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FACTORS INFLUENCING UNDERUTILIZATION OF GOVERNMENT OWNED HEALTH FACILITIES IN MBAUKWU COMMUNITY OF ANAMBRA STATE, NIGERIA

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ABSTRACT

This research project examined factors influencing the underutilization of government owned health facilities in Mbaukwu community of Awka South Local Government Area, Anambra State, Nigeria. The population of the study was 25,579 which is the population of persons aged eighteen (18) years old and above, who are resident in Mbaukwu community from whom the study sample was drawn. The sample size for this study was 200. Multi-stage sampling technique which incorporated cluster sampling technique was used to draw study participants. The instruments for data collection were participant observation, questionnaire and in-depth interview schedules. The data were analysed using Statistical Package for the Social Sciences (SPSS). The study hypotheses were tested using Chi-square test statistics (x^2). It was found that there is high rate of underutilisation of government owned health facilities in the community occasioned by preference of private clinics among other factors. The consequences of underutilization of government owned health facilities in the area include illness and loss of life, low income and reduced productivity. Based on the findings, it was recommended among other things that the government should allocate more funds to her health facilities as well as retain well trained and adequately remunerated health workers in the facilities as a way to motivate them to carry out their duties effectively and efficiently. The need for public enlightenment was also strongly emphasized.

Keywords: *Government Health Facilities, Underutilization, Rural Dwellers, Availability, Affordability.*

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Introduction

World Health Organization (WHO, 2006) defined health as a state of complete physical, mental and social well-being of an individual and not merely the absence of disease or infirmities. Health care service is one of the most

important services provided by the government in every country of the world. In both the developed and developing nations, a significant proportion of the nation's wealth is devoted to health manpower training and development of functional health facilities (WHO 2006). Thus, the provision and level of utilization of available health facilities in any population is an important determinant of health. Accordingly, optimum utilisation of healthcare facilities has particular relevance, both as public health and development issue.

According to Barbar and Hatcher (2004), studies carried out in different parts of the world to evaluate the level of utilization of health facilities reveal problem of underutilization which is a condition wherein modern health facilities available are not being used to their fullest potential by the people. They asserted that underutilisation of modern health facilities is however not a new phenomenon. To them, it is experienced especially in the developing countries.

Uzochukwu and Onwujekwe (2004) also noted that in different parts of the world, especially in Europe and United States of America, studies have been carried out on underutilization of modern health facilities over intervals of time and in varying ways for various populations such as women and children. In Gujarat India, Vissandjee, Barlow and Fraser (1997), identified women's education, income, family structure and kinship affiliation as some of the determinants of the underutilization of modern facilities among rural women

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In Bangladesh, Mahbuhur et al, (2011), reported that rural areas had little access to basic healthcare with overall utilisation rate of modern healthcare facilities as low as 30%. This is notwithstanding the fact that Bangladesh has unique modern healthcare facilities from national to community/rural level. Also, in rural parts of Burkina Faso, Fatimuz and Avan, (2002) reported that modern health facilities are only consulted by 19% of the population. The rest of

Burkinabe population choose home treatment (52%), traditional healers (17%) or local village health workers (5%).

In Nigeria, Iregbu, (2004) frowned that in most states or parts of the country, attitude of health workers, and lack of trained personnel, poverty, and ignorance and belief system have led to underutilization of health facilities by the population. He also noted that rapid population increase and the recognition or appreciation of health needs of the population has given much impetus to the examination of health seeking behaviour of the population.

Specifically, in Awka South Local Government Area (LGA) of Anambra state of Nigeria with a population of 182, 450 women and 162, 666 males; only about 87.5%of women and 33.5% of males utilize modern health facilities in their area. This is despite government sustained action at establishing and equipping new health facilities in the area (Iregbu, 2004).

Mbaukwu is a rural community in the aforementioned Awka South Local Government Area of Anambra state, Nigeria where underutilisation of government owned health facilities is a major problem, especially among menfolk as Iregbu (2004) reported. She is made up of twelve villages and has four functional governments owned health facilities as follows; Mbaukwu General Hospital at Obuofia village, Primary Health Centre (PHC) at Akabor village, and Primary Health Centre at Ovollo village. There is also a Primary Health Centre at Obuofia village which shares premises with the general hospital. These facilities record very low patronage or utilization by residents hence this study focused on examining the factors influencing underutilisation of such health facilities in the community.

