PERCEIVED CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN KADUNA STATE

BY

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2005

DECLARATION

I here by declare that this thesis titled "PERCEIVED CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN KADUNA STATE" has been written by me and that it is the record of my own research work. It has not been presented for any degree either wholly or partially and is not being concurrently submitted for any other degree.

All questions are indicated by quotation marks or indentations and the sources of information are duly acknowledged by means of reference.

…… ……

ASABRU YUSUF **DATE**

CERTIFICATION

This thesis titled "PERCEIVED CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN KADUNA STATE" by Asabaru Yusuf meets the regulations governing the award of Master of Education in Health Education of Ahmadu Bello University, Zaria and was approved for its contributions to knowledge and literary presentation.

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DEDICATION

The research work is dedicated to the Lord Almighty, who saw me through the programme, my late father, my sweet mother who laid the foundation for my educational pursuit and to my husband, who took over from where my parents stopped to the present level, my children, brothers and sisters.

ACKNOWLEDGEMENTS

The researcher appreciates, blesses and exalts God for seeing her through the course. She also thanks God for giving her the grace to start, to continue and to finish. I returned the glory to Him in Jesus name, amen.

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The researcher would not fail to register a sincere gratitude to her employer, Ministry of Education, and Health Management Board, Kaduna State. I am grateful to all those who assisted me in one way or the other throughout the period of the course.

ABSTRACT

The purpose of this study was to investigate the constraints to effective utilization of Primary health care services in Kaduna State.

The population of the study comprises all adults in twenty three local government areas of Kaduna state. A random sample of twelve local government areas were selected. Furthermore, a stratified random sampling was employed in selecting 360 adults (male and female) of 18 years and above from urban and rural areas in Kaduna state.

The ex-post facto research design was used for this study. The instrument used was a questionnaire developed by the researcher and validated by experts. Six null hypotheses were stated to find out if there is any significant difference in the perceived constraints to effective utilization of primary health care services in Kaduna State. Analysis of variance (ANOVA) and a t-test statistic were used to test the hypotheses at 0.05 level of significance. The major finding from the study reveal that:

1) It was discovered that accessibility, acceptability, affordability and availability were perceived by the respondents as constraints to effective utilization of primary health care services.
2) It was also revealed that no significant difference existed between the respondents of different age groups, socio economic status, gender, educational background and location in their perception of the accessibility, acceptability, affordability and availability as

constraints in the effective utilization of primary health care services.

3) Socio-economic status and sex had significant influence in the respondents perception of constraints for effective utilisation of primary health care services.

Based on the findings, recommendations were made which included the followings:

1) Primary health care services should be made available to all Local Governments in Kaduna State.
2) Primary health care service should be accessible.
3) It should be closer to the consumer so that the issue of transportation will be minimized.
4) The services rendered should be acceptable culturally and religiously.
5) The services should be appropriate to the local technology.
6) State Ministry of Health and Management Board to begin on sensitisation campaign across the state particularly in the rural areas.

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DEFINITION OF TERMS

URBAN - All towns designated as Local Government Headquarters.

RURAL AREA - All towns not designated as Local Government Headquarters.

ADULT MALE AND FEMALE – Person aged 18 years and above.

HOUSE HOLD HEAD – Head (Male or Female of the Basic Unit of the Community).

ABBREVIATIONS

PHC	–	Primary Health Care.
WHO	–	World Health Organization
UNICEF	–	United Nation International Children's Education Fund
ICPHC	–	Internal Council of Primary Health Care.
UNDP	–	United Nations Development Programme.
CHEWs	–	Community Health Extension Workers.
TBAs	–	Traditional Birth Attendants.
USAID	–	United State Agency for International Development.
SSS	–	Salt Sugar Solution.
ORT	–	Oral Rhydration Treatment
VHW	–	Village Health Workers.
NPHCA	–	National Primary Health Care Agency.

CHAPTER ONE

1.1 BACKGROUND

The term "primary care" was first used in 1920 in England, when Lord – Dawson reported on first contact medical care and the promotion of primary health centre (Alakija, 1986). In 1962, the term was used in Britain to denote general practice (Alakija, 1986). Primary health care (PHC), therefore, is not a new concept. However, many people are confused about its meaning. The confusion arises because primary health care has different meanings in different contexts, and these have changed over time. It was given international status when it was launched at the WHO – UNICEF Conference in Alma Ata in 1978, where it took a new dimension.

Looking at the origin of the term and the changing ideas that led to its latest formulation, the concept was introduced as a key to attaining health for all by the year 2000 and beyond, and was to be adopted by all member states of the world (Yusuf, 2002). The Primary Health Care is an essential health care based on the following underlying principles:

(a) The health services should be made available to individuals and families in the community at all times when they need it, including rural or isolated population, who in the past were almost totally neglected. Thus, instead of building up urban services to emulate the sophisticated range of medical services in the developed world, it should be creating appropriate services that extend to every one (Ben & Wessen, 1974).

(b) Community participation in health care is more likely to lead to the promotion of better health. Community members are to support Primary Health Centre Services through assuming responsibilities for their health development. They should be involved in planning,

implementing and evaluating health programmes in their community. Therefore, if health is regarded as a process of living and being, people should be involved through their own action in controlling their own lives. This implies a democratic process that allows a certain level of decentralization in health care (Yusuf, 2002).

(c) The focus must be on prevention, because it is there that the greatest strides can be made. However, experience (with maleria or immunization campaign) has shown that preventive measures are not necessarily cheap nor easy to implement, and that curative care is in much demand among both urban and rural populations (Ben & Wessen 1974).

(d) Technology must be appropriate. Primary Health Care Services are to be made available through the use of appropriate technology. Locally available resources are to be utilized and directed towards health services in such a way that is hygienically and socially sound and also adhered to the ethnics of medicine. For example, preparation of salt, sugar solution (SSS), and imported sterilizers may be replaced by boiling water, where fire wood or coal is not scarce (WHO; 1987).

(e) Finally, inter-sectorial collaboration approach recognises that other related sectors in the economy of the community affect health. They

are brought into the health system to participate in solving health problems. For example, education, housing, public water supplies and so on should be involved. There is a well known correlation between health status and education or literacy. Health status is higher when education and literacy are widespread. People are more capable of taking care of their problems. A healthy child is more likely to attend school regularly and to improve his or her performance (WHO; 1987).

Therefore, primary health care approach aims at bringing health services to the door step of the people where they live and work in the community. However despite the provision of primary health care services, their effective utilization depends on a number of factors, like affordability and accessibility. When these factors are not adequate in the target population they become constraints. This study was therefore conducted to find out such constraints.

1.2 STATEMENT OF THE PROBLEM

Primary Health Care has been approach to improve the health status of people by changing their social and economic circumstances rather than providing orthodox medicine. The Alma – Ata decration on health care programme was to ensured achievement of health for every one by the year 2000. However primary health care

services have been reported to be incompletely and inefficiently utilized (Hassan, 1999).

To fully utilized primary health care services, some of the most important constraints that have been identified to limit utilization of health care services include acceptability, accessibility, availability and affordability. First and foremost, for people to utilizes these services, they should be available. Even if they are available, they should be acceptable to the people because utilization of any service depends on great extents, cultural preferences. In developing countries, where their economic conditions are very poor, many health services are not adequately

1.3 RESEARCH QUESTIONS

For the purpose of this study, an attempt was made to answer the following research questions:

1. Is there significant difference between respondents of different age groups in their perception of constraints to effective utilization of primary health care services?
2. Is there significant difference between respondents of different socio-economic statuses in their perception of constraints to effective utilization of primary health care services?
3. Is there significant difference between respondents of different educational backgrounds in their perception of constraints to effective utilization of primary health care services.
4. Is there significant difference between male and female respondents in their perception of constraints to effective utilization of primary health care services.
5. Is there significance difference between respondents of different occupations in their perception of constraints to effective utilization of primary health care services.
6. Is there significant difference between respondents of different of locations in their perception of constraints to effective utilization of primary health care services.

1.4 PURPOSE OF THE STUDY

The specific purposes of the study were as follows:

a) To identify primary health care services available.

b) To determine the level of utilization of the available services.

c) To identify factors that are associated with utilization of primary health care services.

d) To make recommendations on how to improve present status of utilization.

1.5 BASIC ASSUMPTIONS

This study was based on the following assumptions:

1. Primary health care services are accessible, acceptable, affordable and available in all rural and urban areas in Kaduna State.
2. Usage of primary health care services can be influenced by individuals level of educational background, economic status occupation, gender, age and location.
3. The possible factors militating against inadequate utilization of primary health care services in kaduna state can be drawn from responses of subjects.

1.6 HYPOTHESES

On the basis of research questions and assumptions, the following hypotheses were formulated for the purpose of this study:

1. There is no significant difference among respondents of different age groups in their perception of constraints to effective utilization of primary health care services.
2. There is no significant difference among respondents of different socio-economic status in their perception of constraints to effective utilization of primary health care services.
3. There is no significant difference among respondents of different educational backgrounds in their perception of constraints to effective utilization of primary health care services.

4. There is no significant difference between male and female respondents in their perception of constraints to effective utilization of primary health care services.

5. There is significant difference among respondent of different occupations in their perception of constraints to effective utilization of primary health services.

6. There is significant difference among respondent of different locations in their perception of constraints to utilization of primary health services.

1.7 **SIGNIFICANCE OF THE STUDY**

This study was justified on the following bases:

(1) Although primary health care services are provided in both urban and rural areas in Kaduna State, it is not known to what extent they are utilized by the target population. This study would reveal the extent of the utilization of services in Kaduna State.

(2) Provision of primary health care services alone cannot guarantee improvement in the health status of people. It is their effective utilization of these services that contribute to a large extent to the health of the people. Utilization of these services is affected by a variety of constrains, the constrains in their effective utilization of these services are not clear, this study would reveal whether constraints like accessibility, acceptability, affordability and availability affect the effective utilization of primary health care services.

(3) Finally, the study is expected to stimulate interest in other researchers to carry out similar studies on different users of primary health care services like adolescent, to find out if there is any difference.

1.8 **DELIMITATIONS**

The study was delimited to perceived constraints to effective utilization of Primary Health Care Services in Lere, Giwa, Birnin Gwari, Zango Kataf, Kaduna North, Soba, Jama'a, Zaria, Igabi, Kudan, Kajuru and Ikara Local Government Areas in Kaduna State. These constraints included accessibility, acceptability, affordability and availability of health care services.

1.9 **LIMITATIONS OF THE STUDY**

This study was limited in the following areas which would be taken into consideration while interpreting the result.

(1) A survey research like this can provide better result if it utilizes interview and observation technique in addition to utilizing questionnaire.

(2) This study used questionnaire as its main instrument for collecting data. Because of time and economic constraints it was not possible to verify the questionnaire responses through interview and discussion. However, effort was made by the research assistants to make all the statement very clear to respondents.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION

This study examined perceived constraints to effective utilization of health care services in Kaduna state. An attempt was made in this chapter to review related literature from journals, theses, textbooks and conference proceedings. This is presented under the following subheadings:

2.2 Primary Health Care (PHC)

2.3 Components of Primary Health Care

2.4 Problems militating against PHC implementation.

2.5 Primary Health Care Development in Nigeria

2.6 Primary Health Care and Development

2.7 Operational aspects of primary health care

2.8 Bamako initiative: Kaduna state implementation strategy

2.9 Factors affecting utilization of health care system.

2.2 PRIMARY HEALTH CARE (PHC): WHAT IS IT?

Primary Health Care (PHC) started off as primary medical care in the narrowest sense, that is frontline, first – contact care, where patients met health workers. In Britain, these were general practitioners, but in many developing countries they were nurses or community health workers. Implicit in the first contact concept was that it catered for common complaints that could be treated readily, often at low cost. Primary prevention, like immunization, was also sometimes part of primary care (WHO, 1978).

This early definition of PHC thus contained two elements. One focused on the level of services – first – contact, frontline and became almost synonymous with the health workers moulded in the image of the Chinese "barefoot doctor"; the other focused on activities, covering simple diagnosis and treatment (WHO, 1992). Thus, primary health care was sometimes used to denote the peripheral, rural, bottom level of the health service, or the day – to – day activities carried out in out – patient clinics, health centres or health posts the world over. Basic health services in many countries embodied this development away from hospitals towards health centres and auxiliary personnel. The term was used freely in relation to developed or less developed countries.

The concept of PHC launched at Alma Ata included all those aspects, but went further to emphasize that, "primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally sound and socially acceptable methods and technology, made

universal accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self – reliance and self – determination" (WHO, 1978).

