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Factors Influencing the Performance of Primary Health Care Services (FIPPHCS in Niger State, Nigeria

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Abstract: *The present study was conducted to assess Factors Influencing the Performance of Primary Health Care Services (FIPPHCS) in Niger state, Nigeria. Three research questions and null hypotheses were constructed to guide the investigation. The descriptive survey design that is cross-sectional was used for the study. Proportionate stratified random sampling technique was used to select 363 participants from 168 PHCFs across three LGA's of the GPZ in Niger State. The instrument for data collection was an adapted structured questionnaire used in a similar research. The tool consists of 15-items structured on five-point Likert rating format classified into five sub-scales. The reliability of the instrument was determined using Cronbach alpha technique yielded .95. The data collected was analyzed using both descriptive and inferential statistics. The research results reveal inadequate availability of Health Care Personnel and a significantly positive attitude of HCP towards the PPHCS in Niger state. Similarly, the clients' levels of accessing PHCS were significantly high. With these results, recommendations were made which include a call for more qualified HCP needed to keeping HCP-to-patient ratios within safer limits, translating these positive attitudes towards the PPHCS into practice in Niger state. Likewise advocating for a continue strengthen strategies that will significantly limits the ability of clients to access PHCS, not limited to public health sector alone, but extended to private for more holistic prospect. It is the application of these theoretical concepts into practice that will help to promote effective integration of MIS to achieved UHC goal and will of doubt influence performance of primary health care services of modern era.*

Key words: *Factors, Influence, Performance, Primary Health Care, Services.*

I. Introduction

Factors Influencing the Performance of Primary Health Care Services (FIPPHCS) is directly focus to improve quality and better health outcome with emphasis on services delivery to determine changes experienced over a certain period. These aim to lower health expenditure, less hospital admissions and better health outcomes, which depends on the strength and effectiveness of Primary Health Care Services (PHCS) (Bresick, et al., 2019).

PHCS is an essential healthcare service that provides fundamental principle of universal access to quality healthcare services within the available resources to adequately meet people's healthcare demands especially rural communities (Ahmad, et al., 2017). The level addresses short-term—uncomplicated health issues, health promotion and educational aspects, while special services are referred appropriately for a continuity of care

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(Bodenheimer & Hoangmai, 2010). Starfield, et al., (2011) also reiterated PHC Alma Ata declaration's vision of inter-sectorial collaboration, social justice and equity, whose actions is to address health social determinants, as a key constituent of PHC strategy to meet people's health-related needs over time. Thus services are based on full participation of individuals, families, community and country at a cost they can afford to maintain at every stage of their development in the spirit of self-reliance and determination (Kamaliah and Chloe 2017).

Statement of the problem

The focus of FIPPHCS is to improve quality of PHCS at the grassroots to achieve less hospital admission, lower health expenditure and better health outcomes of UHC goal; these depend on strength, and effectiveness of PHCS. However, the level is identified with numerous gaps undermining its performance these drastically limits its capacities to meet the growing health care demand and partly attributed to the failure of PHCS in Nigeria.

In Niger state, despite calls opportunities in health and political environment, PHC remains weak with evidenced of inadequate HCP, poor attitude towards job, and fragment of administrative strategies (State Ministry of Health (SMOH), 2015)as well as dearth of resources (Menizibeya, 2011), Similarly, with rapid expansion of medical institutions; colleges of health technologies, nursing and midwifery colleges in the state, skilled HCP remains critical to achieve health policy goals (Karen and Edna, 2011; Cometto & Witter, 2013)constitutes to deplorable situation and perhaps explain the erratic services to address population's health-related needs (Asamani et al., 2018).

In more recent times, there has been a debate, several studies and reforms put forward to address FIPPHCS. These several studies and reforms that were carryout by the previous governments, researchers, scholars and professionals to address the gaps in this area, none of such studies were in-depth coverage. However, this study will help to filled—in the gaps to address PPHCS demand, and thrust to give administrators, planning, research and statistical (DPRS) a yard-stick in setting up standard to provide degree of excellence within the available resources.

Purpose of the study

The broad aim of this study is to assess the FIPPHCS in Niger State, Nigeria. The specific objectives are to:

1. Ascertain the availability of HCP in PHCFs of Niger state.
2. Assess the attitude of HCP towards their duties in the PPHCS in Niger state.
3. Determine the level of client's access to PHCS in Niger State.

