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# EDUCATIONAL LEVEL AND MEDICAL WORKERS' ATTITUDES TOWARDS EFFICIENT HEALTH SERVICE DELIVERY IN NNEWI COMMUNITY, ANAMBRA STATE

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## **Abstract**

*This study investigated the relationship between medical workers' level of education and their attitude towards efficient and effective service delivery in Nnewi community, Anambra State. To guide the study the Social Cognitive Theory (SCT) developed by Bandura, Zimmerman and others was chosen as the theoretical framework. Five hundred and sixteen respondents were randomly selected and studied. Cluster sampling and stratified random sampling were adopted in the course of this study. Questionnaire was the major instrument for data collection and was supplemented by in-depth interview. The quantitative data collected were analyzed descriptively and inferentially and t-test statistic was used to test the hypothesis. Data from in-depth interviews were analyzed using thematic approach. The findings show that there is a statistically significant difference in attitude to effective healthcare delivery based on the level of education of medical workers ( $\chi^2 = (1; N=516) = 0.44, p = 0.003$ ), indicating that medical workers' attitude to efficient and effective healthcare delivery is related to their level of education. However, in-depth interview data indicate that power relations, between health workers and their patients, often emerge from the educational qualification differentials between the former and the latter and could easily become the basis of deep disagreements and sometimes conflict leading to negative health outcomes. Based on these findings the study calls for a mandatory inculcation of a reflexive mindset as part of the training regime of health workers to obviate continuing and future recurrence of conflicts arising from the transactional, socially constructed power differentials between health workers and their patients.*

**Keywords:** *Nigeria, Medical work, Health workers' attitudes, Efficient health service delivery and Health workers' level of education*

## **Introduction**

Socio-cultural factors affecting healthcare delivery have been variously identified and studied by scholars as they concern the average client or citizen in need of healthcare. According to Karkee, Lee & Binns, (2013), the typical socio-cultural factors studied include maternal age, marital status, ethnicity, religion, traditional beliefs, family composition, mother's education, husband's education and women's status. There has, however, been little research on how the medical workers are affected by similar socio-cultural factors in executing their work of healthcare delivery. Most local researches in this area (for example, Marchie, 2012; Ugal, Uschie, Uschie, & Ingwu, 2012) focus on how these socio-cultural factors affect the host community.

Jesus, Marque, Assis, Alves, Freitas, & Oguisso (2010) in a study titled 'Prejudice in Nursing: Perception of Nurses Educated in Different Decades', stated that "in studying nursing history we observe a distorted and erroneous perception of the profession, a prejudicial concept, which is not an uncommon or only recent phenomenon". In as much as, medical workers are highly educated and trained to carry out their duties

without prejudice to age, sex, poverty, religion, education, race, ethnicity, even among medical workers, these factors may still hinder healthcare delivery in various communities.

According to Jesus et al. (2010), understanding the importance of medical workers in effective healthcare delivery, how they perceive their patients, the relationship between medical workers and their patients, not just the hospital structure but those socio-cultural factors that hinder healthcare delivery from medical workers to patients, is important. This would form the focus of this study. Level of education is therefore, one socio-cultural factor that may hinder healthcare delivery from medical workers to patients, which this study intends to focus on.

Gazali, Muktar, & Mahamoud, (2010) conducted a study in Maiduguri, Borno State, to identify the barriers to utilisation of maternal healthcare facilities among pregnant and non-pregnant women of child bearing age in Maiduguri Metropolitan Council and Jere LGAS. They used survey method to collect data for the study. They administered seventy eight questionnaires and six in-depth interviews plus four sessions of focus group discussion. They conducted three sessions in each of the two local government areas. Findings from their studies reveal that socio cultural factors affect the use of maternal healthcare services in the LGAs under study. These factors are associated with the tradition, norms and values of people that affect the way and manner in which they seek medical help. However, this study could not be generalised due to some limitations. In their study also, they found that socio demographic factors also play an important role in how sickness and illness are acted upon and the pattern of utilisation of healthcare services. Although some factors may be individual others are institution based. In summary, the study revealed the factors responsible for low utilisation of the maternal health care facility in the study areas to include: poverty, socio-cultural beliefs and practices, attitude of health workers and availability of facility and quality service. Others are cost, distance, time, lack of drugs, lack of equipment and lack of qualified health personnel, etc.