It was argued that health services that could act on their own improve the community's health and that the socio economic and political factors affecting poverty and inequality, which themselves affected health, had to be considered to improve health. "Health improvement in developing countries has to relate to the political economy of health, and the PHC approach cannot make significant progress until these fundamental socio-political issues are acted upon" (WHO; 1981). What was being expressed was much more a philosophy of health, or way of looking at health issues, which was differentiated from the earlier concepts of PHC by calling it the primary health care approach. While avowedly applicable to the developed world as well as to the less developed, the PHC approach has up to now focused almost entirely on developing countries. What is more, it has also largely been directed to rural areas, and has tended to ignore the semi – urban slums of third world cities. This has led many to see it cynically as a second – class, rural health system for those countries which cannot afford better healthcare. While this is certainly not what was intended by the protagonists of the PHC approach, they were not blind to the difficulties entailed in implementing a PHC system, which in almost all countries involves reappraisal of health budgets, shifting of resources from hospital – based urban services to rural health services, or putting additional resources into the countryside. The Alma Ata document stated that political will and political commitment would be the most important factors in the implementation of primary health care (WHO, 1992).

The international conference on primary health care was held in Alma – Ata in September 1978. (NPHCA, 1995). The conference expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. In doing so, the conference strongly reaffirmed that health, which is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is the most important world – wide social goal, whose realization requires the action of many other social and economic sectors in addition to health sector.

The conference noted the existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries which is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. It maintained that economic and social development, based on a New International Economic order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and world peace (UNDP, 1990).

As much as the governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures, people have the right and duty to participate individually and collectively in

planning and implementation of their health care. One main social target of governments, international organizations and the whole world community in the coming decades therefore should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice. Now (2005) that goal has not been attained (NHP, 1988).

Primary health care therefore is the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self – reliance and self-determination (reference) WHO, 1992. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO, 1992).

Primary health care, therefore:

1. reflects and evolves from the economic conditions and socio – cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least; education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious disease; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors, and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate; should be sustained by integrated, functional; and mutually – supportive referral system, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.

. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed. Suitably trained socially and technically to

work as a health team and to respond to the expressed health needs of the community, (Kuti, 1990).

In short, Primary Health Care should not be viewed as a set of discrete and isolated activities, but as an organized concept for ensuring more effective health care, based on the co-ordination of all essential services at the community level and effective vertical linkages between lower and higher levels of the system (UNDP, 1990).

2.3 COMPONENTS OF PRIMARY HEALTH CARE

The following are the main components of PHC:

(a) Health education is the key to Primary Health Care services by which members of the families in the community are enlightened on the causes of ill health and methods to identify these causes and how to combat them in order to achieve safe and sound health (Yusuf, 2002).

(b) Immunization is meant to build body resistance against infectious disease, which usually affects the health of individuals and families in the community, (Yusuf, 2002).

(c) Prevention and control of Endemic and Epidemic diseases in the community controlled the causes and predisposing factors of diseases to the barest minimum through environmental sanitation, personal hygiene, proper nutrition and immunization (Yusuf, 2002).

(d) Adequate supply of good water and basic sanitation for the community consumption and other essential utilization has to be safe and free from pathogenic influences, so as to prevent individuals and families from infection. This is achieved through training the source of water and providing adequate purification measure (Yusuf, 2002).

(e) Promotion of food and proper nutrition individuals require food for their daily consumption, which normally provides essential nutrients for normal body function. Such food has to be safe and free from pathogene right from production process to the consumption levels to achieve this, agricultural production has to be promoted in order to prevent disease, (Yusuf, 2002).

(f) Maternal and child health including family planning. Most maternal deaths are associated with childbirth, pregnancy and labour, therefore in order to promote the well being of mothers and children, and also reduce rate of intent and maternal mortality in our communities, postnatal and family planning services are integrated into Primary Health Care component services. (Yusuf, 2002)

(g) Appropriate treatment of common diseases and injuries. Diseases and injuries do commonly occur due to some reasons affecting the well being of individuals and families despite PHC efforts in health education, immunization etc. such common disease and injuries have to be managed using standing orders. (Yusuf, 2002)

(h) Provision of essential drugs and drug revolving system. The drugs that are most needed to satisfy the health care needs of the majority in the community which must be available and at cheaper rate at PHC facilities using revolving system so as to treat any diagnosed or identified disease in the individual and families in the community.

(i) Dental health care: Proper oral hygiene is important in the individual for preventing entrance of disease and promoting well being.

(j) Mental Health Care – community mental health addresses ill-health of individuals and families in the community in terms of thinking, reasoning, interaction and judgement. Primary Health Care identifies and recognizes those that are mentally ill within the community and refer them to psychiatric hospital (Yusuf, 2002).

2.4 PROBLEMS MILITATING AGAINST PHC IMPLEMENTATION

A correct orientation of health care policies as outlined by Alma Ata declaration of PHC is complex and requires sufficient time to adequately implement. This is more so because of some fundamental issues relating to the concerned country's historical economic, socio-political and cultural factors (reference) (WHO, 1978). Thus, there is the need for each country to map out her own appropriate strategies taking into cognisance her peculiarities.

It is a common knowledge that successful PHC services in some part of the world have not included all the eight components. The UNDP evaluation of 1990 identified some common problems which have been experienced by many countries in the process of implementing PHC. Some of the common problems are:

1. Political commitment (or lack of it) to primary health care and its reflection in national budgets of the concerned country.
2. Under utilization and missed opportunities for training of family members as human resources of primary care, particularly in prevention, but also in some areas of curative services such as oral dehydration therapy against diarrhea diseases.
3. Lack of supervision, support and retaining of community – level workers, especially the need for development of a strong linkage between community – level personnel and their supervisors who may be available as infrequently as once per year.
4. Inadequate compensation, poor working conditions and weak incentives for community health workers.
5. Lack of field training and understanding by health personnel of how to work with community groups and power structure, including assisting in forming village development committees and training community health workers.
6. Attitudes and policies on traditional practitioners and midwives which fail to take advantage of their potential contribution to both prevention of diseases and death and delivery of health services.

7. Selection and training of inappropriate candidates for health services particularly at the community and health post levels.
8. Problems of recurrent expenditure and depital cost of financing primary health care.
9. Problems of management, including human resource development.
11. the coverage is inadequate. It is estimated that no more than 35% of the population has access to modern health care services. In rural communities and the surban poor are not well served.
12. the orientation of the services is inappropriate with a disproportionately high investment in curative services to the detriment of preventive services.
13. the management of the services often shows weaknesses resulting in waste and inefficiency as shown by the failure to meet target and goals.
14. the involvement of the community is minimal at critical point in the decision making process. Because the communities are not well informed on matters affecting their health, they often unable to make rational choices. (Kuti, 1990).

2.5 PRIMARY HEALTH CARE DEVELOPMENT IN NIGERIA

Nigerian health system dates back from Pre-colonial period to independence period (1960 – 1975). It emphasis was largely based on curative services. Thus hospitals were built in urban cities, with few dispensaries and nurses concentrated in the urban hospitals. There was poor management of health system and inadequate population coverage with health services. (Yusuf, 2002).

In early 1975 – 1985, the emphasis was still on curative measures but effort to embark on preventive health measures was shaped in the third National Development Plan to:-

a. extend focus to preventive activities

b. use appropriate technology in health services provision through the training of a new cadre of primary health care workers that would be used to provide these services. Thus the primary health care workers-community health officers, CHEWS were bornes and lastly building of clinics, health centres and infrastructural facilities in local government areas and local communities. (Yusuf, 2002)

The implementation of PHC in each local government area included the following steps (Yusuf, 2002).

- conduct of advocacy and sensitisation workshops at all levels.

- reorientation and training of health workers
- putting in place managerial structures, beginning with the village development committee to district, local government area and state development committee. These committees were designed to promote multisectoral collaboration and community involvement.
- setting up health management information systems which included house numbering and placement of home based records.
- setting up village health systems through the training of VHW and TBA.
- strengthening supervision
- provision of technical and financial support by the FMOH.

From 1985 to date, full PHC services lay great emphasis on preventive health services at the grass root level. Hospitals and health centres were built, personnel were trained to provide PHC services and LGAs and communities were fully committed to the services, principles of PHC and PHC personnel were set in motion to provide these services.

TRADITIONAL MEDICAL PRACTICE

Kuti (1990) maintains that it is wrong to believe that there was no health care before the advent of western medicine. Traditional medicine was supreme everywhere, and although it presided over the highest mortality and morbidity rates ever known, the people believed in it and still believe in it.

In Edo and Delta States, it has been found that 56% of traditional midwives do not think it necessary to wash their hands or the woman's body before delivery of the baby and 20% attempt complicated and difficult deliveries in which they invariably fail. (Kuti 1990). Asked about the methods used to resuscitate a baby that fails to cry at birth, the answers varied from "sprinkle alligator pepper on the baby" to "plug the anus with the finger and pour cold water on the baby" and "nothing, it is God;s wish" (Kuti, 1990).

For convulsion due to fever, a mixture is administered containing mainly cow's urine, tobacco leaves and various herbs. This mixture is a major contributor to about 60% of the deaths due to this condition.

When asked about the use of the cow's urine mixture to prevent convulsions, mothers in Lagos stated that they give it to their children regularly, sometimes several times a day, either alone or mixed with other medicines, and that the children in most cases improve. When a child convulse, a large quantity of the mixture is poured down his or her throat. This is the community's attitude to a preparation known to be poisons. (Kuti, 1990).

HEALTH RESOURCES

Although Nigeria has more than one doctor for every 10,000 people, Adegoroye (1989), states that these doctors are poorly distributed, most of them being in the urban areas and the southern states. There are communities that have never seen a doctor and others may have a ratio of one doctor to 200,000 population. On the other hand, it is estimated that Lagos has one doctor per 500 people. Attempts to persuade doctors to serve in the poorer areas of the country has failed, largely because their education does not equip them with the skills needed to work with communities. Another reason is the lack of amenities such as water, electricity, and schools in rural areas. Lastly, there is still a lingering belief that in some states doctors face discrimination in appointments to comfortable posts. Nurses, according to him, are five times more numerous than doctors but they too are poorly distributed. However, many rural health centers throughout the country are staffed by nurses and they do what has been taught to do to the best of their ability.

In the early 1970s, studies indicated that nurses, like doctors, were ill equipped to deliver primary health services, and a major adjustment in their curriculum was required. Although this was done, it did not succeed in removing the overwhelming bias towards the provision of hospital or individual health care services, but it did increase.

In 1978, a new breed of primary health care workers was introduced. These were the community health officers, supervisors, assistants, and aides. In 1987, the names "assistants" and "aides" were changed to "community health extension workers" for the very important reason that the aides, being the most important members of the primary health care team, are expected to spend 80% of their time

in the community, where they motivate the villagers to action in the provision of health services. They will thus be the architects of community participation – a prerequisite for introducing a community to the age of science (Kuti, 1990).

In addition to diagnosing and treating common conditions with simple measures, identifying pregnant women and ensuring that they deliver safely, identify malnourished children, and providing health education in the community, the community health extension workers will mobilize the community for preventive action such as the building of latrines, wells, and roads. This is no mean task, and to call them "aides" is misleading and belittles their important role. In the past, as aides, they were regarded as fit only for menial jobs in clinics and hospitals. As community health extension workers, their role is to spread health care within the community in a responsible manner. They are not aides to anybody but skilled health workers in their own right-agents of change with important functions to perform in the community health team. (Kuti, 1990). Those who used to be known as assistants have a similar role but at a higher level, providing the bulk of clinic-based health care services. These two kinds of community health extension workers form the basic primary health care team and the link between the community and the clinic.

THE HEALTH SERVICES

According to Kuti (1990), there are tiers of health services. The primary, which is closest to the people, is constitutionally the responsibility of local government. The secondary health services, which are for patients whose problems cannot be solved at the primary level, are delivered in general or district hospitals under the supervision of state governments. Tertiary health services are the most sophisticated and costly for government and patients alike. They deal with the most difficult cases referred from the secondary health care system, treating them in teaching hospitals supervised by the Federal Ministry of Health.

The challenge at the primary level is to establish a health care system that will touch the lives of every citizens and tackle the conditions causing the highest mortality. The system must be organised at the grass-roots level and woven into the fabric of the community through the process of community participation. It must integrate preventive, promotive, and curative services, using technology the community will accept and can afford, and it must have an efficient and effective system of supervision and referral. Ben & Wessen, 1974.

The most important principles of primary health care, as defined at Alma – Ata in 1978, is community participation. The government at all time should set in motion the process that will ensure that every Nigerian obtains the health services he or she needs, when and where they are needed, at a cost the country can afford. It should also ensure that the people participate fully in the provision of the services, which means that at the village or street level the community must be involved in planning, implementing, and managing the system. In other words, the community must be in control of the system and of the resources needed to maintain it. (Chiorlenuan & Erinosho, 1989).