The Problems

The provision and utilisation of healthcare facilities especially for vulnerable and underprivileged populations like those in the rural areas has been recommended by the World Health Organisation (WHO, 2006) as a basic strategy towards attainment of heath for all. The organization strongly argued that healthcare should be made universally accessible, affordable and acceptable to all populations irrespective of location. It was in recognition of this fact that various Nigerian governments have made great efforts toward the provision of modern healthcare facilities to the population.

However, according to Kiguli (2009), the under utilisation of modern health facilities by the rural dwellers has been a universal phenomenon in developing countries. Several lapses in the healthcare delivery system of Nigeria contribute to poor utilization of available facilities. For example, there is lopsided and grossly inequitable distribution of healthcare facilities in favour of urban areas where the educated, the rich and government functionaries reside to the disadvantage of rural areas. This has lot of negative effects on national development.

Furthermore, in Nigeria's rural areas, problems of poor location or inaccessibility of modern healthcare facilities remain major concerns. Political considerations rather than need often dominate decisions on location. Regions with difficult terrain are often neglected (Onokerhoraye, 1999). This has a huge negative implication for use.

According to Buor (2005), the dwindling income and purchasing power of the rural dwellers coupled with the high cost of drugs and of treatment, combined to make government owned modern health facilities unattractive and out of reach

of many. Unfortunately, the National Health Insurance Scheme is yet to make a significant impact in cushioning cost of treatment on rural dwellers.

Again, low level of education of the populace and shortage of trained health personnel among other factors have contributed immensely to poor utilisation of few government owned healthcare facilities in their locality. For example, in a study conducted by Dias et al (2008) in rural Kogi State, cited in Nwankwo (2012), they found that education is a major determinant of utilisation of health services with 56.5% of households with tertiary education utilising modern health facilities while 57.9% of households without access to formal education did not utilise health facilities.

Filmer, Hammer and Pritchel (2000), stated that underutilisation of modern healthcare facilities can be a problem among patient receiving care. They enumerated major factors associated with underutilization to include attitude of health workers, lack of trained personnel, insufficient technological equipment, ignorance, cost of treatment/ lack of fund, gender and cultural beliefs and practices, status of women, location of health facilities/poor citing, preference for traditional healers, poor transportation, distance of health facilities, incessant and abrupt stoppage of services through strike at critical periods of care, and out-of-stock syndrome .These problems are substantially applicable to the study area.

Underutilisation of modern health facilities is a great setback on national development; it is a chain reaction where one thing triggers another, such as loss of life, decline in agricultural production on account of ill health and deaths (Adebayo and Oladeji, 2006). Similarly, Ajala, Sanni and Adeyinka, (2005) asserted that underutilisation of modern health facilities in rural areas has led to prolonged state of illness thus reducing labour productivity from areas affected.

It also leads to death, all of which negatively affect sustainable rural development.

For Adebayo and Oladeji (2006), the major consequences of high cost of modern health facilities and their resultant underutilization in the rural areas include: shift to alternative medical treatment, low patronage to modern health facilities, spread of diseases, increase in self medication, proliferation of quacks in medical matters, increased rate of untimely death, recourse to superstitions and reduced life span.

Furthermore, according to Ogunna (1999), views from various strata of Nigerian society have contended that public establishments have been a failure; hence government owned healthcare facilities are seen as no man's business, resulting to inefficiency and underutilisation.

The above problems constitute some of the basic worries; hence this study to find out the factors influencing underutilization of government owned health facilities at Mbaukwu rural community with a view to finding solutions to the menace.

Research Questions

The following questions were put forward to guide the study:

1. What is the level of use or preference of government owned health facilities among residents Mbaukwu community of Awka South LGA, Anambra State, Nigeria?
2. What are the factors influencing underutilisation of government owned healthcare facilities by rural dwellers at Mbaukwu community of Awka South LGA, Anambra State, Nigeria?