Hypothesis Statement

The following null hypotheses are formulated to guide and direct this research. The hypotheses are tested at .05 levels of significance.

HO1. ***The availability of Health Care Personnel will not be significantly adequate in PHCFs in Niger State***
HO2. ***The attitude of Health care personnel towards their duties will not be significantly positive in the performance of Primary health care services in Niger State.***
HO3. ***The Level of clients' access to primary health care services will not be significantly high in Niger State.***

II. LITERATURE REVIEW

The reviews of the related literature on Factors Influencing the Performance Primary Health Care Services (FIPPHCS) in Niger state, the prospect is so rigorous and requires logical approach. Though, its related literature pertinent might be difficult for two main reasons. Firstly, the initiatives are replicated in research practice of healthcare paradigms and researches published in various literatures (Andrew, 2010). Secondly, the objective targeted at improving quality and better health outcome with focus to evaluate services received or provided over a certain period (Starfield, et al., 2011). PHCS is an essential, universally accessible at affordable cost of individuals, families with community participation. Health care system across the world, specifically

low-and middle-income countries aspiring for universal health coverage (UHC); lower health expenditure, less hospital admissions and better health outcome, most focus to strengthen FIPPHCS, for quality services at grass root to achieve PHC strategies aspiration (Asamani et al., 2018; Bresick et al., 2019).

Despite Nigeria strategic position in Africa; the country is greatly underserved in PHC sphere. PHCS remains weak with evidenced of fragment services, and very deplorable quality of care thus; personnel, supplies and infrastructures, inadequate coordination, dearth and distribution imbalance; specifically, at rural areas. Studies have also proved of highly lack of investments in training-in line with lack of career progression and motivation of PHCP (Menizibeya, 2011).

However, despites several reforms put forward by various governments to translate goals setting in addressing the gaps in the system thus; continue to strength ways of measuring PHCP with comparative benchmarking—using global indicator sets, to track progress, discuss strengths, weaknesses and exchange experiences to provide right information—and better performance evidence base to improve strategies, strength and advance PHCP (Kamaliah & Chloe, 2017).

It's based on this premises the researcher is position to examine FIPPHCS thus; HCPA in PHCFs, attitude of HCP towards their job, and level of clients' access to PHCS.

In the recent terms, as number of emerging and remerging public health issues increases, more qualified HCP are needed to advocate the importance of adopting innovative means of addressing health related challenges, Chand and Naidu, (2017), as effective delivery of PHCS requires adequate and well-trained HCP (Oyekale, 2017). In Nigeria, a growing body of knowledge suggests that adoption of inappropriate health workforce planning interventions, weak and failure in PHCS specifically rural communities in the country, partly attributed to the proportion of HCP necessary to provide services in PHCFs (NPHCDA, 2018).

Similarly, in Niger state, the most pressing issues in PHCFs that's been the subject of public intense is increasingly widespread of HCPA at services deliveries which undoubtedly influenced the PPHCS. This creates considerable workload for the HCP in providing services and drastically limits capacities of health programs to meet the growing health care demand (Ravhengani & Mtshali, 2017).

Recent surveys also revealed burnout rates of HCP ranges from 50-70 percent higher. These statistics reflect on ramifications thus; poor patient care, low satisfaction rates, and emotional distance on the part of clinicians, shows significant correlation between burnout rates and increases of infection rates. These creates disconnection between providers and patients, as providers developed unfriendly, cynical and less empathetic attitudes towards clients and their needs, leaves everyone involved unsatisfactory experience (Darren, 2019).

In conclusion, several related literature reveal HCP-to-patient ratios affects the provision of quality care for patients and sparked concern globally. Human resource professionals (HRP) are adequately requires to address impact of overworked, unsupported staff to patient care, reward, recognition strategies and training programs to increase job satisfaction among HCP and ongoing safe staffing legislation, which will mandate keeping HCP-to-patient ratios within safer limits (Darren, 2019).

Access to healthcare services is described as timely use of health services to achieve the best possible health outcomes. Ideally, residents in communities should conveniently and confidently access PHC services… (RUPRI HP, 2014; RHIH, 2002–2019; healthy people, 2020). Clients Access to Healthcare Services is an important construct that efficient and effectively determine the PPHCS (Ansell et al., 2017).