Another important principles is self-reliance. Because the health problems of a community cannot all be solved at once owing to progress at a pace that takes these constraints into account, as long as there is a reduction in mortality and morbidity

and an improvement in the quality of life. The greatest advance in developing health care delivery systems in the past 20 years is the realization that there is no standard method of designing them. For example, it is now widely accepted that a community need not wait until a doctor is available before services can be delivered; many communities throughout the world are being served by categories of health manpower down to the level of village health worker, with excellent community acceptance and satisfaction and a measurable impact on the disease wrecking the most havoc on them. (Kuti, 1990).

Closely linked with self-reliance is the use of appropriate technology. Whatever tasks are carried out to deliver the services, they must be capable of being executed effectively at the technological level of the community. It is useless, for example, to install an x-ray machine or dental chair in a village where there is no piped water or electricity – not to mention radiographers or dental technicians (Kuti, 1990). Urging mothers to use packets of oral dehydration salts to prevent dehydration in children when supplies are erratic will only create a culture of dependence, which may cost lives. Self-reliance can be achieved by teaching mothers to prepare their own solutions with salt and sugar, which are readily available in the kitchens, (Kankiya, 1985).

BASIC HEALTH SERVICE SCHEME

The first serious attempt to put a primary health care service in place was in 1975, when General Yakubu Gowon announced the basic health service scheme as part of the third national development plan (1975 – 80). The aims of the scheme were to increase the proportion of the population receiving health care from 25 to 60 percent, correct the imbalance in the location and distribution of health institutions and between preventive and curative medicine, provide the infrastructure for all preventive health programmes such as control of communicable disease, family health, environmental health, nutrition and others, and establish a health care system best adapted to the local conditions and to the level of health technology (Kuti, 1990).

The plan for the implementation of the scheme was to build in each local government area a comprehensive health centre, four primary health centres, and 20 health clinics. This was called a basic health unit designed to provide health care for a population of 150,000. The health clinics were to be the most peripheral health facilities, each serving a population of 2000. A primary health centre, the intermediate health facility, would serve as a referral centre for four health clinics and serve a population of 50,000. In addition, five mobile clinics would operate out of the primary health centre, serving a total population of 20,000. (Kuti, 1990)

To provide the health personnel required for these services, 19 schools of health technology, one in each state then, were established to train three categories of community health extension workers formerly known as supervisors, assistant, and aides). The officers were to be trained in the teaching hospitals. During the implementation of the scheme, the principles of primary health care

were to applied. The Community did not participate in any way in the process. Up until 1985, no primary health care system, as defined by WHO, existed any where in the country (Kuti, 1990).

PRESENT PROGRAMME

Since 1986, the strategy for the development of Nigeria's primary health care services has changed. The local government areas in which the system is still being developed have been given the ability to supervise and run the services. Those with the skill to implement the service are being mobilized and put to the task. (Kuti, 1990). Every College of Medicine and every school of health technology assisting a nearby local government to set up its primary health care system. Such area then serves as a practice area for the college to train students in the art of providing the strives, whether as doctors or as community health extension workers. (Kuti 1988). Each local government selected in this way was given a sum of 10,000 naira US $2200) to collect two sets of data – one on the state of the health services and the other on the local health problems. The former concentrated partsicularly on the human, material and financial resources available to the local government and on the way in which the services were functioning. The latter dealt mainly with the common diseases in the locality and how the people had tried to tackle them, bearing in mind their culture and traditions. To discuss these data, workshops were held for all the 52 local governments in which primary health care was to be implemented (Kuti, 1990).

Later in the year, further workshops were held to discuss the steps to be taken in implementing the plans and in managing the services. At this point, a sum of 50000 naira (US$110000) per local government was deposited in each state to pay for the programme. It is worth noting that the Chairman and Health Counsellor of each local government participated in all these activities, culminating in the design of the health services. (Kuti, 1990). The villages themselves have, with technical assistance, gone through the same process of identifying local health problems and the resources available for solving them and have decided on the most appropriate strategies for achieving their goals as within the limits of their resources in personnel, materials, and money. To facilitate the implementation of the scheme, the country was divided into four zones, and Health Zonal Offices and Co-ordinators were installed in Ibadan, Kaduna, Bauchi and Enugu state and local governments health committees were also formed. The participating local governments divided their areas into districts, each with a population of about 20000. In one local government area where there was a long-standing primary health care system, the village health workers within each district constituted themselves into district Health Committees to share experiences; they also participated in a programme of continuing education. (Kuti, 1990).

The foundation on which primary health care in Nigeria was built therefore is the village health service. In each village, a person nominated by the villagers is trained to provide care for the main health problems that the villagers themselves have identified. The local government must have the capacity to provide such training. (Kuti, 1990). With the assistance of UNICEF, WHO and the World Bank, a system for the supply of essential drugs is being developed, based on a revolving

found. A list of essential equipment for village health services has been compiled, and the existing lists for health clinics and health centres have been revised to weed out sophisticated and inessential items that have hitherto been supplied to these facilities (Kuti, 1990). Management courses were held in 1986 for local government health administrators in all the 52 participating authorities, with technical assistance provided by the Federal Ministry of Health and USAID, as part of a continuing effort to ensure that the services are efficiently managed. (Kuti, 1990). The indicators needed to measured the effectiveness of the services have been chosen and the records to be collected for this purpose have been designed, and are being used in the village, the health centre, and the central office.

2.5 **PRIMARY HEALTH CARE AND DEVELOPMENT**

Development implies progressive improvements in the living conditions and quality of life enjoyed by society and shared by its member. It is a continuing process that takes place in all societies, few would claim that their development is complete (Hassan, 2000). Any distinction between economic and social development is no longer tenable. Economic development is necessary to achieve most social goals and social development is necessary to achieve most economic goals. Indeed, social factors are real driving force behind development. The purpose of development is to permit people to live economically productive and socially satisfying lives. Social satisfaction and economic productivity will be interpreted in widely different ways according to the social and cultural values prevailing in each societies. Everywhere people themselves realize that their motivation in striving to increase their earnings is not greater wealth for its own sake but the social improvements that increased purchasing power can bring to them and their children, such as better food and housing, better education, better leisure opportunities, and last but not least, better health. Only when they have an acceptable level of health can individuals, families and communities enjoy the other benefits of life. Health development is therefore essential for social and economic development, and the means for attainting them are intimately linked. For this reason, actions to improve the health and socio economic situation should be regarded as mutually supportive rather than competitive. Discussions on whether the promotion of health only consumes resources, or whether it is an economically productive factor contributing to development, belong to the academic past (WHO, 1978).

Since primary health care is the key to attaining an acceptable level of health by all, it will help people to contribute to their own social and economic development. It follows that primary health care should be an integral part of the overall department of society. According to Oladimeji (1993) primary health care contributes to development by improving health status and by stimulating action and organization in support of the development process. As an example, the control of certain communicable diseases by primary health care and other means often helps to promote development in general.. For instance, the control of malaria, sleeping sickness and river blindness can open new areas to settlement, but these successes have to be consolidated by maintaining the settlers' health and their potential for development. Proper nutrition and reduction of sickness increase work productivity. Breaking the vicious circle of malnutrition and infection proves the physical and mental development of the child. In societies where old people are

cared for directly by their family, a reduction in infant mortality can eventually lead to a reduction in family size, because the continued evidence and health of the first two or three children provide couples with the security they are seeking for their old age. In general, a reduction in both child and adult mortality can induce the feeling that the future is worth planning for. In general, a reduction in both child and adult mortality can induce the feeling that the future is worth planning for. In addition, by drawing on untapped human and financial community resources, primary health care can contribute to the awakening of the social interest that is so important for mobilizing people's efforts for development. Thus, primary health care can be a lever for increasing social awareness and interest, initiatives and innovation. (WHO, 1992).

The other levels of the country's health system can also assist development on condition that they are attuned to providing support to the full range of primary health care activities. For example, they can concentrate selectively on combating health risks which directly or indirectly influence poverty. In addition to proving specialized curative services, that can catalyse development by supporting community activities that promote health and prevent disease. They can play a wider role in the training of health workers by showing them how to function in harmony with workers in related social and economic fields for the common purpose of development. They can help to ensure the acceptance, at the appropriate administrative levels of ideas and proposals emanating from communities that will promote an integrated approach to health and development. They can also help to shape, at these administrative levels, the mechanism for arriving at decisions that are conducive to integrate development. (NHP, 1988).

No sector involved in socio economic development can function properly in isolation. According to Kuti (1990), activities in one impinge on the goals of another, hence the need for constant consultation between the major social and economic sectors to ensure development and to promote health as part of it. Primary health care, too, requires the support of other sectors; these sectors can also serve as entry points for the development and implementation of primary health care. The agricultural sector is particularly important in most countries. It can ensure that production of food for family consumption becomes an integral part of agricultural policy and that food actually reaches those who produce it, which in some countries may require changes in the pattern of land tenure. Also, nutritional status can be improved through programme in agriculture and home economics geared to meeting priority family and community needs.

It is particularly important to ensure that women also enjoy the benefits of agricultural development as well as men. In most developing countries the majority of women in rural areas are engaged simultaneously in agriculture, household management and the care of infants and children. They need appropriate technology to lighten their workload and increase their work productivity. They also require knowledge about nutrition which they can apply with the resources available, in particular concerning the proper feeding of children and their own nutrition during pregnancy and lactation. (Anderson, 1993).

Similar policies in support of health care are needed in other sectors. Water for household use is as important as water for cattle, irrigation, energy and industry. Plentiful supplies of clean water help to decrease mortality and morbidity, in particular among infants and children, as well as making life easier for women.

Countrywide plans are required to bring urban and rural water supplies within easy reach of the majority in the shortest possible time. This is in keeping with the target adopted by habitat, the United Nations Conference on Human Settlements, of having safe water for all by the year 1990. The safe disposal wastes and excreta also has a significant influence on health (UNDP, 1990). The health sector can promote investments in water supply and sanitation, but as a rule major investments come from other sectors. In rural areas in particular, the community may well be active in these fields as part of primary health care. Education in the proper use and maintenance of water and sanitary facilities is important (UNDP, 1990).

Housing that is properly adopted to local climatic and environmental conditions has a positive effect on health. Houses, like animal shelters and food storage facilities, need to be proof not only against the elements but also against insects and rodents that carry disease. All these structures, and particularly kitchens and sanitary facilities, should be easy to clean. Here too, education is important for ensuring the proper maintenance of houses and the areas surrounding them (Tones, 1981). Certain aspects of public works and communications are of strategic importance to primary health care, particularly for disposed populations. Feeder roads not only connect the farmer to the market but also make it easier for people to reach villages, bringing new ideas together with the supplies needed for health and other sectors. Two way radio communication, where this can be afforded, puts isolated areas in contact with more centrally located administrative levels, at the same time serving as a vehicle for learning. Low-cost pedal-operated radio communication has been successfully used in primary health care in a number of developing countries (Tones, 1981).

Adegoroye (1989) notes that the educational sector also has an important part to play in the development and operation of primary health care. Community education helps people to understand their health problems, possible solutions to them and the cost of different alternatives. Instructive literature can be developed and distributed through the educational system. Associations of parents and teachers can assume certain responsibilities for primary health care activities within schools and the community, such as sanitation programmes, food-for-health campaigns or courses on nutrition and first aid. The mass media can play a supportive educational role by providing valid information on health and ways of attaining it and by depicting the benefits to be derived from improved health practices within primary health care. For example, they could support a sound pharmaceutical policy by helping to create public awareness that a number of drugs with generic names are just as good as advertised products with brand names. They should also help to popularise primary health care by disseminating authentic news about it in different communities (Adegoroye, 1989).

However, many agricultural and industrial activities can have side effects that are detrimental to health. To mention a few, irrigation schemes can create the right conditions for the breeding of mosquitoes that transmit malaria, artificial lakes can lead to the proliferation of the snails that carry schistosomassis, industrialization can lead to the pollution of air and water with toxic chemicals and the accompanying urbanization can provoke psycho-social problems (Adegoroye, 1989). It is therefore wise to incorporate preventive measures in industrial and agricultural projects which pose particular health hazards. Such measure can be included in irrigation schemes and man-made lakes safety precautions can be taken to reduce industrial accidents and pollution, potential carriers of disease can be

identified wherever there are large population movements, and special attention can be given to protecting the physical and mental of migrant workers. There is a proper place for primary health care in most of these activities.

In addition, the industrial sector can support primary health care by establishing industries related to health, in particular for essential drugs. Local small-scale industries are also important, because they create employment and thereby improve the local economic base and earning power. (WHO, 1997). Coordinated planning at the community level will make it possible to link primary health care closely with other sectors in joint efforts for community development. Thus, community workers can be trained to provide services of different kinds and to complement one another's role. For example, the health worker can advise on the importance of improved food storage at home and on the farm and can give practical guidance on this matter. Similarly, the agricultural worker who understands the basic principles of food nutrition can influence the production of appropriate foods and their consumption by families, helped by a local agricultural policy that favours food crops rather than cash crops. (Eten, 1976).