Also, Idris, Sambo, & Ibrahim, (2013) carried out a study in the Northern part of Nigeria, to determine the barriers to utilization of maternal health services (MHS) from the perspective of mothers in northwestern Nigeria. It was a cross-sectional study of 150 mothers, selected through multistage technique. Data were collected using a structured interviewer-administered questionnaire, and analyzed using SPSS statistics. They found that the use of MHS among the study subjects was poor. The major reasons that the subjects gave for poor use of maternal healthcare facilities were that they had never experienced obstetric complication in the past and also the health care providers in the healthcare facility showed negative attitudes to them. Cost of care was not seen as a prominent factor hindering them from utilising the healthcare facility. They recommended that, while there is a need to increase the use of MHS by raising awareness on it, bringing it closer to the mothers and making it more affordable, there is a more pressing need to improve its quality which could be achieved by building the capacity of the health care providers on modern concepts for delivery of MHS. Furthermore, they prescribed that further studies should be carried out to explore ways through which the negative attitude of health care providers could be alleviated.

Level of education is strongly associated with health status all over the world regardless of race and ethnicity (Agrawal, 2009; Islam, Islam & Banowary 2009; Murphy, 2006). Low education and health status are both causes and effects of low economic status (Altman, 2003). However, indigenous education is traditionally discriminated against both in the occident and the orient. Indigenous children are not formally educated and their language and culture are not taken into account in education (Skutnabb-Kangas, 1999). The studies by Islam Islam & Banowary (2009) and Islam & Sheik (2010) on indigenous community in Bangladesh noticeably revealed that education is one of the most significant determinants of

health. The reproductive health status of Garo people, an indigenous community in Bangladesh, is much better than that of mainstream society due to the influence of Christianity and modern education as the level of education among mothers is 88.8 percent (Islam, Islam & Banowary 2009; Islam & Sheik. 2010). On the other hand, the reproductive health status of Mro people, another indigenous community, is extremely poor relative to mainstream and other indigenous communities (Mahmud, 2006), where the female literacy rate is only 1.12 percent (Rafi, 2006). Another study from Australia also shows that the higher proportion of indigenous people in Australia never attended school which results in poorer health (Altman, 2003).

Meanwhile the need for highly educated medical manpower continues to drive and increase the movement of medical workers from Africa to Europe and North America due to better working conditions, education and several opportunities available to healthcare workers. This exacerbates the pressures that have arisen from health professional workforce shortages (Harris, Kidd & Snowdon, 2008) in Africa, Nigeria inclusive. According to the Philippine Overseas Employment Agency [POEA], between 1993 and 2010 most nurses from Philippine went to Saudi Arabia (90 382), 15 701 followed to the United Kingdom [UK] and 14 895 to the United States [US]. More current trends show that Singapore and the United Arab Emirates have been major recipients in more recent years. International migration by health professionals is an area of increasing policy interest. As Mensah, Mackintosh & Henry (2008) argued, respect for human rights should be paramount in policy responses to the migration of health care professionals. The goal should be equity in healthcare, rather than measures to limit mobility. Key issues that must be addressed include investment in healthcare infrastructure and staff, facilitating return and circular migration, development of knowledge transfer programmes, and the potential 'brain gain' from expatriates and returning migrants (Black & Sward 2009).

Medical workers are an integral part of the healthcare system, hence should be considered in a study of efficient and effective working of the healthcare delivery system. The continued difficulties in healthcare service delivery despite the much that is known on the subject, indicates the need to shift the focus of studies from the patients to other parties and stakeholders involved in the healthcare delivery system. In this light, there is need to examine the socio-cultural factors affecting healthcare delivery from the perspective of the healthcare workers, with the hope that the effort will yield fruitful results; hence, the focus of this study on the level of education of medical workers.

Socio-cultural factors affecting healthcare among users as an area of research focus is virtually adequately covered within extant literature. For instance, there is the work of Ukegbu, Ezeama, Kanu, Ifeadike, & Onyeonoro (2014) on Socio-demographic determinants of maternal health-care service utilization among rural women in Anambra State, South East Nigeria, aimed at exploring pattern of maternal health services utilisation and the socio-demographic factors influencing it in Anambra State.

