drugs ☐ economic status of family
☐ awareness on Radio and TV ☐ Others' influence ..... Who
☐ others ..... (specify)

26. a. What did you experience on your visit to government health facility (write out narrative in full and later tick as relate below)

b. What problem do you face whenever you go to government hospital?

_____

_____

☐ inadequate supply of drugs ☐ health workers not on duty
☐ non availability for prescription writing
☐ non availability of vaccine for immunization

27. (For those who did not use free services last pregnancy) Why did you not use the free services during your last pregnancy?

☐ poor quality ☐ not really free
☐ private gives better ☐ private gives better service ☐ waste in time
☐ attitude of health workers ☐ others specify .....

28. (For all respondents) How will you assess the free health services provided (please write down the narrative)

_____

_____

a. Based on what you just said, how would you rate the attending the government's free health service?

☐ very good idea ☐ good idea ☐ don't know ☐ bad idea
☐ bad idea

29. How can the free health services be improved (please write down the narrative)

_____

_____

☐ govt. should supply more drugs ☐ stop payment of any fee for all services
☐ provide immunization regularly ☐ stop false declaration of free health services
☐ use govt. resources very well ☐ recruit qualified health workers
☐ pay workers well ☐ improve facilities in govt hospital
☐ improve patient-nurse/doctors relationship ☐ others (specify) .....

Thanks for giving us your time. We pray that God will take care of your child