3. What are the effects/consequences of underutilisation of modern healthcare facilities by rural dwellers at Mbaukwu community of Awka South Local Government Area, Anambra State, Nigeria?
4. What are the solutions to the problem of underutilisation of modern health facilities among rural dwellers at Mbaukwu community of Awka South Local Government Area, Anambra State, Nigeria??

Study Hypotheses

1. There is a significant relationship between level of educational attainment and tendency to underutilise government owned health facilities in Mbaukwu community of Awka South Local Government Area of Anambra state, Nigeria.
2. There is a significant relationship between marital status and level of use (underutilisation) of government owned health facilities at Mbaukwu in Awka south Local Government".

Theoretical Thrust: Attachment Theory

Attachment theory is adopted as the theoretical framework of this study. John Bowlby (1985) (who first developed attachment theory), proposed that individuals, internalised earlier experiences with caregivers, forming enduring cognitive schemas of relationship that influence whether they perceive themselves as worthy of care (model of self) and whether others can be trusted to provide care.

The theory is vital in understanding factors influencing underutilisation of modern health facilities by the rural dwellers. In other words, people's past

experience and level of education with the available modern health facilities in their localities determines their frequent utilization of such facilities. Thus, in this sense, continuous usage or none or underutilisation of this available modern health facilities can be attributed to one's early experience and the individual's interpretation of such experience is one of the major influences on utilization.

This model has been criticized to be unilinear. That is, it is a self model; it only talks about individual experience as a factor that influences underutilisation of government owned modern health facilities thereby neglecting group experiences and other factors like culture, income among others that can also influence the underutilisation of modern health facilities by the rural dwellers.

Area of the Study

The area of the study is Mbaukwu community in Awka South Local Governemnt area of Anambra state of Nigeria. She situates about 5 kilometres from Awka, the capital of Anambra state. According to Okeke (1985), the community has a land area of about 20 square kilometres. The 1991 National Population Census of Nigeria gave her population as made of 14, 617 people.

Mbaukwu is surrounded by other communities which include Nibo in the north, Umuawulu in the west, Nise in the east and Awgbu in the south. Among these neighbours, Mbaukwu myth of origin held that she belongs to the same descent group with Umuawulu. This understanding has united the two communities in a series of deep socio-political intercourse to the extent that they are commonly referred to as 'ebeteghete' (community of nine). The figure 'nine' represents the sum of original villages in the two communities.

Materials and Methods

The study is located in Mbaukwu community. The estimated population of persons aged eighteen (18) years and above resident at Mbaukwu in 2013

were 25,579. This represented about sixty four percent (64%) of her total population and constitutes the target population for this study. The sample size was 200 respondents on whom questionnaire were administered. The sample size was adequate for applicable statistical tools employed for the data analysis. In addition, eight (8) respondents were interviewed.

The multi-stage sampling technique was adopted in selecting the respondents for the questionnaire and this incorporated cluster sampling technique. Mbaukwu community presently consists of twelve (12) villages. However, for the purpose of the study, the villages were clustered into five original villages/quarters of the community on the basis of physical proximity, genealogical links and common socio-cultural ties. The five clusters/quarters were Namkpu, Akabor, Uhu, Ovollo and Ogba. Each of the five clusters was enlisted for study. Thereafter, the names of major roads/routes in each cluster/quarter were collated. For each cluster, such names were put into a container and shuffled and with the use of simple random sampling technique, two roads/routes were selected per cluster/quarter (2 roads each from 5 quarters =10 roads/routes). Subsequently, the houses or compounds per road/route were identified and numbered serially. After numbering, 20 compounds/houses were systematically selected from each road (10x20=200 compounds). One respondent aged 18 years and above, whether male or female on whom questionnaire was administered, was randomly selected from a sampling fame that consisted of all adults that live in each compound. Eight (8) respondents were purposively selected for in-depth interview which were made up five senior health staff attached to the five government health facilities in the community. The other three were two males and one female members of the community.

The major instruments for the study were observations, questionnaire and in-depth interview schedules. The questionnaire was divided into two sections (section A and B). Section A contained items about socio-demographic data of the respondents while Section B addressed the substantive issues in the research. The In-depth Interview consists of open-ended questions related to research objectives. The questionnaire was other and or self administered depending on literacy level of each respondent. The researcher was aided by two research assistants who helped in the administration of questionnaires and in recording of proceedings during in-depth interview. Tape recorder and note books were used to record responses from the interviewees.