Community representatives in local government can ensure that community interests are properly taken into account in the planning and implementation of development programmes. Of overriding importance is the principle that public services should be accountable to the committees they serve, in particular for resources that the latter have invested. The desirability of coordinating at the local level the activities of the various sectors involved in socio-economic development, and the crucial role of the community in achieving this integration, make community participation an essential component of primary health care (Kuti, 1990). According to Kuti (1990) a community consists of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social and cultural characteristics, as well as interests and aspirations, including health. Communities vary widely in size and socio-economic profile, ranging from clusters of isolated homesteads to more organised villages, towns and city districts.

Self-reliance and social awareness are key factors in human development. Community participation in deciding on policies and in planning, implementation and controlling development programmes is now a widely accepted practice. (Kuti, 1990). However, it is understood and interpreted in different ways in different countries, being greatly influenced by the overall political structure and the social and economic situation. The case studies on community participation conducted by the UNICEF/WHO Joint Committee on Health Policy have helped to draw attention to and clarify the role of community participation in primary health care (Kuti, 1990). Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid. (Kuti, 1990). They therefore need to realize that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable. They have to acquire the capacity to appraise a situation, weight the various possibilities and estimate what their own contribution can be. While the community must be willing to learn, the health system is responsible for explaining

and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs (WHO, 1978).

Health personnel form part of the community in which they live and work. A continuing dialogue between them and the rest of the community is necessary to harmonise views and activities relating to primary health care. Such a dialogue enables health personnel to acquire a better understanding of the community's feelings, the reasons for its views, the level of its aspirations and the pattern of its organisation and communications. For their part, the people will learn to identify their real health needs, to understand the national strategy for primary health care and to become involved in and promote community action for health. Thus, society will come to realize that health is not only the right of all but also the responsibility of all, and the members of the health professions, too, will find their proper role. (Yusuf, 2002). Accordingly, there are many way in which the community can participate in every stage of primary health care. It must first be involved in the assessment of the situation, the definition of problems and the setting of priorities. Then, it helps to plan primary health care activities and subsequently it cooperates fully when these activities are carried out. Such cooperation includes the acceptance by individuals of a high degree of responsibility for their own health care, for example, by adopting a healthy life style, by applying principles of good nutrition and hygiene, or by making use of immunization services. In addition, members of the community can contribute labour as well as financial and other resources to primary health care (Barbara & John, 1973).

It is also community concern to keep the implementation of primary health care under constant review and to make sure that it functions in accordance with its stated purpose. This involvement will facilitate the identification and resolution of difficulties and the readjustment of activities as necessary (Kuti, 1990). A clear national policy is needed which will promote community cohesion around efforts for health and related development, will foster the coordination at the local level of all sectoral programmes that have a bearing on primary health care, will build up the capacity of communities to make their health and other social aspirations known, and will ensure that the community controls both the funds it invests in primary health care and the personnel providing it. Community participation also requires mutual support between government and community, reinforced by mutual information feedback. It is the responsibility of government to stimulate this kind of support, to set up the necessary intersectoral coordinating mechanisms at the different administrative levels, to pass legislation to support primary health care and, whatever applicable, to provide sufficient human, material, technical and financial resources (Kuti, 1990).

In expressing the importance of decentralization in the development process, Kuti (1990) maintains that the general administrative system of a country is important for ensuring coordinated contributions to development from the different sectors concerned. In the past, there has

been a tendency to concentrate almost entirely on the central administrative level. Only recently has attention been focused on local levels. The importance of decentralization to intermediate levels, such as provincial or district levels, now has to be stressed. These levels are near enough to communities to respond sensitively to their practical problems and needs; they are equally near to the central administrative level to translate government policies into practice. They are particularly useful for harmonizing the activities of the various sectors that jointly promote development. The intermediate administrative levels thus serve as important pivots for coordinated development. To fulfil this role they have to be strengthened in many countries, particularly by deploying to them the manpower required in the various sectors (Kuti, 1990).

2.6 OPERATIONAL ASPECTS OF PRIMARY HEALTH CARE

A health system is made up of components from the health and other sectors whose interrelated actions contribute to health. It is subdivided into various levels, the first of which is the point of contact between individuals and the health system, where primary health care is delivered. The services provided by primary health care will vary according to the country and the community, but will include at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries. The other levels of the health system provide more specialized services which become more complex as they become more centra (WHO, 1992). According to Kankiya (1989), primary health care is the health system. Around it are arranged the other levels of the system whose actions converge on primary health care in order to support it and to permit it to provide essential health care on a continuing basis. At the intermediate level more complex problems can be dealt with, and more skilled and specialized care as well as logistic support provided. At this level, more highly trained staff provide support through training and managerial expertise, highly specialized care, teaching for specialized staff, the expertise of

such institutions as central health laboratories, and central logistic and financial support. How the health system is organized to develop, operate and support primary health care is the subject of the following paragraphs.

The WHO (1978) suggested that planning for primary health care has to be carried out in communities as well as at intermediate and central levels. The ministry of health or its equivalent is responsible for formulating national health policy, including primary health care policy, and for promoting its adoption by the government. Such policies are more likely to be effective if they form part of overall development policies, thus reflecting the social and economic goals of the government. Strategies have to be devised to translate policies into practice; a useful process for this purpose has come to be known as country health programming, which consists essentially of assessing the country's health problems in their socio economic context, identifying areas susceptible to change and formulating priority programmes to include such change. Whatever primary health care has been identified as a priority, which is likely to be the case in most countries, a specific strategy is needed for its formulation and implementation. The primary health care policy and strategy form the terms of reference for all the health and relevant components of other sectors which make up the health system. The strategy has to be translated into a nationwide primary health care programme embracing all levels, supportive and referred as well as community (WHO, 1978).

In developing the strategy and formulating the programme, full account has to be taken of the technologies to be used, the resources to be employed, the support needed at other levels, and the way to organize all this into a coherent system (WHO, 1978). Kuti (1990) advises that health ministries, as well as other national health agencies that may be concerned, need to make planning a function of the highest level of decision making. This is essential to ensure the appropriate delegation of responsibility and authority, the preferential allocation of resources to primary health care and its supporting services, and the proper location of the supporting services so that they are accessible to the communities they are to serve. Training in planning and management at all levels is indispensable to the planning process. Since the planning of primary health care involves political, social and economic factors, multi-disciplinary planning teams are needed, especially at the central level, including among other people with a knowledge of economic, political science and other social sciences.

Central planning should aim at enabling communities to plan their own primary health care activities. It therefore has to provide them with a clear idea of the part they play in the national primary health care strategy and in the overall development process at community level. It is to guide them on how to work out, operate, evaluate and control their primary health care programmes; and it has to provide any essential information that is not available in the community. Strengthened by this guidance and information, members of the community are better equipped to participate fully in the formulating of their primary health care programmes, by analysing their own health problems, taking decisions on priorities, making local adaptations of national solutions, and establishing their own community organization and support and control mechanisms. (Yusuf, 2002). Wherever possible, those responsible for implementing programmes should participate actively in planning them from the earliest stages. In practice, steps have to be taken to ensure the continuity of the planning process, taking into

account that responsibilities for planning and implementation may change hands from time to time, (WHO, 1978).

Ideally, information concerning the primary health care programmes of all communities is fed back through the other levels of the health system to be used for the planning of support and referral at those levels, and for the consolidation of the nationwide programme. Constant interaction is therefore needed between the central levels, where policy is set, major resource allocations made, and standards and criteria established, and the intermediate and community levels, where detailed programmes are developed. (WHO, 1978). Accordingly, ways of planning and organizing primary health care in communities will vary with the type and size of community and with its pattern of social organisation. Thus, solutions applicable to small villages may be vastly different from those appropriate for large urban communities. Nevertheless, certain features have to be taken into account that are common to all forms of community (Kuti, 1990). It is however necessary to decide on the most suitable mechanisms for planning, operating and controlling the community primary health care programme. Local political, administrative and social patterns will help to determine these mechanisms. In all cases, it is necessary to reach agreement on responsibilities – for example, to decide who carries ultimate responsibility for the programme and whether the same individual, or committee as the case may be, is also responsible for its detailed, planning and management. If a committee is elected, how should it be composed – of political or other community leaders, health workers or representatives of the public, and in what proportions? Will such a committee be given absolute powers, or will it be empowered only to make proposals, and if so to whom, or to which body representing the community as a whole? How will coordination with other sectors best be ensured – by including their representatives in the mechanism for planning and organizing primary health care, or by creating another community group consisting of representatives of all the sectors involved in development?

In determining priorities, what are the best ways of ensuring that the voices of the whole community are heard? And once priorities have been determined, are they to be given effect all at once or in stages? The answer to this last question will of course depend on the resources available; decisions in have to be taken concerning the generation of local resources in cash and kind, and assessments made of the resources potentially available from the levels of the health system and from central government. It is also necessary to decide who will deal with the other levels of the health system – for example, health workers at the technical level, or community leaders at the political level, or both, (WHO, 1978).

Once priorities are decided on, decisions have to be taken concerning the methods and techniques to be employed. These have to be acceptable both to those who use them and to those whom they are used. Also, an appropriate mechanism is required for taking those decisions, preferably including participants from the general public and from the health sector. Further decisions have to be taken on the composition and degree of skills of the health team providing primary health care (Milson, 1976). Should this be composed of health workers each providing the same range of service, or by a mixture of health workers each providing different kinds of service? Are there to be part-time or full-time health workers or combination of both? What should be the conditions for their selection and by whom will they be selected? Should they be remunerated and, if so, how and on what scale? Will they have prospects for advancing in their career and how will

this be organized and controlled? Should volunteers be mobilized? What kind of basic training should the members of the health team receive and for how long? How will their continuing training be organized, who will organize it and who will provide it? Who will be appointed team leader? How will individuals and families be incorporated in the health team so that they become full partners in their own health co-development"\? How will they be educated in health matters and by whom?

When decisions have been taken on the methods to be employed for each of the components of primary health care, and on the types of health workers to apply these methods, it will be possible to decide on the equipment and supplies required, the essential drugs and vaccines, the system of maintaining equipment and the frequency of replenishing supplies. A balance will have to be reached between local considerations and national standards, taking into account local initiative and development on the one hand, and the possibilities of organizing a national system of maintenance and supply on the other. Decision also have to be taken on the physical facilities required, their location and size, and their design or adaptation from an existing structure (Yusuf, 2002).

To control the implementation of the community programme, it is necessary to decide on the methods and mechanisms for social, managerial and technical guidance and supervision. Who will have overall responsibility within the primary health care facility? To whom will the person responsible report on progress and how often? To whom will this person turn with managerial, technical or social problems? To whom will the members of the community turn when they have similar problems (Kuti, 1990). These are only some illustrations of the types of question that have to be answered in planning and operating a community primary health care programme. Whatever the solution, there is a need for clear-cut procedures that are known to the community as a whole and to the health workers and are followed by all concerned (Kuti, 1990). Other operational aspects of PHC include coverage and accessibility, appropriate health technology, human resources elements viz community health workers, traditional medical practitioner, professional health workers and family members. Included in these aspects are referral system, logistics of supply, physical facilities, budgeting, decentralization, control and evaluation (Kuti, 1990).

2.7 BAMAKO INITIATIVE: KADUNA STATE IMPLEMENTATION STRAGEGY

This programme uses drugs as an entry point into primary health care, through the active participation of the beneficiary communities. It is designed to make essential drugs available, accessible and affordable to every member of the community at all times. Four Local Government Areas are fully implementing the programme; these are Ikara, Makarfi, Jama'a and Zaria.

In order to ensure active participation of the community in the management of the primary health care / Immunization activities decentralization, training and devolution of resources were carried out in the four local Government Areas. During the exercise, a total of eight hundred and fifty eight (858) participants were trained. They include District Development Committee members, village

Development Committee members, Health workers. They were trained on drug / financial management, resource management, and supervision of primary health care activities in their Communities. This is to ensure sustainability of primary Health Care programme in the State (WHO, 1987). The distribution of resources is yet to be done in Ikara Local Government Area due to the non availability of drugs in the central store and money from the sales of drugs. Efforts are geared towards recovering the amount owned by the Local Government Area.

HEALTH COMMUNICATION

Health communication is the process of communicating Factual Health information in a way people can understand and put into practice. It is mainly concerned with changes in attitude and behaviour (Green, 1978).

Health communication uses the following strategies:

- Advocacy community mobilization and education
- Training
- Production and distribution of educational materials
- Monitoring and Evaluation
- Inter-sectoral collaboration

Health education units exist in all the 23 Local Government Areas of the State. Resource requirements include: refurbishing the broken down vehicle, picture camera and firms, radio cassette recorders, wireless public address systems and slides projectors.

ONCHOCERCIASIS

The onchocerciasis control programme is on going in twelve (12) Local Government Area in the State.

