ASSESSMENT OF BARRIERS TO THE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN BATSARI LOCAL GOVERNMENT AREA OF KATSINA STATE

BY

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DECLARATION

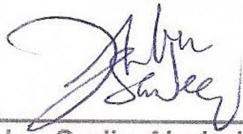
I hereby declare that this research work was carried out by me under the supervision of Dr M.N. Sambo of the Department of Community Medicine, Faculty of Medicine, Ahmadu Bello University Zaria. It has not been submitted for any previous application for other degrees or qualifications .All sources of information and the work of other researchers are duly referred to and acknowledged.

______________________________ ______________________________

Kurfi Abubakar Muhammed **Date**

CERTIFICATION

This thesis entitled **"ASSESSMENT OF BARRIERS TO THE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN BATSARI LOCAL GOVERNMENT AREA OF KATSINA STATE" by KURFI, Abubakar Muhammed** meets the regulations governing the award of the degree of Master in Public Health of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.



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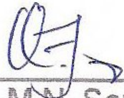

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DEDICATION

This thesis is dedicated to my late mother Mrs Rakiya Muhammad, for her love and guidance throughout her life period, May Allah SWT forgive her and grant her eternal rest in jannatul firdausi

To my loving wife Nazeefa Abubakar and my son Aleeyu (Haydar) Abubakar for their patience and sacrifice throughout the rigorous and expensive period of my studies,

And most importantly to all the less privileged of this nation who cannot afford the cost financing their health care

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TABLE OF CONTENTS

Title page - - - - - - - - -	i
Declaration - - - - - - - - -	ii
Certification - - - - - - - - -	iii
Dedication - - - - - - - - -	iv
Acknowledgement - - - - - - - -	v
Table of contents - - - - - - - -	vi
List of tables - - - - - - - -	ix
List of figures - - - - - - - -	x
List of acronyms - - - - - - - -	xi
Summary - - - - - - - - -	xiv

Chapter One:

Introduction - - - - - - - - -	**1**
1.1 Statement of the Problem - - - - - - -	5
1.2 The Research Question - - - - - - -	6
1.3 Justification for the Study - - - - -	6
1.4 Hypothesis - - - - - - - -	8
1.4 Objectives of the Study - - - - - - -	8

Chapter Two

Literature Review - - - - - - -	9
2.1 Selective versus Comprehensive Primary Health Care - - -	16
2.3 Components of Primary Health Care - - - - -	18
2.3 Utilization of Primary Health Care (PHC) Services - - -	21

2.4 Barriers to the Utilization of PHC Services - - - - 24

Chapter Three

Methodology - - - - - - - - 28

3.0 Study Area - - - - - - - - 28

3.1 Study Design - - - - - - - - 29

3.2 Study Population - - - - - - - - 30

3.3 Sampling Technique - - - - - - - 30

3.4 Sample Size Determination - - - - - - 31

3.5 Data Collection Technique - - - - - - 31

3.6 Data Analysis - - - - - - - - 32

3.7 Ethical Considerations - - - - - - - 32

3.8 Inclusion and Exclusion criteria - - - - - - 33

3.8 Limitations of the Study - - - - - - - 33

Chapter Four:

Results - - - - - - - - - 34

Chapter Five:

Discussions - - - - - - - - - 50

5.1 Socio Demographic Characteristics of the Households - - - 50

5.2 Distribution of Health Facilities in the LGA - - - - 52

5.3 Manpower in the Health sector - - -- - - - 52

5.4 Health Care Problems of the Community - - - - 53

5.4 Accessibility of Health Facilities - - - - - - 54

5.6 Utilization of PHC Services - - - - - - 56

5.7 Satisfaction of the Household with the Services - - - - 57

Chapter Six

Conclusion and Recommendations - - - - - 59

6.0 Conclusion - - - - - - - - 59

6.1 Recommendations - - - - - - - 60

References - - - - - - - - - 62

LIST OF TABLES

Table 4.1: Showing socio-demographic characteristics of the households 34

Table 4.2: Showing the common health care problems of the households in the last one month - - - - - - 36

Table 4.3: Showing the preferred place of treatment for households - 38

Table 4.4: Showing the Outcome of Treatment by Place of Treatment - 39

Table 4.5: Showing Reasons for non utilization of health facility by household - - - - - - - 40

Table 4.6: Showing the solutions to health facility problems from the perception of households - - - - - 41