However, there are hardly literatures found on how these socio-cultural factors are affecting medical workers on service delivery, especially in the Nigerian context and particularly in Anambra State. The present study is therefore a response to this gap. This study will address this gap by examining the socio-cultural factors in terms of level of education of medical workers as it affects healthcare delivery by medical workers in Nnewi, Anambra State. It is hoped that this will help shift the focus to the flip side of the discourse on healthcare delivery in Nigeria thereby helping to engender a corresponding balance in policy on the issue. In this regard, this study would determine specifically whether health workers with higher levels of education are more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education.

## **Methods**

### Participants

The study population includes all the healthcare workers in Nnewi Local Government of Anambra State like doctors, nurses/mid wives and traditional medical workers, etc. The targeted population of medical workers in Nnewi, Anambra state is put at 2122 (PHC Department, Local Government Service Commission, 2018, personal communication).

Nnewi North LGA (NNLGA) is one of the 21 LGAs in Anambra State, South-East Nigeria. The town has an approximate total population of 391,222 people with a sex ratio of 1.02 male/female 0.22. The inhabitants are Igbo, predominantly Christian, and mainly traders, with a few white collar and blue collar workers, farmers and artisans. Nnewi is the second largest commercial town in Anambra State, after Onitsha. It is a town famed for indigenous industrialisation, with raw materials mainly imported from outside the country, thus, attracting dealers on these products from different parts of the country and beyond. Both the federal and state institutions have their offices in Nnewi (Nnebue, Ebenebe, Nwabueze, Obi-okaro, Ubajaka, & Ilika, 2014). Nnebue et al., also report that the Nnewi North Local Government Area (NNLGA) has a number of health facilities, including a federal teaching hospital, Nnamdi Azikiwe University Teaching Hospital (NAUTH) Nnewi. However, there are about 30 private hospitals and clinics, with 28 public primary healthcares (PHCs).

The sample was made up of five hundred and sixteen (516) randomly selected participants. Cochran's (1963) formula was adopted to determine the sample size.

### **Instruments**

Data collection was done mainly by means of questionnaire; supplemented by in-depth interview. The questionnaires part of the study employed other-administration method because of its advantage of making for uniformity in understanding of the questionnaire instrument items by the respondents. Similarly, this method has an added usefulness of giving room for further clarifications to the respondents in the course of instrument administration, if need be.

The questionnaire which was used to collect qualitative data from both traditional and orthodox medical health workers was also administered. The in-depth interview was moderated by the researchers with the help of two assistants who were trained on the study and for purposes of note taking. The IDI guide was used to get the qualitative data for this study. Respondents chosen for the IDI were health workers who had spent at least ten years on the job. The reason for the stated number of years in the inclusion criteria was to draw respondents that have gathered a lot of experience on the job.

Face, construct and content validity for the questionnaire and in-depth interview guide were achieved through engaging three senior academics from the social sciences faculty of the University of Nigeria, who are experienced in research methodology, to validate the instrument. The reliability coefficient (Cronbach alpha) of .77 and .81 were obtained for the instrument. The instrument had a test-retest reliability coefficient of .73. The data collected from the questionnaire instrument were analyzed using the Statistical Package for the Social Sciences (SPSS, version 20).

### **Procedure**

This study adopted an exploratory cross-sectional survey design. According to Barbie (2005) an exploratory study is often cross-sectional in nature. It may combine qualitative and quantitative methods of research. The study was carried out in Nnewi in the four communities within Nnewi Local Government: Otolo, Umuduim, Uruagu and Nnewichi communities.

The study employed probability sampling. Specifically, cluster sampling and disproportionate to size stratified random sampling was used to select 129 respondents (25%) of the sample size from each of the communities, to make it a total of 516 respondents from the four communities that make up Nnewi local government. One-third of the respondents were selected from traditional medical workers that is, 43 respondents from each community amounting to 172 respondents. Two-thirds of the respondents were orthodox medical workers that is, 86 respondents from each community amounting to 344 respondents. The reason is to make sure that variability in perception and opinion due to location can be captured. Making use of the healthcare workers list, a random sampling technique was used to draw the respondents from medical facilities. Simple random sampling was used to draw respondents from a list of members of the association of traditional health workers in the four communities that make up Nnewi.

### **Data Analysis**

All the completed questionnaires were collated and data from the questionnaire instruments analysed using the descriptive statistics such as percentages and frequency distribution. Inferential statistic, namely - Chi-square statistic was used to test the relationship between level of education and attitude of healthcare workers. The qualitative data that the researchers gathered from the field were recorded and transcribed. Then the qualitative data were analysed thematically.

