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Knowledge and Access to Primary Health Care Information Among Women in Rural Setting

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ABSTRACT

Primary health care center offer professional medical care for individuals based on a locality or community before shifting them to more advance hospital-based care. Unfortunately, few studies exist on Knowledge and access to primary health care information among women in rural area in developing countries. This study adopted interpretative paradigm and collected qualitative data using Dervin Sense-Making theory approach. The collected data were analyzed using inductive analytical processes. Findings revealed that knowledge about primary health care center were received through informal relations and they were told not to access or visited primary health care center due to poor health facilities, unprofessional health workers and early closing hours.

KEYWORDS: Access to Health Information, Access to Primary Health Care Information, Primary Health Care Center.

INTRODUCTION

Primary health care (PHC) is the first level of contact of the individual, family and community with national health system, bringing health care as close as possible to where people live and work and contributing the first element of continuing healthcare process (Alma-Ata 1978). Globally, primary health care (PHC) has been adopted and accepted to be the approach to achieving the health-related Sustainable Development Goals (SDGs) and universal health coverage (WHO 2009). Similarly, primary health care system is a grass-root approach meant to address the common health problems in a community, by providing preventive, curative and rehabilitative services (Gofin, 2005, Olise, 2012). While there are abundance of studies on primary health care in developing regions (Obiora, & Anaehabi 2013). However, most of these studies are not focused on knowledge of primary health care and how individuals access information on primary health care in rural setting (Pakenham-Walsh, 2008). Specifically, very little is

known about what rural people know about the knowledge and how primary health care information is access (Obiora, & Anaehabi 2013). In spite of the relevance of information for effective and efficient health care delivery there are still high rates of diseases in rural setting (Mohammed, 2014).

To save life and improve the benefits of Primary Health Care to rural settlers, there is the critical need to uncover the knowledge of Primary Health Care among rural setting and how rural setting access primary health care information to answer their anxieties, uncertainties, and questions about the knowledge of Primary Health Care. However, little or none studies reported knowledge and access to primary health care information and none of these studies apply theoretical framework to guide the investigation Musoke, 2005; Pakenham-Walsh 2008; Burnett, Jaeger & Thompson 2008). These formed the basis on why the researchers intends to explore the knowledge and access to primary health care information among rural setting using 'Dervin Sense-Making theory.

PROBLEM OF THE STUDY

Access to comprehensive, quality primary health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability, premature death, and achieving health equity for all rural settlers (WHO 2009). However, within a primary health care practice you can access a wide variety of health services: preventive care and screenings; care for chronic conditions such as asthma, hypertension and diabetes; and acute care for problems like coughs, digestive issues and high fever (Alma-Ata 1978).

However, despite all the above mentioned benefits in many developing countries, studies indicated that, rural settlers are still having unnecessary disability and premature death and this is due to lack of proper knowledge and access to primary health care information in their locality (Mohammed, 2014). In Nigeria it is estimated that over 5.7 million rural people have little or no access to PHC (Kim 2018). William (2010) lamented that Kaduna State accounts for about 51% of little or no access to PHC. Currently, in Kaduna State Zaria top the list with 14% of little or no access to PHC and only five percent have knowledge about the importance of PHC (Oyekale, 2017; National Bureau of Statistics 2012). It is in this regard that this study tends to find out why and how rural settlers have knowledge and access to information regarding the benefit of PHC. However, few studies reported Attitude, knowledge and access to information regarding the benefit of PHC (Mohammed, 2014; Burnett, Jaeger & Thompson 2008; Musoke, 2005; Obiora, & Anaehabi 2013; Pakenham-Walsh, N. 2008). And yet, none of those few studies apply theoretical framework to guide the investigating. These formed the basis on why the researcher intends to understand the knowledge and access to primary health care information among rural settlers, using 'Dervin Sense-Making theory.

Research Questions

This study seeks to address the following questions:

1. What are the knowledge of Primary Health Care among Women in Rural area of Zaria?
2. How do women access Primary Health Care Information?
3. How does 'Dervin Sense-Making theory explain knowledge and access to Primary Health Care among Rural Settlers?