Table 4.7: Showing the distribution of health facilities in the wards of LGA as well as the health facility to population ratio 43

Table 4.8: Showing distribution of personnel by profession in the facilities 44

Table 4.9: Showing availability of clinical services in the facilities - 45

Table 4.10: Showing the relationship between educational status and use of PHC facility - - - - - - - 46

Table 4.11: Relationship between distance of facility to household and use of PHC facility - - - - - - - 47

LIST OF FIGURES

Figure 4.1: A pie chart showing the utilization of Primary Health Centres among Households - - - - - - 37

Figure 4.2: Showing the degree of satisfaction with the services in the facility by respondents - - - - - - 42

LIST OF ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ARI	-	Acute Respiratory (tract) Infection
BCC	-	Behavioural Change Communication
BCG	-	Bacillus Calmette Guerin (vaccine)
BEOC	-	Basic Essential Obstetric Care
CBO	-	Community Based Organisation
CHEW	-	Community Health Extension Worker
CHO	-	Community Health Officer
DPT	-	Diphtheria, Pertusis, Tetanus (vaccine)
EHO	-	Environmental Health Officer
FMOE	-	Federal Ministry of Environment
FMOH	-	Federal Ministry of Health
GDP	-	Gross Domestic Product
HIV	-	Human Immune Deficiency Virus
IEC	-	Information Education Communication
IMCI	-	Integrated Management of Childhood Illness

IMF	-	International Monetary Fund
IMNCH	-	Integrated Maternal, Neonatal and Child Health
LGA	-	Local Government Authority (Area)
NASCP	-	National AIDS and STI Control Programme
NCD	-	Non Communicable Disease
NDHS	-	National Demography and Health Survey
NGO	-	Non Governmental Organisation
NHMIS	-	National Health Management Information System
NPHCDA	-	National Primary Health Care Development Agency
NPI	-	National Programme on Immunization
OPV	-	Oral Polio Virus (vaccine)
PATHS	-	Partnership for Transforming Health Systems
PHC	-	Primary Health Care
PMTCT	-	Prevention of Maternal to Child Transmission (of HIV)
RBM	-	Roll Back Malaria
SM	-	Safe Motherhood
SMOH	-	State Ministry of Health

STI	-	Sexually Transmitted Infection
TB	-	Tuberculosis
TBA	-	Traditional Birth Attendant
VCT	-	Voluntary and Counselling and Testing
VDC	-	Village Development Committee
VHW	-	Village (Voluntary) Health Worker
WDC	-	Ward Development Committee
WHO	-	World Health Organisation
WHO AFRO	-	WHO African Regional Office
WHS	-	Ward Health System
WMHCP	-	Ward Minimum Health Care Package

SUMMARY

Primary health care (PHC), which is supposed to be the bedrock of the country's health care policy, is highly ineffective and has deteriorated due to the lack of investment in personnel, facilities and drugs. The provision of health care at the primary care level is aimed to serve the individuals and the communities based on a health care system that is promotive, protective, preventive, restorative and rehabilitative within the available resources. Rather, there is a lack of confidence and trust by the public in the health services resulting from the poor state of the facilities and low standards of delivery. The study therefore sought to explore and highlight those barriers affecting the utilization of primary health care services in Batsari Local Government, In Katsina State of Nigeria. The study uses data triangulation involving a cross-sectional community-based descriptive study design to study the utilization of pattern among households. A qualitative dimension was added through an in depth interview with the head of the PHC department and focus group discussions with the heads of households in six randomly selected communities, in all locations questions were asked on the major determinants of access and utilization of primary health care in the LGA, 150 households and 27 health facilities were involved in the process. The findings showed that the predominant health problems in the community were fever, diarrhoea 27.6% and vomiting, cough 26.9%, the majority of the women prefer to seek care in the patent medicine stores 36.3% and 14.4% utilize private practitioners as against 20.1% which utilize public health services, various reasons were advocated for the non utilization of the services top of which is the lack of essential drugs 27.6%, and cost 15.5%. The study has provided a basis for understanding and appreciating the complex factors affecting the utilization of these essential services,

and how these factors translate into a deterioration of our health indices, it is expected that these findings will enrich academic discussions and guide policy makers in formulating guidelines towards improving primary healthcare services.