The Statistical Package for Social Sciences (SPSS) was used in processing and analysing data from the questionnaires. Frequency distribution table and simple percentages were used in the analysis/presentation of data. The study hypotheses were tested, using Chi-square test statistic (x^2). The in-depth-interview was transcribed and analysed using the manual content and narrative method of qualitative data analysis.

Research Findings

Table 1: Personal Data of Respondents

Personal data of the respondents are presented in table 1:

S/N		Variables	Frequency	Percent
1.	Distribution of respondents by sex.	Male	94	47.2
		Female	104	52.3
		No response	1	.5
		Total	**199**	**100.0**
2.	Distribution of respondents by age.	15-24	153	76.9
		25-34	31	15.6
		35-44	6	3.0
		45-54	3	1.5
		55-64	2	1.0
		65 and above	3	1.5
		No response	1	.5
		Total	**199**	**100.0**
3.	Distribution by marital status	Single	181	91.0
		Married	16	8.0
		Separated	2	1.0
		Total	**199**	**100.0**
4.	Distribution of respondents by Religious Affiliation.	Christianity	198	99.5
		African Traditional Religion	1	.5
		Islamic Religion	0	
		Total	**199**	**100.0**
5.	Distribution of respondents by level of educational attainment.	FSLC	4	2.0
		WASCE/SSCE/GCE	132	66.3
		OND/NCE	16	8.0
		B.SC/HND	40	20.1
		M. Sc/Ph.D	2	1.0
		Others specified	1	.5
		No Response	4	2.0
		Total	**199**	**100.0**
6.	Distribution of respondents by Occupation.	Farming	2	1.0
		Civil Servant	19	9.5
		Trading	16	8.0
		Driving	1	.5
		Artisan	2	1.0
		Politician	5	2.5
		Unemployed	12	6.0
		Student	131	65.8
		No response	11	5.5
		Total	**199**	**100.0**

S/N		Variables	Frequency	Percent
7.	Distribution of respondents by level of education attainment 2	FSLC	7	3.5
		WASCE/TC II or equivalent	69	34.7
		Tertiary education	98	49.2
		No response	25	12.6
		Total	**199**	**100.0**
8.	Distribution of respondents by annual income.	100, 000 - 200, 000 per annum	34	17.1
		200, 000 – 300, 000 per annum	14	7.0
		300, 000 – 400, 000 per annum	8	4.0
		400, 000 – 500, 000 per annum	5	2.5
		600, 000 – 700, 000 per annum	5	2.5
		700, 000 – 800, 000 per annum	5	2.5
		900, 000 and above per annum	15	7.5
		No response	113	56.8
		Total	**199**	**100.0**
9.	Distribution of respondents by place of residence/ distance to closest government owned health facility	Below 30 Minutes walk	99	49.7
		Between 31-60 minutes' walk	89	44.7
		Above 60 minutes (an hour)	11	5.5
		Total	**199**	**100.0**

Source: Field survey 2013

Analysis of the Research Questions

The researcher formulated four questions to guide the course of the research work. These questions are re-stated and analysed below:

Research Question 1: What is the level of use/ preference of government owned health facilities among residents of Mbaukwu community of Awka South Local Government Area, Anambra State, Nigeria?

Table 2: Distribution of Respondents by their Perception or Viewpoint about Government Owned Health Facilities at Mbaukwu.

Responses	Frequency	Percent
They are ill equipped, dilapidated and very unkempt	9	4.5
They are fully equipped, have good structures and very clean	12	6.0
They usually lack drugs (out of stock syndrome).	15	7.4
They always have sufficient stock of genuine drugs	19	9.6
Patients recover fast when taken to government health facilities due to efficient and caring/friendly attitude of health workers	26	13.1
Patients end up in mortuaries due to inadequate care and poor attitude to work of health workers at government owned health facilities	67	33.7
The cost of their services is exorbitant (high cost of drugs and of treatment)	24	12.1
They offer cheap services and free immunization	27	13.6
Total	**199**	**100**

Table 2 accounts for the people's perception about government owned health facilities. It shows that the dominant mode of perception of government owned health facilities at Mbaukwu is as facilities where patients end up in mortuaries due to inadequate care and poor attitude to work of health workers. About 33.7%of respondents were of this opinion

Table 3: Distribution of Respondents by their view on whether they prefer private hospitals to Government owned health facilities at Mbaukwu.