LITERATURE REVIEW

This study focused on knowledge and access to primary health care information. A lot of research in primary health care are not rooted base on a subjective reality that allows individuals to understand reality in constructing knowledge in a consensual manner (Spancer, Phillips and Ogedegbe, 2005). Knowledge is rooted within the scholarly content area of epistemology. The concept of epistemological perspective which adopts disease from subjective reality helps in understanding the condition of individuals, which makes room for community perceptions. This is important against the background that community perceptions and reactions to disease and illness are entangled in the socio cultural domain ((Bientzle, Cress and Kimmerle 2014). For instance, in most indigenous communities of Africa, the perception about the causes of disease is usually ambiguous with an explanatory model different from a biomedical model. Therefore, understanding the sociocultural approach and using the appropriate research methods in health research can further enhance local understanding of the disease, (people's experience of disease) and health in Nigeria.

Primary Health Care

The concept of primary health care has been repeatedly reinterpreted and redefined. In some contexts, it has referred to the provision of ambulatory or first-level of personal health care services (Alma-Ata 1978). In other contexts, primary health care has been understood as a set of priority health interventions for low-income populations (also called selective primary health care) (Komolafe, 1994). Others have understood primary health care as an essential component of human development, focusing on the economic, social and political aspects (Musoke, 2005). Primary health care is rooted in a commitment to social justice and equity and in the recognition of the fundamental right to the highest attainable standard of health, as echoed in Article 25 of the Universal Declaration on Human Rights: "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services (WHO 2009).

Access to Primary Health Care Information

Primary health care information must be in clear language that is accessible, reliable and also must be easy to use at the point of care. Information is important not only for effective health care, but also to support the generation of new knowledge and to allow critical interpretation of the relevance and quality of the highly variable new information that is increasingly accessible, particularly through increased access to primary health care Information (Pakenham-Walsh, 2008). Access Primary health care information is essential in health care and health promotion as it improves clinical decision-making and provides both direction and rationale for guiding strategic health behaviors, treatment and diagnosis (Pakenham-Walsh, 2008). However, Access Primary health care information is the entry level to the health system and, as such, is usually a person's first encounter with the health system (Musoke, 2005). It includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions. Access to Primary Health Care Information is comprehensive, quality health information services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Nigerians (Mohammed, 2014). Access Primary health care information improving health care services includes increasing access to and use of evidence-based preventive services (Berkman,Dewalt, & Plynone 2004). Clinical preventive services that:

- Prevent illness by promoting healthy behaviors in people without risk factors (e.g., diet and exercise counseling)
- Prevent illness by providing protection to those at risk (e.g., childhood vaccinations)
- Identify and treat people with no symptoms, but who have risk factors, before the clinical illness develops (e.g., screening for hypertension or colorectal cancer)

Lack of access to Primary health care information, leads to unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, preventable hospitalizations (Egbert, 2010).

Theoretical Framework

It is always important that a good research is linked to theory. This is because theory is used for choosing a methodological approach as well as for developing analytical tools for the research. There are a number of theories that can be used to explain the knowledge and access to Primary Health Care among Rural Settlers. This study was grounded in the 'Dervin Sense-Making theory. The theory is concerned with how people make sense of the world and in particular, the role of information seeking and use or nonuse as part of this process. The theory is rooted in the need to look at information needs in context, and posits that not only needs, but also the interpretation of information obtained and the sense people make of it in respect of whether to use or not to use the information, vary according to particular circumstances. The Sense-Making approach comprises three principles Situations, Gaps/Bridges, Use/Non-use, whereby:

- *Situations* are the conditions in which people found themselves (including 'information')
- *Gaps/Bridges* are the 'misinformation needs' Gaps are seen, not surprisingly, as needing bridging.
- *Use/Non-use* are the ways the individual uses the information obtained/constructed

Previous Studies that Adopted Dervin Sense-Making Theory

Sense-making has been studied by several scholars from various disciplines. This section discussed some of the previous studies that adopted Dervin sense-making theory.

A study conducted by Ismail S. and Rosni J. (2013) carried out a research titled: Sense-making Approach in Determining Health Situation, Information Seeking and Usage in the district of Kuala Selangor, Malaysia. Using sense-making approach as its theoretical framework. The study adopted quantitative methodology. The study asked the following questions. What are factors that motivates towards search for health information? What are relationship between variables such as individual situation, information need, information seeking and usage of health information? Findings indicated that there is no relationship between self-motivation as a subset of intrinsic motivation with information need. Findings from the study also revealed that, information need is not influenced by intrinsic motivation but is influenced by extrinsic motivation. Findings of relationships revealed that there is a relationship between self-efficacy under the self-monitoring dimension and information need. Therefore, self-efficacy influence information need for individual experiencing health problems.