CHAPTER ONE

INTRODUCTION

A PHC-based health system is an overarching approach to the organization of health systems designed to improve population health and maximize equity. Such an approach makes the right to health a guiding principle of the health system, with the health system structures and functions oriented towards achieving equity in health and social solidarity, based on a core set of principles and elements. Primary health care can also act as the basis of the healthcare system by establishing fundamental policies, programs and priorities that respond to the population health needs. In Nigeria, a notion of primary health care is seen as a defined set of services, which are in accordance with local needs, and it is an entry point into the health care system.[1] the services at that level alone are not sufficient to adequately cater for the more complex health needs of the populace. Thus health care systems should work in an integrated manner through the development of mechanisms that coordinate care across the entire spectrum of services, including referral systems.

With this background in mind we can conveniently say the history and development of health systems in Nigeria can be classified in accordance with the historical evolution of the nation into; Pre colonial period, Colonial and post colonial era. The health care system in the pre colonial period was both a combination of the orthodox and the modern which was tailored towards serving the need of the missionaries and the slave traders , the modern system was able to serve them with basic services comparable to their level of development , in the colonial period the first national development plan called the 10 years national development plan and social welfare (1946-1956) was a modest ,realistic,

practicable and adequate plan considering the era in which it was proposed , it provided a plan for the provision of more hospitals , more personnel ,especially doctors and perhaps it is this its therapeutic and infrastructure based orientation and disposition that has persisted up till today leading to neglect of preventive services by our policy makers .[2]

Nigeria as a nation became independent in October 1960 and an automatic member of WHO in 1963 it became a full member of UN after assuming a republican status, but from then on politicization of the policy makers took place, [3] as they became more pre occupied with political matters neglecting other issues of governance, so the first national development plan 1962-1968 could not be implemented, the second national development plan 1970-1974 was more of an attempt to rehabilitate economic activities in the war torn areas, judging from its national objectives which were to ensure just, strong and self reliant nation.

The third national development plan 1975-1980 highlighted serious concerns for rural development with a need to reduce disparities between regions and localities and a fall out of this process is the basic health service scheme, whose major strengths are, [4]

- Delegation of responsibilities to non physicians in order to augment the deficiencies of doctors.
- Location of training centres in environments similar to where trainees will serve.
- Use of home based care records to increase patient's participation in health care.

The Basic health service scheme failed at the end due to the neglect of more important principles of PHC like community participation and intersectoral collaboration.[4,74]

Primary health care is defined as essential health care that is based on 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 can afford to maintain at every stage of their development in the spirit of self reliance and self determination.[1]

It is supposed to be the first level of care for individuals and families with the national health systems and it should at least be able to provide the following components.[80]

1. Immunization against the major communicable diseases
2. Prevention and control of locally endemic diseases and epidemics
3. Maternal and child health including family planning
4. Environmental sanitation including adequate water supply and hygiene
5. Health education on the prevailing health problems and the methods of controlling them
6. Adequate nutrition through promotion of food supply and proper nutrition
7. Provision of essential drugs
8. Appropriate treatment of common diseases and injuries

Recently mental and dental care as well as primary eye care has been included as other components of primary health care. The basic principles of the PHC system are essential health care, community participation, equity, appropriate technology and intersectoral collaboration.

Due to the palpable demand for a grass root based health care system , the WHO in conjunction with UNICEF organized the Alma Ata conference in Kazakhastan (USSR) in

1978, The conference was a scientific movement of professionals, institutions, governments, civil society organizations, researchers and grass roots organizations that undertook to tackle the politically, socially and economically unacceptable health inequalities in all countries, the declaration was clear about the values of social justice, right to health for all, community participation and solidarity, with the overall aim of the attainment of a level of health that will ensure a socially and economically productive life for all by the year 2000.[5]

A part from the basic health service scheme which failed due to the circumstances enunciated above, a second attempt at implementing PHC was done in 1980 and 1985 , during this period the government began the implementation of the various programmes of PHC in pieces without any attempt to integrate them and without any clearly mapped out plan and objectives, this led to the fragmentation of services with both the states and federal governments pursuing different objectives agreeable to them and to donor agencies interested in some of the programmes.