Response	Frequency	Percent
Yes	136	68.3
No	53	26.6
Undecided	-	-
Don't know	10	5.0
Total	**199**	**100.0**

Source: Field survey 2013

Table 3 shows that 136 (68.3%) respondents prefer private health facilities to government health facilities at Mbaukwu, while 53 (26.6%) of respondents prefer government owned health facilities to private ones.

Table 4: Reasons for Preference of Private Health Facilities at Mbaukwu

Response	Responses	
	N	Percent
Private health facilities use modern equipments.	33	16.6%
Private facilities are efficient, caring/friendly and effective.	74	37.2%
Doctors / Staff at private health facilities are always there.	20	10.1%
Private health facilities charge less/instalment payment offer	8	4.0%
Everything that you need is always readily available.	8	4.0%
I don't know	56	28.1%
Total	**199**	**100.0%**

Source: Field survey 2013

Table 4 shows that most of the respondents (74 or 37.2 %) preferred private health facilities because they are efficient, caring and effective. And this agrees with the qualitative data.

For instance, an in-depth interview respondent stated that:

> *The private health facilities are efficient and more effective than the government owned facilities in the sense that the private hospital will give you effective treatment. They have health personnel who are always there. Needed drugs are dispensed to the patient as and when due without bothering him about out-of-stock syndrome (Male, 50's and a staff of NAU pre-science Mbaukwu).*

Research Question 2: What are the factors influencing the underutilisation of modern health facilities by rural dwellers in Mbaukwu community of Awka South Local Government Area?

The findings in respect of this research question are shown in Table 5 and 6 respectively.

Table 5: Factors that Accounts for Underutilisation of Available Government Owned Modern Health Facilities in Mbaukwu

Responses	Frequency	Percent
Loss of hope in the government owned facilities.	38	19.1
Patronage of private clinics in the community	65	32.7
Unavailability of drugs (Out of stock syndrome).	33	16.6
Religious belief system /Attendance of faith clinics	6	3.0
Attitude of health workers in government facilities.	26	13
Adoption of self medication	20	10.1
Don't Know	11	5.5
Total	**199**	**100.0**

Source: Field survey 2013

Table 5, shows that the major reasons for underutilisation of government owned health facilities at Mbaukwu community were patronage of private clinics, loss of hope in the government owned facilities and unavailability of drugs (out of stock syndrome). These three factors have significant influence as evident on table5. According to one of the respondents at Mbaukwu General Hospital,

> *The problem of under utilisation of government owned health facilities in Mbaukwu arose out of the fact that many health staff of these health facilities run clinics in their homes and lure patient to patronise them than go to the government facilities. Also lack of staff quarters in the hospitals make it difficult for health staff to reside in the*

facilities to attend to emergencies all year round. As a result, people in critical conditions, do not want to risk going to the facilities especially at night, since they are unsure if health staff will be on hand to attend to them. (Female, 36yr, Nurse).

Table 6: Other Socio-economic and Cultural Factors Influencing Underutilisation of Modern Health Facilities in Mbaukwu

Variables	Frequency	Percent
Low level of Income (poverty)	88	44.2
Cultural belief.	23	11.6
Inappropriate location of the facilities.	43	21.6
Level of One's Education.	34	17.1
Gender considerations in favour of males	6	3.0
No response	5	2.5
Total	**199**	**100.0**

Source: Field survey 2013

Table 2 shows that other major factor that influence underutilization of government owned health facilities at Mbaukwu are low level of income /poverty and location of such facilities. A total of 44.2% and 21.6% of the respondents subscribe to the two views respectively. This agrees with the data from the qualitative instrument which similarly hold level of income as a key socio-economic factor that influences the underutilisation of government health facilities.