Another study conducted by Peter W. David N. & Paul H. (2003) investigate the non-use of health information kiosks examined in an information needs context. Using sense-making theory as a mirror to guide the investigation. The study adopted qualitative methodology. The research question asked for the study include: the reason for non-

use of health information kiosks within the context of patients' information seeking. Findings from the study elicited many factors accounting for non-use of the system. The first and major source of information remained the doctor, with written or other sources only being consulted where recommended or provided. There was evidence that patients wanted little more than the minimum information or instructions required to deal with their condition. Many appeared unaware of the presence of the kiosk and others assumed either that it was not for patient use or that it would not serve their needs.

Furthermore, Jacky F. (2006) conducted a study on sustaining sense making practices: a case study of a higher education institution. Using dervin sense making theory. The study adopted a qualitative research methodology to address these two research questions. (1) How the sense making behavior is practiced and sustained in organizations and (2) What are the different enabling factors? The findings of study indicated sense making is a circular process involving three core activities which included enactment, selection and retention. However, the sustainability of it depended on whether the institution could construct an amicable organizational context that helped reduce staff resistance to change and improve transparency, so as to create mutual understanding among different parties and individuals. Further findings indicated that experience enabled them to make sense to a new project. They listed out several sources of experience accordingly, such as those given by department heads, project consultants, previous project participants, users or classmates.

RESEARCH METHODOLOGY

Research methodology is a way of thinking and a way of studying social realities (Straus and Corbin, 2008). There are basically three types of research methodology that is qualitative, quantitative and mixed. The researcher adopts qualitative research methodology. Qualitative research methodology, according to Denzin and Lincoln (2003), involves an interpretive, naturalistic approach to its subject matter; it attempts to make sense of, or, to interpret, phenomena in terms of the meaning people bring to them. Qualitative research is suitable for this study because it provide deeper understanding of human information behavior in social phenomena (Silverman, 2005). The purpose of this study is to understand and explain the knowledge and access to primary health care information among rural settlers, and also how do rural settlers perceive health care providers.

A case study research design was used for this study. According to Yin (2003) a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly defined. A case study method selects a very limited number of individuals as the subjects of study. Participants from this study were recruited through purposive sampling technique. In purposive sampling, few participants are deliberately selected to reflect particular features of community within the population (Markwei 2013). Purposive sampling is appropriate for this study, particularly criterion purposeful strategy, because it offers a frame for selecting women that will answer the research question in this study. The respondents for this study were selected based on the following criteria: Must be a childbearing women, aged 20-40. Living in Zaria city and not attending any primary Health Care center. Based on the above criteria, twelve (15) respondents were met the study criteria and hence formed the sample for the study.

DATA COLLECTION

Data collection is the process that enables the researcher to systematically gather relevant answers to research questions (Milanzi, 2009). The data required for achieving the objectives of this study were collected using in-depth interview. In-depth interview was onward to be a suitable for this study because it allow for asking open ended questions to a small sample and exploring individual experiences, perceptions or behaviours. Three women were used as a research assistant. The research assistants were trained and retrained on how to collect the data. The participants were briefed on the description, nature and purpose of the study as well as the procedure and criteria for participation. Privacy, confidentiality and anonymity involved in the research as well as the benefits of the research were carefully explained to the participants. Data was collected from participant in the following geographical location in Zaria; 5 participants from gwargwaje, 5 participants from Kaura Rimin Doko, 5 participants from kofan doka. The participants were given participation consent form to sign and permission were asked for responses to be recorded. The data were transcribed for analysis.

Data Analysis

In this study, thematic analysis approach was used for data analysis. Using this approach, the researcher determines the important themes, and selects the data to support, describe and derive meaning from these. The process of thematic analysis as described by Braun & Clarke (2006) and adopted in this study is as follows.