A deliberate attempt to adapt and nationalize the entire components of the PHC system started in 1986 in 52 pilot LGAS, which culminated in the adaption of the national health policy by the armed forces ruling council in 1987 and launched in 1988.[6,7] The goal of the national health policy is the attainment of a level of health care that will enable Nigerians live and achieve socially and economically productive lives, through the emergence and institutionalization of a comprehensive primary health care system ,that is promotive, protective ,restorative and rehabilitative.[7] By 1990 the federal government has extended the PHC system coverage to all the LGAs of the country.[8]

The major progress achieved so far under the PHC system include the rolling out and the entrenchment of the Bamako Initiative in 1988, the complete demarcation of the roles and responsibilities of the three tiers of government , the introduction of the referral system as well as the establishment of schools of health technologies to provide available and affordable critical manpower gaps in the sectors , the institutionalization of the concept of ward and village development committees as well as some degree of intersectoral collaboration, others are the establishment of the national primary health care development agency that will support government in monitoring PHC plan and implementation and provide continuous technical assistance to the government in PHC implementation in 1992.

1.1 Statement of the Problem

The fundamental problems of PHC as outlined at the Alma Ata conference have been recognized and respected by all nations and yet there are divergences and ambiguities in interpretation across countries worldwide, a recent report by WHO African region puts the level of PHC utilization at 5-7%,[9] this translates to about 95% underutilization of the services , despite the monumental budgetary expenditure on PHC through mass construction of clinics, staffs recruitment ,continuous training and series of collaborations across all sectors

The 2009 world development report released by UNDP and the national demographic health survey 2008 portrays the extent of poor utilization of primary health care system in the nation in general and the northern states in particular, as the level of utilization of individual components of PHC is very poor, for example the overall national

immunization coverage is 29% and state like Katsina recorded less than 1% coverage for all antigens, national contraceptive prevalence rate was 15% and 1% in Katsina, the state had antenatal coverage of 14.4% and only 4.7% of women delivering in the hospital.[10,11]

In view of the fact that so much investment has been done and is still being done by all sectors of the government towards strengthening the system, yet patients still by pass the it and go to other secondary and tertiary centres , therefore over stretching the existing secondary and tertiary health facilities, there is therefore a need to for a study to analyse the various barriers to effective PHC utilization as well as explore all the broad issues affecting health at the primary health care level.

1.2 The Research Question

Based on the Alma Ata declaration, primary health care is supposed to function on the principles of equity and social justice which will serve as a vehicle for the attainment of the legendary health for all by the year 2000, [12] the essential components of primary health care have been outlined, but numerous factors serve as barriers to the utilization of these essential services, it is imperative therefore that a research is carried out to highlight these factors, hoping that this findings will enrich academic discussions and affect policy making towards finding a realistic solution to the problem of health care at PHC level.

1.3 Justification for the Study

In line with the global commitment for health for all by the year 2000 and in consonance with the declaration of Alma Ata, Nigeria adapted primary health care as the first level of care to provide a comprehensive preventive, curative and restorative care for its citizens., The demand for primary health care services are daily dwindling and the expenditure on

the part of the government and other stakeholders is on the rise, yet there is a decline in the rate of utilization.[13,14,15] Thirty two years after the Alma Ata conference the services at the primary health care level are deteriorating and the care been offered is either inverse or fragmented, and in most cases impoverishing in nature, this justifies the need to ascertain why despite the monumental investment the services are not improving, and despite the increase in the number of primary health care centres and primary health services in the state in particular and the nation in general, the indices for morbidity and mortality are on the rise.[16,17]

As an additional measure of commitment on the part of the Government, the nation has also invested heavily on the primary health care in policies, infrastructures and institutions, in terms of policies for instance the national health policy 1988 had primary health care as its fulcrum and the revised 2004 national policy also retained PHC as its major fulcrum too, the establishment of the national primary health care development agency NPHCDA to provide technical guidance as well as source and mobilize resources for PHC in Nigeria is also an added another measure of commitment, likewise the huge expenditure on PHC by the nation in terms of man power and material resources , despite all these the people still by pass the PHC system leading to congestion and over stretching of the nations secondary and tertiary health centres.

Some other achievements in the nations attempt to institutionalize primary health care include the rolling out and the entrenchment of the Bamako Initiative in 1988, the complete demarcation of the roles and responsibilities of the three tiers of government , the introduction of the referral system as well as the establishment of schools of health

technologies to provide available and affordable critical manpower gaps in the sectors, the institutionalization of the concept of ward and village development committees as well as some degree of intersectoral collaboration.

Based on the above summations there is a need to conduct a research in order to determine the rationale behind such disparities as well as identify barriers to utilization of these services in order to make recommendations that will aid in increasing the utilization of PHC services in line with the national health sector reform programme and in tandem with the national health strategic development plan 2010-2015.