### **Theoretical Framework**

The theoretical framework chosen to guide this study is the Social Cognitive Theory (SCT). The theory was developed by Bandura and Zimmerman with others, who include but are not limited to Rosenthal, Berger and Schunk (Inman, 2003). According to Bandura (1986; 1997; 1999), SCT was first known as social learning theory, as it was based on the operation of established principles of learning within the human social context. With further development, SCT would embrace concepts from sociology and political science to advance the understanding of functioning and adaptive capacities of groups and societies. The theory also has integrated and developed concepts from humanistic psychology by analyzing the processes that underlie self-determination, altruism, and moral behaviour. It would eventually be renamed Social Cognitive Theory when concepts from cognitive psychology were integrated to accommodate the growing understanding of human information processing capacities and biases that influence learning from experience, observation, and symbolic communication.

According to Bandura (1978; 1986), SCT emphasises reciprocal determinism in the interaction between people and their environments. Most behavioural and social theories focus on individual, social, and environmental factors that determine individual or group behaviour (for example, barriers, rewards and punishments and social norms portrayed in mass communication). SCT posits that human behaviour is the product of the dynamic interplay of personal, behavioural, and environmental influences. Although it recognises how environments shape behaviour, this theory focuses on people's potential abilities to alter and construct environments to suit purposes they devise for themselves. In addition to a person's individual capacity to interact with their environment, SCT emphasizes the human capacity for collective action.

Using the reciprocal determinism concept of Social Cognitive Theory, health system interact with the individuals and groups found within the environment, which influences people's behaviour within and possibly outside the environment. On the other hand, the social and cultural perspectives influence the healthcare services delivery within the environment despite world or national standards on healthcare services delivery. One example is the probable evolution of a difference in attitude to effective healthcare delivery based on the level of education of medical workers, with medical workers of higher educational



attainment growing increasingly more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education, who might evolve more of negative attitudes to efficient health services.

Another example is the introduction of prayers in healthcare facilities before the healthcare facilities are opened and after closing hours, not minding the fact that it could be a source of noise pollution to other patients or staff using the facilities as well as a potential source of waste and huge losses in man-hours. This equally increases the waiting time of the patients considering that the time of prayer in healthcare facilities is taken out from the time meant for attending to patients. According to Bandura (1997), planned protection and promotion of public health can be viewed as illustrations of this kind of reciprocal determinism, as societies seek to control the environmental and social factors that influence healthcare delivery and healthcare outcome.

## Results

**Table 1: Chi-Square Contingency Table on Level of Education of Health Workers and Effective healthcare delivery**

More educated workers deliver better care?	Educational Level		Total
	Higher	Lower	
Yes	160	142	302
No	105	109	214
Total	265	251	516

$$X^2 = 0.438, \quad DF = 1, \quad P < 0.05$$

(Source: Field Survey, 2018)

$$\lambda^2 = (1; N=516) = 0.44, p = 0.003$$

This study hypothesized that there is a statistically significant difference in attitude to effective healthcare delivery based on the level of education of medical workers, with medical workers of higher educational attainment more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education. In testing the above hypothesis, data from the questionnaire instrument were first summed and Chi-square test was then used to determine whether health workers with higher levels of education are more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education at 0.025 significance level. Given that the hypothesis is a non-directional hypothesis, the rejection region is at both ends of the distribution curve tails and the Null hypothesis ( $H_0$ ) will be rejected if the  $p$ -value ( $\alpha$ ) is less than 0.025.

From Table 1, Chi-square analysis shows that the Chi-square = 0.438 and is  $P = .003$  which is greater than the alpha value of .025. This implies that there is a statistically significant difference in attitude to effective healthcare delivery based on the level of education of medical workers, with medical workers of higher educational attainment more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education. This means that we reject the null hypothesis and accept the alternative. The study therefore concludes that there is a statistically significant relationship between the level of education of health workers in Nnewi community and better attitude to effective healthcare delivery.

## Discussion of Findings

The findings of this study reveal that there is a statistically significant relationship between the level of education of health workers in Nnewi community and better attitude to effective healthcare delivery. This finding is somewhat in consonance with those of Agrawal, (2009), Islam, Islam & Banowary (2009), and Murphy (2006) whose studies severally revealed a strong relationship between level of education and health outcomes all over the world regardless of race and ethnicity.