The following activities were conducted in 1997:

1. Monitoring and supervision
2. Training of community health extension workers (289)
3. Distribution of Mectizan to 669 villages in 12 local Government Areas with 544,000 tablets, community Directed treatment (Yusuf, 2002).

Attended Zonal oncoerciasis Task Force meeting in Abuja and primary health care review meeting in Kwara State. Resource requirements include; bicycles, motorcycles for monitoring and distribution of Mectizan.

MATERNAL AND CHILD HEALTH

Maternal and child Health activities are on going in all primary Health Care centres, clinics and Hospitals. With mobilization activities in the state, expectant

mothers are utilizing the services of trained personnel and trained Traditional Birth Attendants (TBA). An orientation on harmful traditional practices was carried out for Traditional Birth Attendants and traditional medicine healers. Mothers are aware of the importance of personal and environmental hygiene, nutrition, immunization, etc (Yusuf, 2002).

CONSTRAINTS:

Inadequate basic equipment for maternal and child health and first referred centres weighing scales and Traditional Birth Attendants, Kits (Yusuf, 2002).

NATIONAL PROGRAMME ON IMMUNIZATION

1. Supported the National programme on Immunization with some dose of vaccines. This was followed by a campaign on measles in January in all the 23 Local Government Areas of the State.
2. Monitoring and supervision was made to all the Local Government Areas by the Technical Team of the ministry.
3. Routine immunization is ongoing and cold chain equipments have been repaired.
4. A micro planning workshop on National Immunization day was conducted for all the 23 Local Government Area, Primary Health Care co-ordinators, 23 National Programmes on Immunization Managers, 23 Local Government Areas M. & E. Officers and 10 state Ministry of Health Officials in the state.
5. Two rounds of National Immunization Day campaign were conducted in November and December 1997 in all the Local Government Areas with emphasis on polio and the state able to achieve 76% coverage on polio

NUTRITION

The economic situation in the 90's has worsened the nutritional status of children and women in the country. This is because the essential nutrients necessary for growth and development are inadequate, consequently, malnutrition sets in. Contributory factors to malnutrition are: ignorance, lack of basic education, lack of knowledge and skills in food production, processing, preservation and utilization (Yusuf, 2002). Orientation programme on iron deficiency anaemia, nutrition education and growth monitoring have been conducted for primary school teachers, Traditional Birth Attendants and Local Government Areas health workers. Nutrition education is continuous on vitamin A sources, breast feeding and iron deficiency Anaemia. Supplementation of iron to start soon; communities have been identified and mobilized for the exercise. Growth monitoring activities are ongoing in the various health centres and communities (Yusuf, 2002).

CONTROL OF DIARRHEAL DISEASES

Diarrhoea claims many lives especially in developing countries where hygiene practices and environmental sanitation are low. The programme has involved communities and are participating and using the salt, sugar solution (SSS) for the

treatment of diarrhoea at home. Most of the health facilities personnel are managing ORT centres in the state (UNDP 1990). Orientation and training programme have been conducted for NGOs and health workers in various communities of the state to encourage ORT and using SSS in order to reduce the number of deaths due to diarrhea diseases. Oral dehydration therapy kits have been distributed to Local Government Areas and some schools in the state. Problems faced is inadequate supply of ORS and ORT kits for all the health facilities in the state (Yusuf , 2002).

MONITORING AND EVALUATION

Monitoring and Evaluation of Primary Health Care activities is carried out by the state and Local Government Areas, Primary Health care personnel, Local Government Areas are reporting on the primary Health Care monitoring and evaluation formats. Primary school teachers, health workers and NGOs have received orientation on Primary Health Care (Yusuf, 2002).

BABY FRIENDLY HOSPITAL INITIATIVE

The various communities have accepted the initiative and are participating and mobilizing others to breast feeding exclusively. Many hospitals have been designated baby friendly and others are awaiting designation (NPHCA, 1995).

(a) **Implementation Strategies:**

(i) The state Ministry of Health intends to intensify advocacy and mobilization of policy makers at the various levels, community leaders, Non-Governmental Organizations, Women Groups, Religious leaders and District/Village Development Committees for the support of primary Health Care activities.

(ii) Ensure the empowerment of women in health and other developmental activities through development of their knowledge and skills.

(iii) Specific community members, women groups, Non-Governmental Organizations and health personnel to receive orientation on primary health care activities to enhance their knowledge and skills.

(iv) Ensure that gender issues and concerns are adequately addressed in primary health care programmes.

(v) Ensure timely reporting from Local Government Areas and the provision of feedback through graphs, charts and incentives to best performing Local Government Areas.

(vi) Intensify supervision to all Local Government Areas.

(vii) Strengthened state, Local Government Areas, Community, women groups and Non-Governmental Organizations to deliver basic health services to children and women.

(viii) To enforce policies and laws for the promotion and protection of the rights of children and women in the state (Yusuf, 2002).

(b) **Resources Requirements:**

The state has received support from UNICEF, Federal Ministry of Health and other Non-Governmental organizations. However, for the effective implementation of Primary Health Care programmes, adequate supplies of equipment and their logistic support is solicited (Chiorlenuan & Erinosho, 1989). The state on her part will advocate to all Local Government Areas to repair and maintain their broken down vehicles, motorcycles, bicycles and cold chain equipment.

2.8 FACTORS AFFECTING THE UTILIZATION OF A HEALTH CARE SYSTEM

For health care system to be complete some basic elements must be present. It should therefore be noted that the existence of a complete range of services does not suggest that those services will be used not to talk of being used well. Torrens (1978) reports certain factors in patients, in the provider of health services, as well as the society in general that once in existence directly affect the utilization of services. A consideration of these factors may provide an ideal system of health care services. These could be designed and implemented but might never have the impact it should on the health of the patients to be served.

PATIENT FACTORS

The first set of factors affecting utilization of health care services relates to the patients to be served. In category, emphasis is on two important aspects. These are:

1) Those factors relating to the patient's knowledge and appreciation of services, and
2) Those factors relating to the patient's actual ability to utilize the services (Torrens, 1978).

KNOWLEDGE AND APPRECIATION OF SERVICES

For the first set of factors, it is important for the public to know that certain health care services are available and how they can be reached if those services are ever to be utilized. The public that does not know of the existence of a community health centre, or have knowledge of how to gain entry to the centre, can not take full advantage of whatever services are rendered (Freud & Kalumba 1994).

Equally important to knowing that a service exists, is that the potential patients should have a personal appreciation for what the particular health service can do for them. In the case of the community primary health centre, for example, potential users might know that the centre exists and might know how to enter the centre, but, in fact, they may have no understanding or appreciation of the value of the centre's services. If they feel that psychiatric services are useless or a waste of time, they will not utilize the services no matter how attractive the centre may be (Freund & Kalumba 1994).

Finally, in addition to knowing about the existence of a health service and appreciating its usefulness, patients should have a desire to actually use it. A poor local mother in an obscure area of the state may know that a community primary health centre exists, and she may also know that the services are said to be helpful. However, if she has a cultural belief that psychiatry is not appreciate for women, if she is worried about her ability to communicate in English with a physician, or if she has had unfortunate experiences in using similar services previously, she may simply have no desire to use the service even though it is there (Freud & Kalumba, 1994).

ABILITY TO UTILIZE SERVICES

According to Freud & Kalamba (1994) it is not enough that patients know about the services, appreciate that they are useful, and desire to use them. If the patients are not able to use them, they will not be used. For the local mother to use a community primary health centre that is located a few kilometres miles away, a system of transportation must exist to get her there. If she does not have access to a car or a good system of public transportation, there may simply be no way that she can get to the service in question – or at least get there easily and cheaply. Furthermore, if the service requires the payment of some money in advance and she has no money at all, she may not be able to use the particular service even though she may want to. It is important however, for patient to have ability to communicate in proper language with the primary health care personnel. According to Hassan (2000), health care services should therefore be organised to permit all categories of individual, irrespective of their literacy level, the chance to effectively communicate with health care personnel. In addition to the need for money, patients need to have time, energy, and freedom of movement to use health services well. The local mother may have five young children. When one of them gets sick, her ability to obtain medical care for that child may be limited by her ability to get someone to care for the other four. If the mother does not have the time or the energy to take her children to obtain health care, she may not do so. She may want to go out she may find that there simply not enough hours in the day or energy in her body to do it. As a result, the services go unused (Lewis & Edwin 1975).

Briefly put therefore, potential patients must show that services exist, desire to use them, and have the necessary personal resources of time, energy, and money to be able to use them. The degree to which these conditions are met will directly affect how well the services are utilized.

PROVIDER FACTORS

Just as certain patient-related factors influence the utilization of health care services, certain provider-related factors also play an important part. Torrons (1978) categorises these factors into several areas:

1) The provider's knowledge of the public's need for certain health services;
2) The provider's ability to deliver these services, and
3) The provider's general manner and attitude in delivering these services. (Torrens, 1978).

KNOWLEDGE OF PUBLIC'S NEED FOR SERVICES

If primary health care service personnel do not know that a group of patients requires a certain type of service, there is little prospects that they will try to offer that service to the public. Primary health care personnel, for example, must be able to determine the patients' needs for services if they are to develop and offer appropriate services to the right patients (Torrens, 1978).

ABILITY TO DELIVER SERVICES

Once a need is identified, the degree to which it met may depend on the provider's desire to meet that particular need. For example, Torrens (1978), reported that for many years the voluntary hospitals of Mahattan possessed detailed knowledge of widespread heroin addiction among the patients they served, and most of these hospitals realised that specialised services were needed by these patients. However, because heroin addicts were particularly difficult patients with whom to deal and because there was little financing available to pay for these services, most of the hospitals were reluctant to take on this difficult task. The knowledge of the need was there, but the desire to develop new services was not (Torrens, 1978).

More frequently, the limiting factor is not whether a provider wants to offer a particular health service, but whether the provider is able to offer it. It is obvious that a provider cannot offer a health service unless the necessary personnel, equipment, facilities and financing are available (Torrens, 1978). A primary health care centre may wish to offer round the clock emergency room service, but if it cannot offer that particular service to the public. In like manner, a hospital may wish to offer surgical services to its patients, but if it cannot obtain the services of a surgeon, an operating room nurse, an anesthesiologist and all the other specialised personnel required, those services simply cannot be offered to all. If a hospital does not have an appropriate facility or the requisite equipment for providing a particular service either it in an incomplete or unsatisfactory manner. A hospital or clinic may wish to provide special testing services for deaf children that require sound proof testing rooms with two-way mirrors and elaborate electronic testing equipment. If it does not have the appropriate testing room or the proper equipment, either it may not offer the service at all or it may offer it in a place that is really not satisfactory (Torrens, 1978).

Probably the most limiting factors in the provider's ability to offer health services is the availability of financing for a particular service or if there is some question that a particular service may not generate enough revenue to keep it going once it is started, the provider may have no interest in developing the services in the first place (Torrens, 1978). Once established, if there is limited money to keep it going, the service may operate poorly or not at all. A labour union health and welfare trust may wish to offer a package of preventive medical services to its members as a special additional benefit. But if the member do not want to pay on these service or if the labour management negotiating process does not produce the money to pay for them, only a limited set of preventive services may be offered and those perhaps to only a selected group of members. If a health department wants to offer family services but cannot get the state or the local government council's approval of a budget item to support those services, the services simply will not come into being. (Torrens, 1978).

MANNER AND ATTITUDE IN DELIVERING SERVICES

Availability of resources and ability to offer certain health services does not necessarily mean that the services will be offered in the optimal fashion, by any means. The manner and attitude with which those services are offered may seriously affect the utilization of those services. A situation where a health department establishes a less poisoning screening project for children and expects the children to come to health department centre for testing, the results of the

service will be very disappointing. This manner of offering the service is simply not in line with the reality of the situation; if you want to reach certain high-risk population who a subtly exposed to long-term disability, you must actively go out and identify them in the community, it is not a matter of sitting back expecting them to come to the centre (Torrens, 1978). In the same way, if a provider is going to offer a service, the success of that service may depend on the degree to which it fits the life-style and needs of the patients to be served. It must be offered at a time and in a place that is compatible with the way patients actually live. Many hospitals and health departments develop special programmes for the elderly, a group that is particular burdened with chronic disabilities, much as blindness, arthritis, and heart disease that make it particularly difficult for them to move around freely. If the hospital or health department does not bring the service to the patients in their homes or provide transportation to the service, the highest risk group of patients may simply never to able to use them. (Torrens, 1978).