1.4 Hypothesis

The Null hypothesis for this study is that the people of Batsari Local Government do not utilize primary health care services, while the alternative hypothesis is that the people of Batsari Local Government do utilize primary health care services.

1.5 Objectives of the Study

The main objective of the study is to:

- Determine the factors affecting the utilization of primary health care services in Batsari Local Government Area of Katsina state.

The specific objectives are:

1. To determine the pattern of utilization of primary health care services among the people in the community
2. To determine the common health care problems of the people of the community
3. To assess the barriers to the utilization of PHC among the members of the community.

CHAPTER TWO

LITERATURE REVIEW

The concept of Primary Health Care was formulated and adopted by 134 countries that met at the Alma-Ata Conference in Russia on the 12th day of September, 1978, under the auspices of World Health Organization (WHO) and the United Nations Children Fund (UNICEF). [18] It is that system of health care that is closest to the communities and that is meant to serve those in the most vulnerable group whose needs for health are paramount and critical. Thus, all activities performed at this point are supposed to be first-line, aimed at bringing health care as close as possible to where people live and work and contributes the first elements of a continuing health care process.

Primary Health Care (PHC) arose as a result of the clear realization of the numerous mismatches in the health care system viz, the colossal mismatch between the innumerable health needs of people and the scarce resources meant to address these needs. There is also a mismatch between health needs and inter-sectoral health expenditures. While 80% or more of our problems are preventable our spending on health are in the opposite direction, another mismatch is between population distribution and health services distribution; (the so called inverse pyramid of health care), these series of problems and dislocations have led to the alienation of the people and made the beneficiaries of the system passive and docile. There is therefore the need for a people oriented system that will be able to address all the above challenges; it is believed that Primary Health Care can do that.

The World Health Organization defined Primary Health Care as 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, which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.[19] The World Health Organization (WHO) went ahead to itemize the aims and objectives of the Primary Health Care system as follows: [19,83]

1) To make health services accessible and available to everyone wherever they live or work.
2) To tackle the health problem causing the highest mortality and morbidity at a cost that the community can afford.
3) To ensure that whatever technology is used must be within the ability of the community and use effectively and maintained.
4) To ensure that in implementing health programme, the community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance.

In summary, a good primary health care service must be essentially aimed at promoting health, preventing and curing disease as well as rehabilitating people to ensure that they live full normal lives after illness or disability.

In the 1999 Constitution of the Federal Republic of Nigeria and the National Health Bill (2008), which was a document meant to provide a framework for the regulation, development and management of a national health system through setting standards for rendering health services in the federation. In the Constitution of the federal government,

health is in the concurrent legislative list and by implication; the three tiers of government are vested with the responsibilities of promoting health at various levels of care. According to these documents, the federal, state and local government shall support in a coordinated manner. The three tier stepwise system of health care viz: [22]

- Primary Health Care to be coordinated by the local government;
- Secondary Health Care by the state government and
- Tertiary Health Care by the federal government.

Therefore, Primary Health Care at the grass root shall serve as the focal as well as the entry point for all health care activities.

The National Health Bill also made a provision for the establishment of the National Primary Health Care development fund; which shall be financed from the consolidated revenue account, via not less than 2% of the fund, 50% of the funds shall be used for the provisions of basic minimum package of health care services to all citizens in the Primary Health Care through the National Health Insurance Scheme; while 25% of the funds are for the provision of materials and transport facilities in the Primary Health Care, while 10% of the funds shall be used for the development of human resource. [23]

The ward minimum health care package is the minimum health care package includes health interventions and/or services that address health and health related problems that result in substantial health gains at low cost. In defining this package, a number of considerations were made; disease patterns, economic considerations (e.g. cost of services) and proportion of population affected/benefiting from health services. This package targets the grass root level through the delivery of a minimum set of

interventions needed to meet the basic health requirement of the people hence contributing to achieving the global target of health for all and the attainment of the Millennium Development Goals (MDGs). Technically, this package comprises of cost-effective interventions known to promote health and development and reduce mortality and morbidity from major/common illnesses. Based on these and other considerations, a package is proposed.[84,85]

The essence of the ward minimum health care package is to define a ward minimum health care package that would be made available at PHC level to improve access to quality health care at community level particularly for the rural population and address the inequalities between and within wards in health service delivery, it basically consists of the following six packages ,Control of Communicable Diseases (Malaria, STI/HIV/AIDS), Child Survival , Maternal and Newborn Care, Nutrition, Non-Communicable Diseases Prevention, Health Education and Community Mobilization.[85]