The results from testing the hypothesis that there is a statistically significant difference in attitude to effective healthcare delivery based on the level of education of medical workers, with medical workers of higher educational attainment more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education indicated that such statistical significance exists in the data; hence the rejection of the null hypothesis and acceptance of the alternative. The foregoing finding, among other things, may be related to the issue of power relations between health workers and their patients as revealed by our qualitative part of the study, which often emerges from the educational qualification differentials between the former and the latter. This issue of power relations emanating from educational qualification differentials between the health worker and the patient was pursued in some detail in the qualitative segment of the study.

The ultimate aim of healthcare practice is to achieve wholeness in the life of a patient. Consciously working to get a patient out of a pathological state of health is the presumed sole aim of the orthodox health service delivery. This process has an implication of submission on the part of the patient, because the healthcare provider cannot carry out his or her duties very well if the patient has not fully submitted to the course of the treatment of diseases.

Data from qualitative sources in our study indicate that the issue of submission is the beginning or the first of the numerous challenges that are militating against effective health service delivery. Indeed, the patients often perceive the social relation that ensues between them and medical workers as a power relation. By seeking for healthcare, the patient usually finds him or herself in a kind of power relation that he or she is the subordinate; and, except in very difficult situations where he or she is utterly helpless, some patients despite seeking help tend to disobey instructions that may help cure their pathology. In corroboration of this a nurse and midwife in one of the IDI sessions has this to say: “...these patients sometimes, especially the men feel that we are exercising too much power over them by telling them what to do, what not to do, how to do, how not to do...” [IDI,nurse/midwife]

In a similar case,

*a local chief would back out of a treatment regime simply because he feels a young girl like the healthcare provider cannot be dishing out commands to him in the name of treatment of his disease. Here the culture emphasizes respect for the elderly and a situation that is not in support of that norm is bound to be rejected* [IDI, a nurse in Nnewi].

Some other times this same power tussle manifests in the form of the patients refusing to maintain dosages of a particular treatment. They may choose not to heed medical prescriptions and proscriptions just because they would not like the idea of having their lives and lifestyles being controlled by another person. A respondent also gave an account that substantiates this saying that her patient lost her life simply because

the woman felt she was exercising too much power over her by insisting she steers clear of starchy food and any other food that is high on carbohydrate as a pregnant woman. Unfortunately when it was time for delivery, the woman's baby was too big to pass through the uterus and in the process of attempting a normal delivery because she went into labour at home, there was a rupture and by the time she got to the hospital, she died of post-partum hemorrhage [IDI, a nurse in Nnewi]. This observation is in line with the findings of Gazali, Muktar, & Mahamoud, (2010). According to Gazali, Muktar, & Mahamoud, (2010), the value and culture of the people affect their health seeking behaviour, so that the major barriers are not just availability but social, cultural and religious reasons.

## Conclusion

As the study has shown, there is a statistically significant difference in attitude to effective healthcare delivery based on the level of education of medical workers, with medical workers of higher educational attainment more likely to have positive attitudes towards rendering efficient health services to patients than those with lower levels of education. The finding among other things validates the Social Cognitive Theory (SCT) developed by Bandura, Zimmerman and others, which was chosen as the theoretical framework to guide the current study. Also, this finding would appear to be in consonance with previous studies as such studies by previous researchers severally revealed a strong relationship between level of education and health status all over the world regardless of race and ethnicity (see for example Agrawal, 2009; Islam, Islam & Banowary 2009; Gazali, Muktar, & Mahamoud, 2010; Murphy, 2006).

In a number of instances, however, as the qualitative part of the study reveals, the issue of power relations emanates from educational qualification differentials between the health workers and the patients. As we find from the qualitative segment of the study, this power relations from educational qualification differentials between the health workers and the patients often ultimately culminate in negative health outcomes for the patients as they strive to resist the perceived hegemonic power that the health workers seek to wield over them through many processes including what the postmodernists would refer to as the expert gaze, which seeks to distance medical workers from the patients and treat them as dependent subjects.

This study finally suggests that in spite of the literature gap already filled by the present study, further research needs to be done to cover all the other regions of Nigeria and as well as other socio-cultural factors that may have a bearing on the attitudes of health workers towards rendering efficient health services. Also, based on the findings of this study, there is an urgent need for a mandatory inculcation of a reflexive mindset as part of the training regime of health workers to obviate the continuing and future recurrence of conflicts arising from the transactional, socially constructed power differentials between health workers and their patients.

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