Phase 1: familiarizing yourself with your data

Regardless, it is vital that you immerse yourself in the data to the extent that you are familiar with the depth and breadth of the content. To accomplished this task the research read and re-read the data in an active way - searching for meanings, patterns and themes.

Phase 2: generating initial codes

To accomplished this task the researcher data into meaningful groups and condense them in to 220 open code

Phase 3: searching for themes

This process involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. Essentially, you are starting to analyze your codes, and consider how different codes may combine to form an overarching theme. To accomplish this task the researcher used table to write the name of each code (and a brief description) on a separate piece of paper and play around with organizing them into theme-piles.

Phase 4: reviewing themes

This phase involves two levels of reviewing and refining your themes. Level one involves reviewing at the level of the coded data extracts. This means you need to read all the collated extracts for each theme, and consider whether they appear to form a coherent pattern. Further condense 220 open code in to 15 sub-categories

Phase 5: defining and naming themes

By “define and refine” we mean identifying the “essence” of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures. To accomplished this task the research further condense 15 sub-categories in to 6 categories

Phase 6: producing the report

This phase is the final analysis and write-up of the report. The write-up must provide sufficient evidence of the themes within the data – i.e., enough data extracts to demonstrate the prevalence of the theoretical theme/construct. To accomplished this task the researcher further collapse 6 categories to 3 theoretical constructs.

FINDINGS

Description of Emergent Categories

This unit describes the five (6) categories and eighteen (15) sub-categories that emerged from the three hundred and eleven (220) open codes. The categories, sub-categories and quotations were arranged properly, to allow the person who reads an opportunity to draw on the reflection of thoughts given to the participants‟ responses. The responses provided multiple views and insights into complex socio cultural factors relevant in understanding knowledge and access to information on primary health care among women living in Zaria city.

The nearest hospital to get emergency treatment

This category quotes from the respondents about their knowledge and understanding on primary health care round them. As stated by these respondents: "*My own understanding on primary health care center is the first stage a person will go for checkup when he is ill and they will give you an emergency treat before the illness will become worst"*

Another participant with different point of view reported that: *Is the hospital that is close to us, go for your treatment.* Similarly this respondent explained that: *Primary health care center is the first hospital a person goes for an emergency treatment.*

Hospitals situated in rural areas

This category portrays narratives related to understanding of women on primary health care before a person go to urban areas. As mentioned be the following participants: "*My own understanding of primary health care center before a person go to urban areas, this hospital helps in tackling problems"* in addition this participant stated that: "*My own understanding of the primary health care center is the first hospital a person goes most especially we in the rural areas"*

Non-challant and unprofessional health personnel

This category explained the reason for not attending primary health care center in Zaria city. As described by these respondents: "*First of all no-good health personnel, and they don't take good care of their job. There is no any attention given to patient"* Another respondent stated that: *.....how do you expect me to carry my family such a place that there is no care and concern shown to patient.*

Health personnel close early or not accessible

This category describes narratives related to reason for not going to primary health care center in Zaria city, in which respondents complained that, the primary health care (PHC) center usually closed early, as mentioned by these respondents: "*My first reason of not going to primary health center in my village once it 12noon you will not see any health personal"* Another respondent stated that: "*some time when go to the primary health care you will not see any doctor, the nurses will keep saying we should wait for the doctors to come*"

Poor health facilities

The above mentioned category emerged from the responses about the reason why women are not attending primary health care center. Majority of the respondent complaining about the inadequate and poor health facilities as mentioned these respondents: "*.....no facilities in our primary health care center"* Similarly the respondent stated that: *……but sometimes if a person go for scanning or X-ray they will said the machine spoil, it wasn't work or no drugs etc."*

Sources of Information on Primary Health Care

This category identifies the various sources of information about primary health care expressed by women in Zaria city. As mention by these respondent: "*there was a time I am not feeling well, my senior brother said we should go to primary health care in rimin doko kaura*" In the same vein another respondents explained: "*I was first had about primary health care from my husband, but he said the center is not function very well due to poor health facilities and health workers*"

Other respondents were first exposed to primary health care through radio, bellow are there responses:

"*I was first received the information about primary health care in radio during 1pm news*"

"*I learned the information about primary health care on radio*" Another respondent stated that: "*I learned the information about primary health care from two of my friends, they visited my when I was seek, and warned me not to go due to unqualified doctors and nurses*"

Discussion of Findings

Findings from this study was discussed best on the research questions in the study.