The delivery of this package shall be coordinated by the National Primary Health Care Development Agency in close collaboration with the various state and local government health care departments. The National Primary Health Care Development Agency (NPHCDA) was established by Decree 29 of 1992, set up with the primary aim of ensuring sustainability of the Primary Health Care system in Nigeria.[24] As a parastatal under the Federal Ministry of Health, to give support to the health policy through motivating of Primary Health Care plans and implementation, as well as provision of technical support to Primary Health Case implementation. For ease of administration, it operates based on the geo-political nature of our political system. It aims to mobilize support nationally and internationally for programmes implementation, administer or

commission studies on Primary Health Care issues; if properly utilized, National Primary Health Care Development Agency(NPHCDA) was designed in such a way that it could serve as a capacity building organization.

The federal government attempt to express its national commitment to improving the countries health care system led to the emergence of the National Health Policy in 1998, with the explicit aim of serving as a formal framework for the management of the country's health system. The policy was approved in 1987 and in 1988, which aims to establish a comprehensive health care system based on PHC, i.e. promotive, restorative and rehabilitative. Recently, this policy has been revised in 1997 and adopted in 2004 with some ancillary appendages of policies on health programmes like HI/AIDs, Malaria, TB, National Programme on Immunization, reproductive health, health management information systems, etc. Yet, this revised policy still retains primary health as its pivot focal point.

The federal government under the Olusegun Obasanjo administration has taken a series of concrete steps aimed at transforming the Primary Health Care system for the better. These reforms are all part of the New-Partnership for African Development (NEPAD), which include the Economic Empowerment and Development Strategies (NEEDS I and II), as well as the recent vision 20-2020. One good feature of all these reforms is the decision to develop and expand public private partnership in health care, even though the overall goals still remain that of making health care assessable, available and affordable. The major thrusts of the NEEDS documents are job creation, poverty eradication, value-reorientation and employment generation.[25]

The Primary Health Care system stands on the tripod of:

i) Principles

ii) Monitoring and evaluation and

iii) Indicators.

The four basic principles of primary health care are: universal accessibility, community participation, intersectoral collaboration and appropriate technology.[26] Universal accessibility refers to the availability, affordability and accessibility of health care for all those who need it. Intersectoral collaboration on the other hand is concerned with the need for all other sectors, agencies, and parastatals to closely collaborate and coordinate their activities together for a common goal. Community participation aims to promote maximum community involvement and engagement in all stages of health care viz planning, operation and control. The various instruments of evaluation of Primary Health Care are routine reporting system where data are collected on mortality and morbidity. Sentinel reporting system using special reporting sites, specifically chosen to provide data known to be more accurate than those provided by routine disease reporting system. Coverage survey on the other hand is meant to evaluate accurately the performance of programme and to validate the information from routine reporting system.

Outbreak investigation is used to clearly delineate the existence or otherwise of an unusual increase in morbidity and mortality beyond what is expected. Others are programme review and cost analysis, which involves bringing together the appropriate measures and resources to be used in executing a programme and the cost evaluation of expenditure with results obtained.

Indicators for monitoring PHC system are a function of the type of programme to be evaluated, type of activities to be carried out as well as the availability of resources at our disposal.[27] Above all; indicator matrices are a function of which component of PHC one is supposed to measure. For example, education concerning prevailing health problem will include the proportion of population with access to media outlets and measurement of adult literacy activities in the community. Immunization indicators include immunization coverage measured by the percentage of children at risk, and percentage of pregnant women fully immunized during a specific period. [27] Maternal and child indicators include the percentage of deliveries attended by trained personnel, which is given as number of deliveries attended by trained personnel over the expected number of births. The expected number of births is the product of crude birth rate and the midyear estimate of the population.[28] it also includes the proportion of pregnant women receiving ante-natal and post-natal care, as well as proportion of eligible women receiving family planning; otherwise referred to as the contraceptive prevalence rate of the community.