In Nigeria, despite the availability of PHC centers established across the country (Osahon, 2017), to ensure equity access to quality HC services (Oyekale, 2017) the strategy become critical to achieved (Jin et al., 2017). Rural residents when compared with urban environment, often encounter barriers that limits their ability to obtain healthcare they need (Abdulraheem et al., 2012; as cited in (Osahon, 2017). They also experience; health insurance status, logistic support and stigma associated with some clinical conditions e.g. HIV/AIDS, substance abuse or mental health (RHIH, 2002–2019). Musoke et al., (2014) poor access to PHCS, cost of services, illiteracy, poverty and limited knowledge on illness, wellbeing and cultural prescriptions are barrier to the provision of PHCS and impact on health indicators in developing countries. Healthy people.gov, (2020) racism, ethnicity, socio-economic status, disability, gender, age, sexual orientation and location, is attributed to poor access to PHCS. The complexities of these inter-related varieties of challenges significantly

influence PPHCS (Ikeji, 2013). However, access to health services encompasses; coverage, services, timeliness and emerging issues.

In conclusion, for rural communities to adequately access affordable, available, and effective PHCS at obtainable timely manner, PHC strategies and process have to address thus; Insurance coverage, confidentiality-trust, and HCP availability. While Process includes; Delays in receiving appropriate care and other unmeet health needs (Rockville, 2014). This required meaningful and sustained relationships between HC provider and clients to provide integrated services while practicing within the context of family and community care (healthy people 2020; Rockville, 2015).

Similarly, access to healthcare also requires distinct steps thus; health facility services accessibility and access to HCP whom the patients trust and communicate freely as well as geographical location (Rockville, 2015). More focus is also required to training and deploy HCP that is better geographically distributed to provide culturally competent care to diverse populations (Hadley, 2007; Uberoi et al., 2016).

PHC UHC aspirations of quality PHCS for better health outcome strongly depends on attitudinal behaviors, knowledge and skills of HCP (Nshimirimana et al., 2016). Attitude is described as the tendency to view with favor or disfavor of an object, situation or particular behavior. Attitudes always predict not behavior but often guide the way a person behaves, thus making HCP attitudes towards clients very important in dealing with stigma and discrimination associated them (Kolawole et al., 2016).

In the other hand, negative attitude and discriminatory behavior of health professionals constitute a major obstacle in healthcare environments. However, Understanding the attitude of HCP is crucial, as evidently in-depth study examining attitude of HCP across the globe, have shown prevalence of negative attitudes towards clients thus; Zimbabwe (75.6%), Kenya (75%), Jamaica (61%), Tanzania (58.9%), Switzerland (55.2%) and Nigeria (53%) and Ethiopia ranges from 27 to 57%. Others rejecting behaviors are; stigmatizing, discouraging advice and remarks, all take account of attitudes and knowledge of HCP which have been argued to be a major determinant of quality performance (Yoseph et al., 2019).

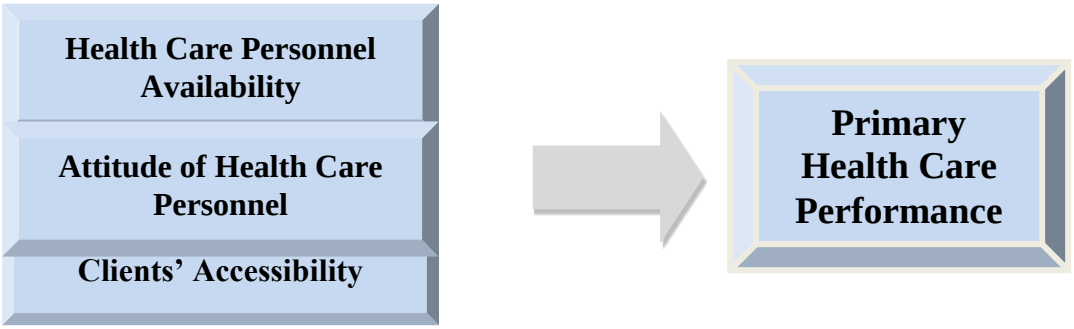
Similarly, less training, minor exposure and experience in ill health has negative, intolerant, un-fearful attitudes and perceptions towards clients and might attribute to fear or predictable nature of illness and lack self-belief in ability to manage such patients, include; low priority, poor infrastructure available to support and care for the illness of HCP (Kolawole et al, 2016). Yoseph et al., (2019) Attitude in medical practice plays a major role in patient care and contributes to patients bypassing the health facility and seek health care elsewhere. However, HCP by virtual of their training are expected to have adequate knowledge in developing positive attitude towards clients.