Knowledge of Primary Health Care among Women in Rural area of Zaria City

Findings from the study reveals that the participant consider primary health care as a first or nearest hospital to get emergency care or treatment before going to the general, specialist or teaching hospital in the urban area. Participants revealed their understanding on primary health care as a first stage a person will go for checkup when he is ill and they will give you an emergency treat before the illness will become worst. However, another findings also revealed that, their knowledge and understanding of primary health care center is any hospital before a patient go to the urban area or urban hospital, this hospital help in tackling the problems before going to the urban hospital. Findings also discovered that some of the participants believed that any hospital situated in a rural area it is a primary health care center, wither is a government or private hospital. This findings are substantiated by other studies conducted by (Musoke, 2005) who affirmed that most of the women in a rural area believed that any hospital build in a rural setting they consider it as a primary health care center.

Access Primary Health Care Information

Findings of the study revealed that women access primary health care information through friends and relative (inter subjective discourse with informal relations) during visitation or when they visit them during their illness. Findings indicated them women come know about the primary health care by visiting them when they are not feeling fine and advise them to go there for treatment and care. Discovering from the study only few women come to know about the primary health care through radio. Findings discovered from the study indicated that women access to primary

health care information through their friends and relatives has an implication. This is because friends and relatives are close associate and they are not official source of primary health care information, as a result both suitable and unsuitable information are accessed.

Another findings also revealed that after having access to primary health care information by women in Zaria city they were told not to attend the primary health care by their husband and relative due to some reasons such as, unprofessional health personnel, health workers closed early or not accessible, poor health facilities and so on. Participants revealed that first of all no-good health personnel, and they don't take good care of their job. There is no any attention given to patients and poor health facilities. Findings also revealed that most of the health workers closed early once it 12noon you will not see any health personal. This finding is consistent with previous studies conducted by (Mohammed, 2014 and Komolafe, 1994) reported that poor health facilities and equipment, unprofessional health workers and inaccessible medical practitioners are the reasons for not attending primary health care center.

How does 'Dervin Sense-Making theory explain knowledge and access to Primary Health Care among Rural Settlers?

The theory is rooted in the need to look at information needs in context, and posits that not only needs, but also the interpretation of information obtained and the sense people make of it in respect of whether to use or not to use the information, vary according to particular circumstances. The Sense-Making approach comprises three principles Situations, Gaps/Bridges, Use/Non-use.

Situations are the conditions in which people found themselves (including 'information'). Findings of the study indicated that when women were in the situation of illness most of their friends and relatives visited them and asked them whether the go to the hospital for checkup and treatment and in some instants they were told or give them information on the primary health care.

Gaps/Bridges are the 'misinformation needs' Gaps are seen, not surprisingly, as needing bridging. Finding from this study revealed that friends, relatives and their husband give the information about primary health care such as: Information about the staff, closing hours and facilities in the primary health care center in order to make sense of it and bridges the gap of their illness.

Use/Non-use are the ways the individual uses the information obtained/constructed: findings also discovered that after making sense of the information received from their informal relatives, they were not using the information or resistance to information by refusing to attend primary health care center due to misinformation received by their friends, relatives and husbands about poor health facilities, unprofessional health workers, and close early before the time. The interpreted the information received make sense of it and decided not to use.

CONCLUSION/RECOMMENDATION

Several studies was conducted to find out the knowledge and access to primary health care but the uniqueness of this study is based on Dervin Sense-Making theory perspective to derive a solution on how women understand and access primary health care information in rural area of Zaria city. Findings base on dervin sense making theory revealed that women in Zaria city were told about information on primary health care by their friends, relatives and husband and also were told by the same people not visit primary health care due to poor health facilities,

unprofessional health workers and also most of the medical practitioners are not accessible. Findings also revealed that only few women received information about primary health care center through radio. Therefore there is critical need for the health policy makers such as ministry of health, world health organization (WHO), to consider husbands and wife, also district head when designing enlightenment and awareness programs on knowledge and access to primary health care in order to improve knowledge and access to the primary health care. There is also need for the government to provide good facilities, professional health workers and extend working hours and make sure all the staff are punctual in their duty station and also to close at the right time.

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