Food and nutrition indicators include the percentage of children (under 5 or 3 years) of age [29] that are below the reference value for weight for age, while nutritional status of pregnant women can be measured by the percentage of new born with weight below 2500 grams. Water supply and sanitation indicators include the percentage of population with safe water in the home or with reasonable access to safe water that is population with safe water at home and those with 200 metres of portable water. Sewage indicators include the percentage of people with adequate facilities for excreta disposal or living within 50 metres of pit latrine or toilet. Treatment care of common and endemic disease in the locality includes percentage of population living within 5km or 30 minute to 1 hour travel

time of a health facility or village health worker. Number of children below 5 years treated with home or oral rehydration salts per number of reported cases of diarrhoea in percentage. The proportion of fever (malaria) treated with correct anti malarial (ACT) within 24 hours on onset, proportion of acute respiratory tract infections treated with common antibiotics, proportion of malnutrition treated with supplementary feed and proportion of injuries or accidents treated by first aid or simple treatment are all indicators for the care and treatment of common diseases.[30]

2.1 Selective versus Comprehensive primary health care

The Alma-Ata Declaration was criticized for being too broad and idealistic and having an unrealistic timetable .[65,66] A common criticism was that the slogan "Health for All by 2000"was not feasible.[67] Concerned about the identification of the most cost-effective health strategies, "Selective Primary Health Care, was adapted as an Interim Strategy for Disease Control in Developing Countries.[66,68] Looking at specific causes of death, paying special attention to the most common diseases of infants in developing countries such as diarrhea and diseases produced by lack of immunization, selective PHC is therefore an "interim" strategy or entry point through which basic health services could be developed, for the attainment of goals and cost-effective planning, it basically meant a package of low-cost technical interventions to tackle the main Preventable diseases, these interventions were reduced to 4 and were best known as GOBI, which stood for growth monitoring, oral rehydration techniques, breastfeeding, and immunization.[69] The first intervention, growth monitoring of infants, aimed to identify, at an early stage, children who were not growing as they should. The second intervention, oral rehydration, sought to control infant diarrheal diseases with ready-made packets known as oral rehydration

solutions. The third intervention emphasized the protective, psychological, and nutritional value of giving breast milk alone to infants for the first 6 months of their lives. The final intervention, immunization, supported vaccination, especially in early childhood. These 4 interventions appeared easy to monitor and evaluate.

Moreover, they were measurable and had clear targets. In the next few years, some agencies added FFF (food supplementation, female literacy, and family planning to the acronym GOBI, creating GOBI-FFF.[69,70] The educational level of young women and mothers being considered crucial. Interestingly, acute respiratory infections, a major cause of infant mortality in poor countries, were not included.[71] These were thought to require the administration of antibiotics that nonmedical practitioners in many of the affected countries were not allowed to use. Selective primary health care attracted the support of some donors, scholars, and agencies .According to some experts; it created the right balance between scarcity and choice. The notion of comprehensive primary health care, as the holistic original idea of primary health care began to be called, considered selective primary health care to be complementary to the Alma-Ata Declaration, while others thought it contradicted the declaration and view it as a narrow techno centric approach that diverted attention away from basic health and socio economic development without addressing the social causes of disease, and resembled vertical programs.[72] In addition, critics said that growth monitoring was difficult since it required the use of charts by illiterate mothers (recording data was not an easy operation, weighing scales were frequently deficient, and charts were subject to misinterpretation).[72,73]

2.2 Components of Primary Health Care

The components of Primary Health Care include at least the following: [31]

i. Education concerning prevailing health problems and the methods of preventing and controlling them.
ii. Promotion of food supply and proper nutrition.
iii. Adequate supply of safe water and basic sanitation.
iv. Maternal and child health care including family planning.
v. Immunization against major infectious diseases.
vi. Prevention and control of locally endemic diseases.
vii. Appropriate treatment of common diseases and injuries.
viii. Provision of essential drugs.
ix. Community mental health care.
x. Dental Health.

Mental health and dental health are recent additions to the PHC component, but due to shortage of resources in Nigeria, the two are not made presently available.[32] The principles of PHC have been highlighted in subsequent discussions, but it is vital to appreciate that PHC is more than just the delivery of medical services. PHC always attempts to address people's health through an integrated approach, utilizing other sectors such as agriculture, education, housing, social and medical services. Bearing in mind that majority of disease affecting the populace in Africa is preventable.