Research Question 3: What are the effects/consequences of underutilisation of modern healthcare facilities by rural dwellers at Mbaukwu community of Awka South Local Government Area, Anambra State, Nigeria??

Table 7: Respondents' View's on the Major Consequences of Underutilisation of Government Owned health facilities in Mbaukwu

Responses	Responses	
	N	Percent
Waste of resources in building public health facilities that are not utilised.	54	27.1%
It encourages the private health facilities to exploit users	35	17.6%
It leads to illness and loss of life	71	35.7%
It leads to low income and low productivity.	10	5.0%
It leads to the collapse of modern health facilities.	22	11.1%
I don't Know	7	3.5%
Total	**199**	**100.0%**

Source: Field survey 2013

Table 7 shows that there were three major consequences of underutilisation of modern health facilities at Mbaukwu community in the opinion of respondents The first was that it leads to illness and loss of life (increased morbidity and mortality) reported by 35.7% of respondents. The second is waste of resources in building public health facilities that are not utilised, while the third is that it encourages the private health facilities to exploit users.

Information gathered from in-depth interview showed similar findings. One of our respondents had argued that

> *Underutilisation of government owned health facilities leads to recurrent or protracted illnesses, reductions in population's productivity and death. (Male, 66yrs, an environmental health officer)*.

Research Question 4: What are the solutions to the problems of underutilisation of government owned health facilities at Mbaukwu rural community?

The findings are shown in tables 8 below.

Table 8: Respondents view on Action to be taken by Government in order to improve use of government health facilities.

Variable	Responses	
	N	**Percent**
Train health staff, renovate and equip public health facilities	42	21.1%
Stock pharmacy sections with varieties of drugs only	8	4.0%
More trained health workers should be employed only.	8	4.0%
Government should build good road network to her facilities.	13	6..5%
Government should allocate more funds to the health sector.	18	9.0%
Regular public enlightenment about facilities and services	6	3.0%
All of the above	104	52.3%
Total	**199**	**100%**

Source: Field survey 2013

Table 8 shows that 104 (52.3%) of the respondents were of the view that all the measures listed are relevant to improving utilization of health facilities at Mbaukwu community.

One interviewee proffered a similar solution to the problem of underutilisation of government health facilities when he suggested that,

> *The government should make such facilities attractive through infrastructural improvements, adequate funding, well trained staff*

and affordable services. (Male, 66yrs, an environmental health officer).

Test of Study Hypotheses

The researcher tested the two hypotheses postulated for this study as follows:

Hypothesis 1: There is a significant relationship between level of educational attainment and tendency to underutilise government owned health facilities in Mbaukwu community of Awka South Local Government Area of Anambra state, Nigeria.

Data in Table 9 formed the basis for testing the hypothesis.

Table 9: Relationship between level of educational attainment and underutilisation of modern health facilities in Mbaukwu, Awka South Local Government Area.

What is your highest educational qualification?	How often do you use government owned health facilities in Mbaukwu?				
	Never	**Always**	**Sometimes**	**Undecided**	**Total**
FSLC	3	0	1	0	4
WASSCE/GCE	59	17	29	23	128
OND/NCE	6	0	3	7	16
B.Sc/HND	18	6	8	8	40
M.Sc/HND	2	0	0	0	2
Other Specify	0	0	1	0	1
Total	**88**	**23**	**42**	**38**	**191**
$X^2 = x^2(15, N = 191) = 15.544.582$ P = .413					

Source: Field survey 2013

The computed value of Chi square is 15.544 while the table value of Chi square at 0.05 level of significance with a degree of freedom (df) of 15 is 24.996. Since the computed Chi square value is less than the table value, the researcher rejected the alternative hypothesis. It implies that there is no significant relationship between level of educational attainment and use of government owned health facilities at Mbaukwu. It means that a person's level of education

has no effect on the person's utilisation or otherwise of government health faculties.

Hypothesis 2: "There is a significant relationship between marital status and level of use (underutilisation) of government owned health facilities at Mbaukwu in Awka south Local Government".
Data in Table 10 formed the basis for testing the hypothesis.

Table 10: Relationship between marital status and use (underutilisation) of modern health facilities at Mbaukwu Awka South Local Government Area.