Therefore, it's important for HCP to undertake continuing professional development training (CPDT) to update their knowledge and skills in order to deliver safe, effective health outcomes. There is also need for more research on additional skills and competencies require to rebuild attitude of HC Professionals (Donald et al, 2016) and redesign programs direction to improve nation's PHCS (Kolawole et al, 2016).

III. Conceptual Model

Conceptual framework to this survey is structured to address identified knowledge gaps in PHCS through extensive review of literatures related. The constructs are strong FIPPHCS draw to strengthen and improve PHCS for better health outcome in low and middle-income countries (PHCPI, 2018). The framework is grounded tools for internal quality improvement to evaluate theory and explicitly identifies the process of PHCS strives to achieve improvement quality, equity and effective PHC system, align with staff and organizational objectives, foster insight practices and provide a focus for learning lead improvements (Gardner, 2007).

Fig.1 FIPHCP Framework



IV. RESEARCH METHODOLOGY

The study adopted descriptive-cross sectional quantitative research method. The target population of this study is health care personnel of different cadres working in Niger State.

The available data has shown 6,534 as population sizes of HCP working in PHCFs of Niger state (NSPHCDA-DPRS, feb.8, 2021). However, HCW's working at PHCFs of the selected LGAs within three GPZ of Niger state are the inclusion, while those declines the consent, on leave, ill-health or otherwise absents during survey are excluded (Kenpro, 2012).

Multi stage sampling techniques approach was adopted thus; first stage, PHCFs are classified based on LGA and their geo-political zone (GPZ); thus;

1. Zone A: Gbako, Lavun and Mokwa
2. Zone B: Bosso, Paiko, and Tafa while
3. Zone C: are Borgu, Kontagora and Mashegu respectively.

Second stage, simple random sampling technique was used to select three (3) LGA from each GPZ. While at third stage, proportionate stratified random sampling method was used to arrive at final sample size of subjects to recruit in each of the GPZ, and Krejcie & Morgan Table (1970) of sample size determination was adopted. However, 363 HCP were draw as sample size to participate in the study (Krejcie& Morgan, 1970). The surveys were conducted in 168 PHCFs of 1,676 PHCFs in Niger state, 56 PHCFs at each of the GPZ using disproportionate stratified random sampling method as Forth stage and convenience method was used at fifth stage, to distribute questionnaire at selected LGAs PHCFs for subject's response respectively.

Structured questionnaires were adapted as instrument for this research, covers standard domains used in US and Lebanon surveys by other authors used in similar studies (Elkhalil, 2017; Faizan, 2018). The instrument is divided into sections. Section A elicited the demographic profile of the respondents. Section B gathered data on the availability of health care personnel in the state, measured by right items. Section C is on the *attitude of Health care personnel towards their duties measured by five items, while section D the Level of clients' access to primary health care services measured by eight items. All items are formatted based on five-point Liker rating pattern* t scale domain thus; A: Agreed, SA: Strongly agreed, N: neutral, DA: Disagreed SDA: Strongly disagreed respectively.

The researcher is the team leader in the process of collecting data for this research. Research assistants or data collectors (surveyors) will be trained, who will visit the three sampled/selected LGA PHCDA's under each senatorial district in the state to assist researcher in follow up, ensure adherence and address gaps until copies of the questionnaire are administered and ensure the sample size is achieved and returning of the questionnaire. The recruitment processes will last for a week (Kolo, 2017). Ethical considerations were adhered to in the process of data collection. The data collected were analyzed using both descriptive and inferential statistical tests of One-sample t-tests in testing the null hypotheses.

V. DATA ANALYSIS AND PRESENATATION

A total of 363 copies of the questionnaire were distributed across the study areas in various primary health care settings. A total of three hundred and fifteen (315) duly completed and verified questionnaire, representing 87% of the total number distributed, collected and were used for data analysis.