According to Freund & Kalamba (1994), the attitude with which patients are treated, not in a medical sense but in a personal sense, also has an effect on how health services are utilized. If a patient attempts to use an emergency room for a condition that he or she feels is important and is coldly informed by the emergency room staff, "This isn't really an emergency you know" that patient will certainly not readily return to that emergency room. (Freud & Kalamba, 1994). If a patient asks the doctor at the end of an outpatient clinic visit for more detailed information about the prescriptions that were written and is brusquely told. "Talk to the nurse; she'll tell you." That patient probably will not ask again and may feel unwanted in that particular clinic. Also if the entire atmosphere of a particular health care service is greatly at variance with the prevailing culture, life-style, language, or belief of the patients to be served, the patients may never utilise the service fully or enthusiastically. A rebellious teenager may be dragged into a highly-structured, church-run counselling service the first time, out if he doe not get some sense of sympathy or understanding for his values, his conflicts, or the real ties of his life as he sees them, he probably will not return or participate fully while he is there. (Freud & Kalamba, 1994). Probably the most important provider-related factor that influences the utilization of health services is the provider's set of value, the reasons why the provider is offering the services in the first place. This is centrally important, because the reason why a provider wants to offer a health service may well decide how it is offered. In turn how a service is offered, may determine whether it is utilized fully or not (WHO, 1970).

Briefly put therefore a provider's knowledge of the community's needs for health services, ability to provide these services, and manner of actually providing them will directly affect the utilization of the services themselves.

COMMUNITY / SOCIETY FACTORS

Although the factors related to patients and providers are important, perhaps the most important factors to consider are those related to the community and society in which the patients and providers function. These factors are critically important since they frequently set the framework in which health services are offered, determine the resources to be made available, and establish the constraint and limitations within which the individual patients and providers operate. In other words, the patients and providers may only be able to exercise those individual

initiative that the society allows or makes possible Freund and Kalamba 1994. Generally, three sets of community/society factors affect the utilization of health care services;

1. the values a society holds regarding health;
2. the resources the society makes available to provide health services, and
3. the system of health care a society establishes to deliver those health services, (WHO, 1991).

VALUES

A 1991 World Health Organization report maintain that a society's values play an important part in the development of health services and their use. It is critically important, for example, how a society views health and illness, and how it regards health services as compared with other societal concerns such as education, housing, transportation, and national defense (WHO, 1991). If society says, "We are virtually concerned about the education of the young, the welfare of the disadvantaged, and the health of all, at whatever cost. "these values establish one set of conditions for health care. On the other hand, if a society says. "We are only interested in early grade school education, in disability payments for workers injured on the job, and in basic sanitation and prevention of epidemics," this establishes a different set of value and a quite different set of implications for health care (WHO, 1991).

RESOURCES

The way in which a society answers the value questions is very important, since it determines what resources will be made available for the provision of services. Health services cannot be offered by providers and utilized by patients unless there are trained personnel to offer them, finances to pay for them, and equipment and facilities to expedite them (Torrens, 1978). If a society determines that health care has a high social priority, it may provide the financial support and the political mandate for the creation of new medical and nursing schools, new hospitals for the mentally ill, or new programmes of financing medical care for the needy. It may also provide extra incentives for the construction of clinics and the payment of health workers to practice in rural areas. On the other hand, a society feels that education is more important than health, it may divert majority of its resources to the development of a widespread system of primary schools throughout a region and not provide as much support for public health programmes or hospitals. The higher the value placed on health, the greater the resources that will be made available and the more health services that can be provided to people who need them, (Torrens, 1978).

SYSTEM OF HEALTH CARE

The third set of community / social factors that affect the utilization of health services relate to the system of health care that a society establishes to deliver those services to the people who need them. In many ways, the system of health care that is established by a society reflects both the values of that society and the resources that the society wished to make available. In addition, however, once the system is

established, it becomes yet another variable affecting how easily or how well health services will be utilized. (Regina & Charles, 1988).

The utilization of health services by patients is affected by a number of factors related to the patients, the providers, and appreciation of the value of the services is important. The providers knowledge of the public's needs for services, its ability to deliver those services, and the manner in which they are actually delivered are equally important. Also the society's values regarding health, the amount of resources it makes available, and the system of health care that it established play important roles as well. The utilization of every health service is affected by one or more of those factors, and the challenge to the health care professional is to understand which factor is the most important in each particular situation. With a real understanding of these factors and how they operate, the health care professionals can see to it that health services are not only used, but are used well (Roemer, 1951).

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

The study was on perceived constraints to effective utilization of primary health care services in Kaduna state. This chapter is therefore an explanation of the research design, the population, sample and sampling technique, research instrument, validation of instrument, pilot study, administration of instrument and statistical technique used in the study.

3.2 RESEARCH DESIGN

The research design adopted in this study was ex-post fact to research design. This design was used because the facts required for the purpose of this study were already available with the subjects of the study. The major underlying assumption of this design was that the respondents would be different in their perception of some variables and the researchers would make effort to identify the major factors responsible for such differences.

In this study perceived constraints to effective utilization of primary health care services among the people of Kaduna state, might vary due to differences in economic status, gender (Male and Female) location, educational background, age and all other related factors of utilization.

3.3 POPULATION

The population of this study comprised of male and female adult in Kaduna State, who were 18 years and above in age. An adult in Nigerian context is a person who is 18 years and above. (Joye and Igweike, 1982).

3.4 SAMPLE AND SAMPLING TECHNIQUE

The sample for this study comprised of 360 male and female adults aged 18 years and above, residing in urban and rural area of Birnin Gwari, Lere, Giwa, Zango Kataf, Kaduna North, Soba, Jema'a, Zaria, Igbagbi, Kubau, Kudan and Kajuru, local government areas of Kaduna state, representing 50% of the total local government areas in Kaduna state. The local governments were randomly selected using hat drawn method. In using this method the names of all the local government areas in the state were written out on small pieces of paper, rolled and then put into a hat. Each time the hat is shaken one of these rolled paper is taken out and the name on it is written down. This process was repeated until the desired number of local government areas were selected.

The urban area for each local government was the head quarters of each of the local government areas. While the rural areas were areas outside the headquarters. Three rural areas from each local government area were randomly selected using hat drawn method. From each urban area of each local government fifteen (15) subjects were selected randomly by using house number both male and female. From each

rural area of each local government five (5) subjects were selected randomly using the same method. Thus a total of three hundred and sixty subjects, 180 male and 180 female adults were selected. The distribution of the subjects by area and gender for each local government is shown in table 3.1.

TABLE 3.1 DISTRIBUTION OF RESPONDENTS BY GENDER AND AREA IN EACH LOCAL GOVERNMENT AREA.

L. G. A.	Gender by Area			
	Rural		Urban	
	Male	Female	Male	Female
Birnin Gwari	8	7	7	8
Lere	8	7	7	8
Giwa	7	8	8	7
Zangon Kataf	7	8	8	7
Kaduna North	7	8	8	7
Soba	8	7	7	8
Jama'a	7	8	8	7
Zaria	8	7	7	8
Igabi	8	7	8	7
Kudan	7	8	7	8
Kajuru	8	7	7	8
Ikara	7	8	8	7
Total	**90**	**90**	**90**	**90**

3.5 INSTRUMENTATION

The purpose of this study was to identify the constraints to effective utilization of primary health care services among adults in Kaduna state. In order to achieve this objective, a questionnaire was developed. This questionnaire consisted of two sections. Section one was on personal information of the respondents with (7) seven statements. Section two (2) was on constraints in the utilization of primary health centres which had 16 statements under item 8 that were to be responded on a five point scale.

Item 9 – 17 consisted of statements on other constraints. The questionnaire thus prepared was distributed to 5 jurists in order to establish face validity. On the basis of the suggestions made by the jurists, some of the statements were restructured after which the final questionnaire was prepared which contained two sections.

Section One (1) was personal information with 7 statements, section 2 was on constraints in the utilization of primary health care centres that contained 10 statements.

3.6 VALIDATION OF THE INSTRUMENT

Structure questionnaire using likert – type scale of measurement was used to design the questionnaire. After the initial draft, a copy of the questionnaire was corrected and validated by the researcher's supervisors. In order to establish the face and content validity, the questionnaire was sent to some experts in health education in the Department of physical and health education and community medicine, A. B. U. Zaria in order to ensure reliability of the instrument.

3.7 ADMINISTRATION OF THE INSTRUMENT

The researcher obtained a letter of introduction from her department. With this the personal visits were made to each of the twelve local government areas chosen for the study with the assistance of two research assistants chosen from among health workers in each local government area. The questionnaire was administered on the subjects with the help of the health personnel of the local government. The researcher visited the subjects twice with an interval of about three weeks between the visits. In most cases, it was in the second visit that the duly completed questionnaires from the respondents was collected.

3.8 STATISTICAL ANALYSIS

Data collected for this study were statistically analysed using descriptive statistical method of percentage to describe the demographic information. Hypotheses 1, 2, 3, and 5 were analysed using One Way Analysis of Variance (ANOVA) for differences among different types of groups in their perception of constraints. Hypotheses 4 and 6 were analysed using t-test statistical method in order to find out the significant differences between the variables stipulated in the study. All the hypotheses were tested at 0.05 alpha level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 INTRODUCTION

The data collected for this study were statistically analysed in this chapter in order to achieve the study's objectives. Toward this end, effort was made to profer solutions to the research questions raised in the study. Also, the hypotheses postulated for the study were duly tested.

4.1 RESULTS

Twelve local government areas in Kaduna State were sampled in this study. Table 4.1 shows the local government areas and the number of respondents selected from each of the local government areas.

TABLE 4.1 **NO OF COPIES OF QUESTIONNAIRE**

LOCAL GOVERNMENT	NO. OF COPIES OF QUESTIONNAIRE ADMINISTERED	NO. OF COPIES OF QUESTIONNAIRE RETURNED	NO. OF COPIES OF QUESTIONNAIRE UNRETURNED
Birnin Gwari	30	27	3
Lere	30	27	3
Giwa	30	26	4
Zango Kataf	30	26	4
Kaduna North	30	27	3
Soba	30	26	4
Jema'a	30	27	3
Zaria	30	26	4
Igbabi	30	30	-
Kudan	30	27	3
Kajuru	30	26	4
Total	360	322	38

Table 4.1 indicates the number of respondents who correctly filled the questionnaire in each local government area out of thirty copies of questionnaire administered in each local government area. The response rate ranged from 86% to 100% with an average of 89.1 % return rate.

Information regarding the demographic characteristics of the responds is shown in table 4.2.

TABLE 4.2: DEMOGRAPHICS OF RESPONDENTS

S/NO	CHARACTERISTIC	FREQUENCY	PERCENTAGE
1.	Age:		
	(a) Below 20 years	53	16.5
	(b) 21 – 25 years	52	16.1
	(c) 26 – 30 years	62	19.3
	(d) 31 – 35 years	69	21.4
	(e) Over 35 years	87	26.7
2.	Gender:		
	(a) Male	182	56.5
	(b) Female	140	43.5
3.	Qualification:		
	(a) Primary / Qur'anic	107	33.2
	(b) Secondary	116	36.0
	(c) Tertiary	55	17.1
	(d) No Qualification	43	13.4
	(e) No Response	1	0.3
4.	Location:		
	(a) Urban	182	56.5
	(b) Rural	138	42.9
	(c) No Response	2	0.6
5.	Socio-economic:		
	(a) Low income	164	50.9
	(b) Middle income	116	35.0
	(c) High income	42	13.1
6.	Occupation:		
	(a) Farmer	119	37.0
	(b) Business	104	32.3
	(c) Technician	48	14.9
	(d) Civil Servant	50	15.5
	(e) Others	1	0.3

Careful observation of table 4.2 shows that most of the respondents (69.4%) were within the age group of 26 years and above, 56.5% were male and 43.5% female. Most of them had either primary / quaranic education. (36%) 56.5% were from rural areas. Most of them were either from low income level (50.0%) or from middle income level (36%). Most of them were either farmers (37%) or business people (32.3%).

Information regarding the perceptions of the respondents about inability to access primary health care services, acceptability, affordability and availability of these services is presented in table 4.3.

Inability to access services was indicated by four items which are shown in table 4.3. all the items in the questionnaire were on a 5 point likert scale, any item that gets a score of 3.5 and above was considered as a constraint.

Information regarding the perception of respondents about accessibility and constraint to the effective utilization of primary health care services is shown in table 4.3.1.

HYPOTHESIS I:

There is no significant difference among respondents of different age group in their perception of constraints to effective utilization of primary health care services.

In order to find out whether there were differences between respondents of different age groups in their perception of constraints to effective utilization of PHC services, one way analysis of variance was used, the results of which are shown in table 4.4.