What is your marital status?	**How often do use government owned health facilities in Mbaukwu?**				
	Never	Always	Sometimes	Undecided	Total
Single	78	23	36	40	177
Married	10	0	5	0	15
Separated	0	0	2	0	2
Total	**88**	**23**	**43**	**40**	**194**
$X^2 = x^2(6, N = 194) = 15.101.582$ Therefore: P = 019					

The computed value of Chi square is 15.101 while the table value of Chi-square at 0.05 level of significance with a degree of freedom (df) of 6 is 12.592. Since the computed Chi-square value is greater than the table value, the researcher accepted the alternative hypothesis. It implies that there is a significant relationship between marital status and use of government owned health facilities at Mbaukwu, Awka South Local Government Area. This means

that single persons are more likely to underutilise modern health facilities than the married ones in the area.

Brief Discussion of Findings

Government, especially in developing countries must not only provide facilities or social services, but must institute measures to ensure that such facilities are fully utilised by those they are meant for. In this study, it was found that major factors affect utilization of government owned health faculties at Mbaukwu were the nature of public perception of the facilities and patronage of private clinics in the area. Others are one's level of income and location of the facilities. These findings agree with earlier works like Iregbu (2004), Buor (2005) and Fatimuz and Avan (2002) all of whom agreed that one's level of income is one of the factors responsible for underutilisation of modern health facilities.

More so, in this study, it was found that there are three major consequences of underutilisation of government owned health facilities at Mbaukwu. First is that it leads to illness and loss of life. Others include waste of resources spent in building these public health facilities, and exploitation of the people by private health facilities. These findings agree with the works of World Health (2006), Adebayo and Oladeji, (2006) and Ajala, Sanni and Adeyinka, (2005).

Furthermore, the solutions proffered by respondents were far reaching. They include that government should allocate more funds to health sector; the government should also ensure equitable distribution of resources and access of all members of the society to health facilities by deliberately locating them properly. The government should imbibe maintenance culture; there should be a calculated attempt to retain health workers in government health facilities among others. This findings are in line with the solution proffered by Erinosho (1998) who opined that the Federal Government of Nigeria should increase its

budgetary allocation/ to the health sector so that health facilities could be refurbished. Castro-leal, Dayton and Demery (2000) in their studies in parts of Africa also canvassed for fund allocation and capacity building of health staff as viable tools for improving access and patronage of health services in rural areas of the continent.

Conclusions and Recommendations

Underutilisation of government owned health facilities is not only a problem in rural communities like Mbaukwu but also a major handicap to national development. This is because it has gross negative implications for the health of the people and healthy nation, is a wealthy nation (WHO, 2006).

There is therefore need to stop the trend especially as the nation pursues the goal of 'easy access to health services for all'. The following measures are hereby recommended by the researchers to improve utilization of government owned health facilities at Mbaukwu community and beyond.

1. The government should allocate more funds to these public health facilities and increase the salaries of health workers which will motivate them to carry out their duties effectively and efficiently without need to open nearby health clinics where they attract patients to.
2. Government or public health facilities should be properly locate and distributed equitably. Four facilities at Mbaukwu are inadequate and far from some villages.
3. There is need to make health services at government facilities affordable in such a way that all members of the society (whether rich or poor, rural dwellers or urbanites) to have equal access to these facilities. A payment system that accommodates payments in instalments for

services, which is a key strategy adopted by private clinics should be adopted by government facilities in the absence of viable health insurance scheme for rural dwellers.

4. Government and non-governmental organisations should embark public awareness/enlightenment campaign to educate rural people on the benefits of utilisation of government health facilities and as well as the dangers associated with underutilisation of such health facilities.
5. The government should liaise with the host community to set up monitoring machinery to make sure that health workers are punctual to work and carry out their duties to the satisfaction of clients/patients so that resources used in establishing these facilities will not be a waste.
6. The government should also centralise the provision of these modern health facilities, they should not use politics to put health facilities to remote rural areas that is inaccessible to the people, rather government should centralise the location of these modern health facilities to a place accessible to everybody including those in rural areas and those in urban areas

References

Adebanjo, A. A. & Oladeji, S. I. (2006). *Health Human Capital Condition: Analysis of the Determinants in Nigeria (in Folola T and Heaton M. eds).* Traditional and Modern Health Systems in Nigeria, Africa World Press; Trenton and Asmara: pp. 381- 398.