Presentation of Results

Hypothesis One: The availability of Health Care Personnel will not be significantly adequate in PHCFs in Niger State

Table 4.9: One sample t-test analysis of availability of Health Care Personnel

Variable	*Sample Mean*	*Sample SD*	*Reference t-value*	*T*	*Sig.*	*Remark*
1. ***Availability of Health Care Personnel***	*18.06*	*7.73*	*24*	*-13.64*	*<.001*	*S*

In testing the first null hypothesis, the variable of interest is the *availability of Health Care Personnel*, measured by eight (8) questionnaire items. The respondents' scores on the scale were summed-up. For the *availability of Health Care Personnel* to be considered significantly adequate or high, the scores made on the scale should be significantly higher/greater than 23 (which is the midpoint between strongly agree and strongly disagree). This implies 3.00 X 8, the number of items measuring the construct. This null hypothesis was tested with a one-sample t-test) otherwise called population t-test). The results are presented in Table 4.9, which reveals a statistically significantly but inadequate or low *availability of Health Care Personnel*, among the respondents (M =18.06, SD =7.73), t(314) = -13.64, P <. 001. The magnitude of difference in the mean (mean difference =-5.94), 95% CL: -6.79 to -5.08) was moderate (eta squared = 0.37). With these results the first null hypothesis is hereby not supported and rejected for the alternative. It then implies that the *availability of Health Care Personnel*, in Niger state is inadequate

Hypothesis Two: The attitude of Health care personnel towards their duties will not be significantly positive in the performance of Primary health care services in Niger State.

Table 4.10: One sample t-test analysis of f Health care personnel attitude towards their duties

Variable	*Sample Mean*	*Sample SD*	*Reference t-value*	*T*	*Sig.*	*Remark*
Attitude of Health care personnel	*6.50*	*2.08*	*6*	*4.880*	*<.001*	*S*

In testing the second null hypothesis, the variable of interest is the attitude of Health care personnel towards their duties, measured by two (2) questionnaire items. The respondents' scores on the scale were summed-up. For the attitude of Health care personnel towards their duties to be considered significantly positive, the scores made on the scale should be significantly higher/greater than 6 (which is the midpoint between strongly agree and strongly disagree). This implies 3.00 X 2, the number of items measuring the construct. This null hypothesis was tested with a one-sample t-test) otherwise called population t-test). The results are presented in Table 4.10, which reveals a statistically significantly positive towards their duties in the performance of primary health care services, among the respondents (M =6.50, SD =2.05), t(314) = 4.880, P <. 001. The magnitude of difference in the mean (mean difference = .502), 95% CL: 0.271 to 0.733) was very small (eta squared = 0.06). With these results the second null hypothesis is hereby not supported and thus rejected for the alternative. It then implies that the attitude of Health care personnel towards the performance of primary health care services is significantly positive in Niger state.

Hypothesis Three: The Level of clients' access to primary health care services will not be significantly high in Niger State.

Table 4.11: One sample t-test analysis of Level of clients' access to primary health care services

Variable	*Sample Mean*	*Sample SD*	*Reference t-value*	*T*	*Sig.*	*Remark*
Level of Clients access to PHC services	*17.32*	*4.35*	*15*	*9.49*	*<.001*	*S*

In testing the third null hypothesis, the variable of interest is the level of clients' access to primary health care services, measured by five (5) questionnaire items. The respondents' scores on the scale were summed-up. For the Level of clients' access to primary health care services to be considered significantly high, the scores made on the scale should be significantly higher/greater than 15 (which is the midpoint between strongly agree and strongly disagree). This implies 3.00 X 5, the number of items measuring the construct. This null hypothesis was tested with a one-sample t-test) otherwise called population t-test). The results are presented in Table 4.11, which reveals a statistically significantly high Level of clients' access to primary health care services, among the respondents (M =17.32, SD =4.35), t(314) = 9.49, P <. 001. The magnitude of difference in the mean (mean difference = 2.32), 95% CL: 1.84 to 2.81) was very small (eta squared = 0.22). With these results the third null hypothesis is hereby not supported and thus rejected for the alternative. It then implies that the Level of clients' access to primary health care services is significantly high in Niger state.

Discussion of findings

The first finding of this study implies that the *availability of Health Care Personnel*, in Niger state is inadequate. This finding is not surprising because it affirms with Ravhengani & Mtshali, (2017) in Niger state, that state the most pressing issues and been the subject of public intense in PHCFs is increasingly widespread of inadequate HCPA at services deliveries which undoubtedly influenced the PPHCS. This creates considerable workload for the HCP in providing services and drastically limits capacities of health programs to meet the growing health care demand. Darren, (2019) also stated that this shortage left employers in dilemma to address and attract prospective HCP burnout in providing services, thereby compounds employee's turnover effects and its impact on client's and safety, as emotional-physical exhaustion leaves providers (HCP) unable to perform their best.