TABLE 4.4:

SUMMARY OF ANOVA FOR DIFFERENCES AMONG DIFFERENT AGE GROUPS IN THEIR PERCEPTION OF CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	SOURCE	DF	SUM OF SQUARE	MEAN SQUARE	*F-RATIO*
Accessibility	Between group	4	0.3794	0.0949	0.5799
	Within group	317	51.8527	0.1636	
	Total:	321	52.2321		
Acceptability	Between group	4	2.0284	0.5071	0.5297
	Within group	317	303.4764	0.9573	
	Total:	321	305.5048		
Affordability	Between group	4	1.6110	0.4028	1.3652
	Within group	317	93.5173	0.2950	
	Total:	321	95.1283		
Availability	Between group	4	.3805	0.0951	0.2341
	Within group	317	128.8231	0.4064	
	Total:	321	129.2036		

F (4,317) = 2.37 P < 0.05)

Table 4.4 reveals that the f – calculated values of accessibility, (0.5799) acceptability, (0.5297) affordability, (1.3652) and availability (0.2341) are less than freedom (4,317) at 0.05 alpha level of significance. Therefore the null hypotheses which stated that, there is no significant difference among respondents of different age group in

their perception of constraint to effective utilization of primary health services is retained.

HYPOTHESIS II:

There is no significant difference among respondents of different socio-economic statuses in their perception of constraints to effective utilization of primary health care services.

To test this hypothesis, the data collected were analysed by using one way Analysis of variance for differences between respondents of different socio-economic statuses, the results of which are shown in table 4.5.

TABLE 4.5: SUMMARY OF ANOVA FOR DIFFERENCES BETWEEN RESPONDENTS OF DIFFERENT SOCIO ECONOMIC STATUSES IN THEIR PERCEPTION OF CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	SOURCE	DF	SUM OF SQUARE	MEAN SQUARE	*F-RATIO*
Accessibility	Between group	2	0.3579	0.1789	**1.1004**
	Within group	319	51.8743	0.1626	
	Total:	321	52.2321		
Acceptability	Between group	2	7.1666	3.5833	3.8315
	Within group	319	298.3382	0.9352	
	Total:	321	305.5048		
Affordability	Between group	2	0.3022	0.01511	0.5083
	Within group	319	94.8261	0.2973	
	Total:	321	95.1283		
Availability	Between group	2	0.7473	0.3737	0.9279
	Within group	319	128.4563	0.4027	
	Total:	321	129.2036		

F = (2,319) = 3.00 < 0.5 P < 0.05

Table 4.5 reveals that the f-calculated values sof accessibility, (1.1004) affordability, (0.5083) and availability (0.9279) are less than the f-critical of (3.00) with a degree of freedom (2,319) at 0.05 alpha level of significance. Therefore the null hypothesis which stated that, there is no significant difference between respondents of different socio-economic statuses in their perception of constraints in the

effective utilization of primary health care services is retained. The null hypotheses is rejected in the aspect of acceptability because the f – calculated (3.8315) is greater than the f – critical of (3.001) with a degree of freedom (2,319) at 0.05 alpha level of significance. Therefore the differences between respondents of different socio – economic statuses did not affect their perception of accessibility, affordability and availability as constraints in the effective utilization of primary health care services, but difference between different respondents of different socio economic statuses affect their perception of acceptability as constraints in the effective utilization of primary health care services.

HYPOTHESIS III:

There is no significant difference among respondents of different educational backgrounds in their perception of constraints to effective utilization of primary health care services.

In order to find out whether there were differences between respondents of different educational backgrounds in their perception of constraints in the effective utilization of primary health care services, the data collected were analysised by using one way analysis of variance, the results of which are shown in table 4.6.

TABLE 4.6: SUMMARY OF ANOVA FOR DIFFERENCES AMONG RESPONDENTS OF DIFFERENT QUALIFICATIONS IN THEIR PERCEPTION OF CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	SOURCE	DF	SUM OF SQUARE	MEAN SQUARE	*F-RATIO*
Accessibility	Between group	3	0.2226	0.4552	0.7138
	Within group	317	51.6820		
	Total:	321	51.9046		
Acceptability	Between group	3	10.1858	3.6455	0.0130
	Within group	317	297.2389		
	Total:	321	305.4247		
Affordability	Between group	3	1.1981	1.4131	0.2389
	Within group	317	89.5904		
	Total:	321	90.7886		
Availability	Between group	3	0.1124	0.0920	0.9644
	Within group	317	129.0901		
	Total:	320	129.2025		

F (3,317) = 2.60 < .05 P < 0.05

Table 4.6 reveals that the f – calculated values of accessibility, (0.7138) acceptability (0.0130) affordability (0.2389) and availability are less than the f – critical of (2.60) with a degree of freedom (3,317) at 0.05 alpha level of significance. Therefore the null hypothesis which stated sthat, there is no significance difference between respondents of different educational backgrounds in their perception of constraints in the effective utilization of primary health care services is retained.

HYPOTHESIS IV

There is no significant difference between male and female respondents in their perception of constraints to effective utilization of primary health care services.

To find out whether there were differences between male and female respondents in their perception of constraints to effective utilization of primary health care services, t-test for differences between male and female respondents was used, the results of which are presented in table 4.7.

TABLE 4.7: MEANS, STANDARD DEVIATIONS AND t-VALUES OF MALE AND FEMALE RESPONDENTS, PERCEPTION OF CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	SEX	MEAN	STANDARD DEVIATION	STANDARD	t-calculated
Accessibility	Male	3.0874	0.389	0.027	0.58
	Female	3.0611	0.415	0.036	
Acceptability	Male	2.5556	1.049	0.078	1.17
	Female	2.6815	0.874	0.075	
Affordability	Male	3.3497	0.529	0.039	0.94
	Female	3.2907	0.567	0.049	
Availability	Male	3.1913	0.617	0.046	0.81
	Female	3.2500	0.667	0.056	

$t\ (320) = 1.96 < .05$

Table 4.7 reveals that the t – calculated values of accessibility, (0.58) acceptability, (1.17) affordability (0.94) and availability (0.81) are less than the t – critical of (1.96) a degree of freedom (320) at 0.05 alpha level of significance. Therefore the null hypotheses that stated, there is no significant difference between male and female respondents in their perception of constraints in the effective utilization of primary health care services is retained.

HYPOTHESIS V

There is no significant difference among respondents of different occupations in their perception of constraints to effective utilization of primary health care services.

To find out whether there were differences between respondents of different occupation in their perception of constraints, in the effective

utilization of primary health care services, the data collected were analysed by using one way ANOVA, the results of which are shown in table 4.8.

TABLE 4.8: SUMMARY OF ANOVA FOR DIFFERENCES BETWEEN RESPONDENTS OF DIFFERENT OCCUPATION IN THIER PERCEPTION OF CONSTRAINTS IN THEIR EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	SOURCE	DF	SUM OF SQUARE	MEAN SQUARE	*F-RATIO*	*P. PROB*
Accessibility	Between group	4	0.6068	0.1517	0.9315	0.4458
	Within group	317	51.6254	0.1629		
	Total:	321	52.2321			
Acceptability	Between group	4	6.4388	1.6097	1.7062	0.1483
	Within group	317	299.0660	0.9434		
	Total:	321	305.5048			
Affordability	Between group	4	1.2321	0.3080	1.0399	0.3867
	Within group	317	93.8962	0.2962		
	Total:	321	95.1283	0.5243		
Availability	Between group	4	2.0972	0.5243	1.3076	0.2670
	Within group	317	127.1064	0.4010		
	Total:	321	129.2036			

F (4,317 = 2.37 < .05)

Table 4.8 reveals that the f – calculated of accessibility (0.9315) acceptability, (1.7062) affordability (1.0399) and availability (1.3076) are less than the f – critical of (2.32) with a degree of freedom (4,317) at 0.05 alpha level of significance. Therefore the null hypotheses that

stated, there is no significant difference between respondents of different occupations in their perception of constraints in their effective utilization of primary health care services is retained.

HYPOTHESIS VI:

There is no significant difference among respondents of different locations in their perception of constraints to effective utilization of health care services.

In order to find out whether there were differences between respondents of different locations in their perception of constraints in the effective utilization of primary health care services, the data collected were analysed by using t – test, the results of which are shown in table 4.9.

TABLE 4.9: MEANS, STANDARD DEVIATIONS AND t-VALUES OF MALE AND FEMALE RESPONDENTS, PERCEPTION OF CONSTRAINTS TO EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	LOCATION	MEAN	STANDARD DEVIATION	STANDARD ERROR	*t*
Accessibility	Urban	3.0536	0.394	0.029	0.85
	Rural	3.0924	0.418	0.036	
Acceptability	Urban	2.7106	0.944	0.070	0.58
	Rural	2.4903	1.009	0.086	
Affordability	Urban	3.3091	0.0261	0.042	2.01
	Rural	3.3533	0.526	0.045	
Availability	Urban	3.2363	0.627	0.046	0.52
	Rural	3.1993	0.646	0.055	

T (318) = 1.96 < .05.

Table 4.9 reveals that the t – calculated values of accessibility, (0.85) acceptability (0.58) availability (0.52) are less than t – critical (1.96) with a degree of freedom (318) at 0.05 alpha level of significance. Therefore the null hypotheses that stated, there is no significant difference between respondents of different locations in the effective utilization of primary health care services is retained. The table also shows that the t – calculated of affordability (2.01) is greater than the t-critical (1.96) with a

degree of freedom (318) at 0.05 alpha level of significance. Therefore the null hypotheses is rejected.

DISCUSSION

Primary health care is internationally accepted approach to improve the health statuses of the people. The success of implementation of primary health care services has been hampered by a number of constraints. This investigation was therefore conducted to determine the factors that are perceived to be affecting the utilization of primary health care services. The main factors included in this study are accessibility, acceptability, affordability and availability. The underlining purpose of finding out the constraints to effective utilization of primary health care services in this study is to conceptualise beyond the most frequently criticized limited perspective of research on constraints on effective utilization of primary health care services. This research focus is on behavioral conceptual of constraints especially on utilization verses non-utilization of primary health care services (Kuti, 1990). This study does not show significant influence of demographics of the respondents on the perception of constraints in the utilization of primary health care services. Three inferences can be drawn from this findings, first the aspect of utilization which has been used most frequently as the context, within which to measure perception and experience of constraints, that is, the desire but the inability to utilize the health care services. The single most constraints aspect of utilization of health services was to utilize as frequently as one would like. (Yusuf, 2002). The implication of this finding is the constraints less frequently block absolute utilization of health services, then inhibit the frequency or intensity of

utilization in which at least some degree of utilization is registered, on the other hand, the aspect of constraint utilization of health services has been found to be the least influential in the utilization of health services. (Yusuf, 2002), it thus appears that people utilizing health services are generally satisfy with the services. (WHO, 1997). Therefore the absence of influence of demography and the perceptions of the respondents about the constraints to health care services is justified. Secondly these results also suggest that it is not the level or intensity of constraints that distinguishes among the aspect of constraints utilization but rather the nature of constraints experienced by the respondents. This explanation lend further support to the concept of constraints as non homogenous concept, as previously reported by others. (WHO, 1987).

Thirdly and perhaps most importantly, differences in the type of constraints between aspects of constraint in utilization were only observed and not measured in this study, suggesting new interpretation about the experience and response to structural constraints. Research has shown that the four (4) category of constraints accessibility, acceptability, affordability and availability are encountered and negotiated in a sequential hierarchy depending on the level of utilization. The results of this study suggest that factors like cost and awareness act as the main barriers to initial utilization. Once this has been achieved, people may then begin to find the intensity and frequency of the utilization limited by accessibility, acceptability, affordability and availability. Season utilization may likely not result from these constraints unless if constraints of availability and

awareness are encounter. In other word, if people start utilizing health care services but find it to be very expensive or difficult, they would stop utilizing. If these barriers are not encountered and the further barriers come to surface, utilization may be compromise by reduction in the frequency and intensity of utilization.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 SUMMARY

In almost all countries of developing nations the rural population usually is at varying degree of deprivation and suffering, particularly from modern infrastructures and social services including health care system (UNICEF, 1981). The need for good health care delivery system as part of an enlarged poverty alleviation programme makes primary health care delivery system essential to all. The care to be provided under it should therefore be based on practically and socially sound and acceptable to target consumers.

For primary health care delivery system to be beneficial to any group of people all its members should be privileged to access its services both physically and economically. According to Adeyoroye (1989), it is also important to identify barriers which may inhibit utilization in order to accelerate its utilization.

The WHO (1992) has also pointed to the significance of both economic and cultural accessibility as a way to effective utilization. According to WHO if a service is available but neither the individual nor the community can afford it economically it is not accessible. Cultural accessibility according to WHO is recognizable in the context of the acceptability and relevance of its services to the general and specific population particularly the children and adults too.

The purpose of this study was to determine constraints to effective utilization of primary health care services in Kaduna State. In order to achieve this purpose six hypotheses were formulated. Resource materials related to the problem of the study were consulted in line with the hypotheses and this formed the framework of the study. The review of related literature was essentially based on the research questions and hypotheses.

The study used twelve out of the twenty three local government areas in the state and sourced data from three hundred and twenty two persons, out of a target of three hundred and sixty using a expost-facto research designed structured questionnaire. The copies of questionnaire were analysed using descriptive statistics for personal information of the respondents and both ANOVA and T-test for testing the hypotheses.