Adeyemo, D. O. (2005). *Local Government and Healthcare Delivery in Nigeria*. Journal of Human. Ecology; 18(2): 149-160.

Ajala, O. A., Sanni, L. & Adeyinka, S. A. (2005). *Accessibility to healthcare Facilities: A Panacea for sustainable rural development in Osun State South-Western Nigeria*. J Hum Ecol, 18(2): 121-128.

Babar, T. S. & Hatcher, J. (2004). Health Seeking Behaviour and Health Services Utilisation in Pakistan: Challenging the Policy makers. *Journals of Public Health*, 27(1): 49-54.

Beegle, K., Frankenburg, E. & Thomas, D. (2001). *Bargaining power within couples and the use of prenatal and delivery care in Indonesia*. [Stud fam Plann; 32: 130-46].

Buor, D. (2005). "Determinants of utilisation of health services by women in rural and urban areas in Ghana". *Geo Journal*, 61(1): 89-102.

Castro-leal, F., Dayton, J. & Demery, L. (2000). Public Spending on healthcare in Africa: Do the poor benefit? *Bull World Health Organ:* 78; 66-74.

Erinosho, A. O. (1998). *Health Sociology*. Ibadan: Estlink Nigeria Enterprise.

Filmer, D., Hammer, J. & Pritchel, L.(2000). *Weak links in the chain: A diagnosis of health policy in poor countries*. World Bank Res. Obs; 15: 199-224.

Fatimuz, Z. & Avan, I. (2002): "Demographic Socio-economic and environmental determinants of utilization of antenatal care in rural setting of Pakistan". *Journal of Pakistan Medical Association;* 52: 138-142.

Green, M.M.(!1964) *Igbo Village Affairs,* London: Frankass and Co. Ltd.

Ifemesia, Chieka,(1979). *Traditional Humane Living Among the Igbo: An Historical Perspective,* Enugu: Fourth Dimension Pub. Co. Ltd., .

Iregbu, K. (2004). "Healthcare Systems Neglected". *Daily Champion Newspaper*, October 28, pg. 36.

Joseph, Azoro (2010). *The history and culture of the Igbo people before the advent of the Whiteman*. Owerri, Nigeria. *Books.google.com>History Africa-Central*.

Kiguli, L., et al. (2009). *Increasing access to quality healthcare for the poor: Community perception on quality care in Uganda*. Patient Preference and Adherence.

Mahbubur, Rahman, Mofakharul, M. D., Ratiqul, Islam, M.D., Gautam, Sadhya & sAbdul, Latif, M.D. Monet, M. (2011). Health service seeking

behaviour and factors associated with underutilisation of public healthcare facilities in rural area of Bangladesh. *IJPTP*, 2(3), 108-116.

National Population Commission,(NPC), Awka Office.*Population figures for Mbaukwu1991, and Awka South Local Government Area 2006*.

Nwala, T.U., *Igbo Philosophy*, (Lagos: Literame Pub. Ltd., 1985).

Nwankwo, I. U. (2012). *Illness Behaviour*. Lecture Mimeograph on Sociology of Medicine, Nnamdi Azikiwe University, Awka.

Ogunna (1999). "Some causes of Nigeria's Reform Policy": *Challenges of reforms policies in Nigeria*. Aba: P.O.U Ventures Nigeria Ltd.

Onorkerhoraye, A. G. (1997). Inequalities in the Distribution of Healthcare facilities in Nigeria, Vol.2.

Shaikh, B. T. And Hatcher, J. (2005). "Health seeking behaviour and health service utilization in Pakistan", Vol. 27; Oxford University Press.

Uzochukwu & Onwujekwe, (2004). Socio-economic Differences and Health Seeking Behaviour for the diagnosis and treatment of malaria: *A case study of four local government areas operating the Bamako Initiative Programme in South-east Nigeria.*

World Health Organisation (2006). Health Promotion in Developing Countries. *Briefing book to the Sundsvall Conference on Supportive Environment, Geneva*.