This research finding concord with several related literature that reveal HCP-to-patient ratios imbalance affects the provision of quality care for patients and sparked concern globally. Human resource professionals (HRP) are adequately requires to address impact of overworked, unsupported staff to patient care, reward, recognition strategies and training programs to increase job satisfaction among HCP and ongoing safe staffing legislation, which will mandate keeping HCP-to-patient ratios within safer limits (Darren, 2019).

The second finding of this study reveals that the attitude of Health care personnel towards the

Performance of primary health care services is significantly positive in Niger state. This finding is not in line with evidently in-depth study that examining attitude of HCP across the globe, showing prevalence of negative attitudes towards clients thus; Zimbabwe (75.6%), Kenya (75%), Jamaica (61%), Tanzania (58.9%), Switzerland (55.2%) and Nigeria (53%) and Ethiopia ranges from 27 to 57%. Others rejecting behaviors are; stigmatizing, discouraging advice and remarks, all take account of attitudes and knowledge of HCP which have been argued to be a major determinant of quality performance (Yoseph et al., 2019).

Similarly, this finding do not also in line with Kolawole et al, 2016., Yoseph et al., (2019) of less training, minor exposure and in-experience on ill health by Niger state HCP attributed to the negative, intolerant, un-fearful attitudes and perceptions towards clients which contributes patients bypassing the health facility and seek health care elsewhere. It also states the need for more research on additional skills and competencies require to rebuild attitude of HC Professionals (Donald et al, 2016) and redesign programs direction to improve nation's PHCS, as attitude in medical practice plays a major role in patient care (Kolawole et al, 2016).

The third finding of this study then implies that the level of clients' access to primary health care services is significantly high in Niger state. However, this finding does not agreed with Osahon, (2017), that

states despite the availability of PHC centers established across the country to ensure equity access to quality HC services (Oyekale, 2017) the strategy become critical to achieved (Jin et al., 2017). Rural residents when compared with urban environment, often encounter barriers that limits their ability to obtain healthcare they need (Abdulraheem et al., 2012; as cited in (Osahon, 2017). They experience; poor access to PHCS, cost of services, lack of logistic support and stigma illiteracy, poverty and limited knowledge on illness, wellbeing and cultural prescriptions are barrier to the provision of PHCS and impact on health indicators in developing countries (Musoke et al., (2014). Healthy people.gov, (2020) racism, ethnicity, socio-economic status, disability, gender, age, sexual orientation and location, is attributed to poor access to PHCS. The complexities of these inter-related varieties of challenges significantly influence PPHCS (Ikeji, 2013).

Conclusion

FIPPHCS focus to improve quality of PHCS at the grassroots to achieve UHC goal. This aimed to lower health expenditure, less hospital admission, and better health outcomes, though highly depend on the strength and effectiveness of PPHCS (Bresick et al., 2019).

The level is identified with numerous gaps undermining its performance these drastically limits its capacities to meet the growing health care demand and partly attributed to the failure of PHC in Nigeria (NPHCDA, 2017).

This research is thrust to address the gaps on "FIPPHCS" with focus on HCPA, attitude towards job and Level of clients' access to PHCS in Niger state with in-depth review of related literatures and theories of scholars. Thus; addresses emerging challenges on FIPPHCS in terms of policy guides and mechanism (Leonie &Tom, 2009). These calls for hope, truth and social-just message to the clients', employers and employee's (Obama, 2004), alleviating burnout rate with reward and recognition strategies to increase care providers job satisfaction.

Recommendations

The increasingly demand of ideal team-design, perceived facilitating factors and barriers to implement ideal quality medical services to address FIPPHCS. These calls for a continue to strengthen ways of measuring PPHCS with comparative benchmark—using global indicator sets—to track progress, discuss the strengths, weaknesses and shared experiences to provide right information and better performance evidence base for strengthen PPHCS (Kamaliah& Chloe, 2017).

Similarly, due to complexity of medical field, the researcher suggests integration of US and Europe methods of medical intelligence and surveillance systems (MIS) into Niger state and Nigerian PHCS to serve and create a comprehensive progress in PHCS needs for modern era (Menizibeya, 2011).

This research thrust the need for NSPHCDA to address various threats on FIPPHCS to have a robust management policy, timely and accurate medical information from a wide range of sources for effective performance, taking into consideration real-time data on emerging and re-emerging disease profile, population dynamics and strengthen HCP, not limited to public health sector alone, but extended to private for more holistic prospect.

Similarly, Clinicians and HR managers most emphasis strengthens training programs and ways of tracking and evaluating their performance using global standard or set indicators (Kamaliah& Chloe, 2017).

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