In the study, it was discovered that accessibility, acceptability, affordability and availability were perceive by respondents as constraints to their effective utilisation of primary health care services. It was also reveal that no significant difference exist between the respondents of different age groups, socio-economic status, gender, educational background, occupation and location in their perception of accessibility, acceptability, affordability and availability as constraints in their effective utilization of primary health care services. But significant difference exist between respondents of different socio-economic status in the area of acceptability. Significant different exist between respondents of different sex in their perception of constraints in their effective utilization of primary health care services.

On the basis of the above, primary health care services should also be made available to all at all time when they need it. Primary health care services should be accessible, it should be closer to the consumer so that the issue of transportation would not be a problem. Also the services rendered should be acceptable culturally and religiously. The services should be appropriate to the local technology in the environment.

5.2 **CONCLUSION**

Health is Wealth: In line with this, in 1978 during the WHO-UNICEF conference in Alma Ata, primary health care was formulated as a key to attaining health for all by the year 2000 and beyond. It was a programme designed to make health services available and accessible to all including rural or isolated population who were neglected in the past. The programme was based on community involvement through their own action in controlling their lives, prevention and the use of technology most appropriate. Therefore primary health care aim at bringing health services to the door step of the people where they live.

From the analysis of data, the programme is challenged by constraints such as accessibility, acceptability, affordability and availability which according to the perception of respondents limit their effective utilisation of primary health care services.

In the study, it was discovered that accessibility, acceptability, affordability and availability were perceived by the respondents as constraints to their effective utilization of primary health care service. It also revealed that differences exist between respondents of different age groups, socio-economic status, gender, educational background and location in their perception of accessability, acceptability, affordability, availability as constraints in their effective utilization of primary health care services. Therefore primary health care services should be made available, accessible, affordable to all irrespective of age, sex, socio-economic status, educational backgrounds etc.

5.3 **RECOMMENDATIONS**

On the basis of the findings of this study, the following recommendations are made:

1) There is urgent need for the State Ministry of Health and Health Management Board to begin sensitization campaigns across the state and particularly in the rural areas highlighting the importance and value of PHC delivery system.

2) The state government should as a matter of priority embark on construction of PHC centres in order to make such available to a wider population of people in the state.

3) Focus group discussions on the meaning, context and values of PHC delivery system should be held with consumers across the state and on regular basis to further sensitize the rural dwellers.

4) Primary health care services should be accessible to the consumer so that the issue of transportation would be minimized.

5) The services rendered should be acceptable culturally and religiously.

6) The services should be appropriate to the local technology.

7) Their curriculum should be adjusted to meet the principle of primary health care services.

5.4 RECOMMENDATION FOR FURTHER RESEARCH

Similar study across the nation be conducted to determine the extent of utilization of primary health care services in line with recommendations of Bamako initiatives.

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20th May, 2000.

Dr. E. S. Essien,
Dr. (Mrs) C. O. Adegbite,
Dr. C. A. Okuofu.

REQUEST FOR CRITICAL EXAMINATION OF QUESTIONNAIRE ON THE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

Mrs. Asabaru Yusuf is a postgraduate student of Physical and Health Education Department. In partial fulfilment of the requirement of the programme, she is conducting a research on the Utilization of Primary Health Care Services in Kaduna State. In this regard, she has prepared a questionnaire to be fill in by household head.

In view of your proficiency and experience, you have been selected as one of the jurors to critically examine the questionnaire. I am sending here with a copy of the questionnaire with the request to make suggestion to improve the validity and reliability of the questionnaire. I will appreciate very much if you can go through the questionnaire critically and make your suggestions to improve the standard of the questionnaire.

Please go through the questionnaire critically and return it to the bearer with your suggestions, as soon as possible.

Thanking you.

Prof. K. Venkateswarlu,

Physical and Health Education

Department.

APPENDIX

QUESTIONNAIRE FOR HOUSEHOLD HEAD
DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION
AHMADU BELLO UNIVERSITY, ZARIA

I am an M. Sc Student of the Department of Physical and Health Education. In partial fulfillment of the requirements for the award of M. Sc. degree in Health Education. I am conducting a research on "Constraint to Effective Utilization of Primary Health Care Services in Kaduna State".

In this regard, I seek your co-operation to honestly respond to the items in this questionnaire.

Asabaru Yusuf (Mrs)
(Researcher)

HOUSEHOLD HEADS QUESTIONNAIRE

SECTION ONE

PERSONAL INFORMATION

(Please put a tick (x) in any column that best suits you.

1. Local Government Area:

(i)	Birnin Gwari	( )
(ii)	Lere	( )
(iii)	Giwa	( )
(iv)	Zango Kataf	( )
(v)	Kaduna North	( )
(vi)	Soba	( )
(vii)	Kafanchan	( )
(viii)	Zaria	( )
(ix)	Igabi	( )
(x)	Kubau	( )
(xi)	Kudan	( )
(xii)	Kajuru	( )

2. Age of Respondent:

(i)	Below	-	20	years	( )
(ii)	21	-	25	years	( )
(iii)	26	-	30	years	( )
(iv)	31	-	35	years	( )
(v)	Above 35	years			( )

3. Gender:

(i) Male ( ) (ii) Female ( )

4. Level of Highest Education attained:

(i) None ( )

(ii) Primary/Koranic ( )

(iii) Secondary ( )

(iv) Teriary ( )

5. Location (where do you live?):

(i) Urban ( ) (ii) Rural ( )

6. Socio-economic Status:

(i) Low income below ₦30,000.00 ( )

(ii) Middle income up to ₦90,000.00 ( )

(iii) High income ₦150.000.00 and above ( )

7. Occupation:

(i) Farmer ( )

(ii) Trader/Businessman/Woman ( )

(iii) Technician ( )

(iv) Civil Servant ( )

(v) Others (please specify) ……

SECTION TWO:

CONSTRAINTS IN THE UTILIZATION OF PRIMARY HEALTH CARE CENTRE

(Please put a tick (x) against each of the statements below as each of them is applicable to you.

	Strongly Agree	Agree	Undecided	Strongly Disagree	Disagree
8. PHC Constraints: (i) Place where services offered to far.					
(ii) Cost of Transportation on to PHC Centre is very high					
(iii) There is no PHC Centre in my area					
(iv) There is no motorable road to the nearest PHC Centre in my area.					
(v) I have the fear of possible side effects.					
(vi) Services offered do not fit the life style of users) consumers.					
(vii) I have difficulties accepting the idea of PHC.					
(viii) PHC is a deceit hence waste of resources.					
(ix) Only a few service centres are functional.					
(x) Death personnel at centres are inadequate and most of the time lacking.					
(xi) Vaccines and drugs are not available.					
(xii) Adequate medical attention is lacking in the centres.					
(xiii) Cost of drugs is beyond the reach of consumers.					

(xiv) Limited Financial resources is the bane of successful programme.					
(xv) I do not (utilise) patronise the centre because of financial inability.					
(xvi) PHC personnel pay more attention to people who can afford to give extra monetary inducement.					

9. Do you know of the existence of primary health care services in you area?

(i) Yes ( ) (ii) No ( )

10. If yes, how distant is the centre from where you live?

(i) Not far ( )

(ii) A little bit far-away ( )

(iii) Very far away ( )

(iv) Can not be specific ( )

11. If no, have you ever hear of it before from any body?

(i) Yes ( ) (ii) No ( )

12. Do you know what immunization is?

(i) Yes ( ) (ii) No ( )

13. Have you ever taken your children or yourself for immunization?

(i) Yes ( ) (ii) No ( )

14. If yes, where were you or your children immunised?

(i) The PHC centre nearest to us ( )

(ii) We went to nearby primary school for it ( )

(iii) In a private hospital ( )

15. If and when you are sick, where do you think you can obtain necessary medication?

(i) PHC centre ( )

(ii) Private hospital ( )

(iii) Traditional healing home ( )

(iv) Spiritual healing ( )

(v) None of the above ( )

16. You wish to go health care centre when ill, but constrained by:

(i) Transportation ( )

(ii) Finance ( )

(iii) Lack of care by PHC staff ( )

(iv) Spiritual healing ( )

(v) None of the above ( )

17. How would you rate cost of medication in PHC centres?

(i) Very high ( )

(ii) High ( )

(iii) Moderate ( )

(iv) Low ( )

Information regarding the perception of respondents about accessibility as constraint to the effective utilization of primary health care services is shown in table 4.3.1.

TABLE 4.3.1: FREQUENCY AND PERCENTAGES OF RESPONSES ON ACCESSIBILITY AS CONSTRAINT IN THE EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	ITEM	STRONGLY AGREE		AGREE		STRONGLY DISAGREE		DISAGREE		UNDE
		FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ
Accessibility	Places where services are offered too far.	192	59.6	125	38.8	2	0.6	-	-	3
	Cost of transportation to clinic is very high.	178	55.3	132	41.0	5	1.6	-	-	7
	There is no PHC center in my area.	140	43.5	172	53.4	4	1.2	2	0.6	4
	There is no road to the nearest PHC.	23	7.1	16	5.0	184	37.1	8	26.7	13

Table 4.3.1 shows that respondents perceived item 1, 2 and 3 as constraints to the effective utilization of primary health care services because the average score of the 3 items is more than 3.5 while item 4 is perceived by respondents as not a constraint of utilization of primary health care services because the average score (2.55) is less than 3.5. On the whole, table 4.3.1. reveals that the respondents

perceived accessibility as constraint for effective utilization of primary health care services, as it average score was 3.98.

Information regarding the perception of respondents about acceptability as constraint to the effective utilization of primary health care services is shown in table 4.3.2.

TABLE 4.3.2: FREQUENCY AND PERCENTAGES OF RESPONSES ON ACCEPTABILITY AS CONSTRAINT IN THE EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	ITEM	STRONGLY AGREE		AGREE		STRONGLY DISAGREE		DISAGREE		UNDE
		FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ
Acceptability	I have the fear of possible side effects	33	1.2	186	57.8	7	2.2	3	0.9	93
	Services do not fit my life style.	75	23.3	200	62.1	14	4.3	2	0.6	56
	I have difficulties accepting the idea of PHC	112	34.8	138	42.9	14	4.3	1	0.3	28
	PHC is a deceit hence a waste of resources.	141	43.8	138	42.9	14	4.3	1	0.3	28

Table 4.3.2 indicates that all the items stated were perceived by the respondents as constraints to effective utilization of primary health care services because the average score of the items is more than 3.5. On the whole, acceptability was perceived as a constraints in the effective utilization of primary health services as its average score is 3.64.

Information regarding the perception of respondents about affordability as constraint to the effective utilization of primary health care services is shown in table 4.3.3.

TABLE 4.3.3: FREQUENCY AND PERCENTAGES OF RESPONSES ON AFFORDABILITY AS CONSTRAINT IN THE EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	ITEM	STRONGLY AGREE		AGREE		STRONGLY DISAGREE		DISAGREE		UNDE
		FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ
Affordability	Cost of drugs is beyond the poor.	162	50.2	125	38.8	14	4.3	5	1.6	16
	Finance hinders its success	157	48.8	135	41.9	12	3.7	2	0.6	16
	I do not patronize because of money.	156	48.4	138	42.9	13	4.0	1	0.3	14
	PHC personnel attend more to the rich.	173	53.7	129	40.1	11	3.4	2	0.6	7

Table 4.3.3. shows that item 1 – 4 are perceived by the respondents as constraints to effective utilization of primary health care services because the average score of the items is more than 3.5. On the whole, table 4.3.3. reveals that the respondents perceived, affordability as a constraint for effective utilization of primary health care services, as its average score was 4.3.3.

Information regarding the perception of respondents about availability as constraint to the effective utilization of primary health care services is shown in table 4.3.4.

TABLE 4.3.4: FREQUENCY AND PERCENTAGES OF RESPONSES ON AVAILABILITY AS

CONSTRAINT IN THE EFFECTIVE UTILIZATION OF PRIMARY HEALTH CARE SERVICES

CONSTRAINTS	ITEM	STRONGLY AGREE		AGREE		STRONGLY DISAGREE		DISAGREE		UNDE
		FREQ.	%	FREQ.	%	FREQ.	%	FREQ.	%	FREQ
Availability	Only a few centers are functioning.	156	48.4	132	41.0	15	4.7	3	0.9	16
	Personnel are inadequate.	150	46.6	133	41.3	20	6.2	2	0.6	17
	Vaccine and drugs are not available.	156	48.4	130	40.4	20	6.2	1	0.3	15
	Adequate medical care is lacking.	158	49.1	121	37.6	18	5.6	5	1.6	20

Table 4.3.4., it reveals that the respondents perceived items 1-4 as constraints to their effective utilization of primary health care services because the average score is greater than 3.5. On the whole, table 4.3.4. reveals that the respondents perceived, availability as a constraint for effect utilization of primary health care services, as its average score was 4.25.