Individually, education on the prevailing health problems involves the conscious dissemination of curative and preventive information to the people, with the explicit

purpose of making health care accessible to all through community and self-help processes. Provision of adequate water and sanitation involves the overall environmental improvement involving water supply, sanitation as well as hygiene and general community involvement in environmental management. This is manifested in programmes like water and sanitation programme (WATSAN). The WASH Programme and the key household responsibilities global commitment towards guinea worm eradication, maternal and child health, including family planning is perhaps the vastest of all the Primary Health Care components. Inadequate or improved provision of maternal and child health services are major contributing factors to the worsening maternal and infant mortality and morbidity in Nigeria.[4]

Vital indices of child and maternal health vary according to states and regions in Nigeria, with a mean TFR of 5.7%.[6] It means an average Nigerian woman will bear about 5-7 children in her life time. Family planning refers to a conscious effort by a couple to limit or space the number of children. It has been defined as the sum total of all services offered to couples to educate them about family life and to encourage them to achieve their desired wishes with regard to preventing unwanted pregnancies, securing designed pregnancies, spacing of pregnancies and limiting the size of family in the interest of family health and socio-economic status.[33]

The maternal mortality rate in Nigeria is currently 800/100,000 live births. Infant mortality 87/1000 as mortality of 150/1000.[34] the average contraceptive prevalence rate in Nigeria is 15.0% and 14.4% ante natal coverage, and only 4.7% of women have ever delivered in a hospital.[5] 60% of all babies born were also born after an interval of less than 24 months.[34] Immunization is today the most powerful cost-effective means of

preventing all or most of the deadly child diseases, and the conscious efforts by the WHO, UNICEF, and other stakeholders to immunize all eligible children led to the emergence of the expanded programme of immunization, whose aim is to achieve.[6]

i. 80% immunization coverage of the target population by the year 1990 and a mid-term goal of 60% by 1987.
ii. To reduce by 1990 at least 50%, the incidence of the target disease, i.e. TB. Diphtheria, pertusis, tetanus, poliomyelitis and measles through immunization and other preventive measures.
iii. To establish an efficient system of surveillance and programme monitoring activities to ensure reliable systematic vaccine procurement strategies.
iv. To foster intersectoral cooperation and community involvement and participation in these activities at all levels and thus, to enhance the ability of the programme to sustain itself.

The importance of this programme led to the emergence of the National Programme of Immunization as a parastatal under the Ministry of Health by Decree No. 12 of August, 1997. It has the following specific objectives:

- To achieve polio eradication by the year 2005.
- To eliminate maternal and neo-natal tetanus by the year 2005.
- To reduce measles morbidity by 90% and mortality by 95%.

Among other objectives, it has the target of conducting the cold-chain rehabilitation plan by 2007 and ensures knowledge and skill developments are pursued.[35]

Whether or not these targets are met is subject to debate. But some literatures point to the fact that the overall national immunization coverage is 29% and in some states, it is as low as 1%.[4]

Promotion of food supply and proper nutrition to check or to correct prevailing nutritional problems in Nigeria, the percentage of U-5 who are malnourished has been taken to be 36%. [36] while another more reliable figure is 54%.[4]

Provision of essential drugs and supplies, the national drug list was drawn in 1985 and consists of about 420 items. The local government primary health care uses only 40 items at the community level, with a maximum participation of not more than 3 drugs allowed.[32]

2.3 Utilization of Primary Health Care (PHC) Services

The procedure for implementation of Primary Health Care services include baseline survey, situation analysis, preparation of detailed geographical maps, settlement demarcation, registration of households, formation of district and village health communities with the aim of mobilizing the community; training including retraining of existing health workers and volunteers. Upgrading of existing health facilities to perform the function of comprehensive health care and finally, a detailed monitoring and evaluation of clinic, community and local government of various activities of primary health care services.[36]

The structure of the local government primary health care department is composed of the Primary Health Care coordinator as the head, 5 departmental heads of Monitoring and Evaluation, Disease Control Essential Drugs, Health Education and Maternal Child

Health exist with each department being headed by a coordinator under the Primary Health Care Department coordinator. The recently created Water and Sanitation Department also does some part of the Primary Health Care jobs and has the following under its department; water quality and control, all with the coordinators under the PHC coordinator. The various health facilities in the village are named by various cadres of health personnel, with PHC implementation committees at the local government area which has the local government as chairman. Local government PHC coordinators as the secretary with members drawn from the LGA Health Department, Traditional Rulers Institutions, clergymen as well as other influential members of the society. The aim of any Primary Health Care system is to provide the whole population with essential health care that is universally accessible and available. This however, is independent on numerous factors which affect the overall utilization of these services. Utilization here being a measure of the provision of health care services and is expressed as a proportion of people in need of a service who actually received it in a given period of time.[39]

Enhancing the utilization of health care services has two faces:

a) Increasing initiation of patient to treatment and
b) Ensuring their subsequent retention.

Initiation refers to the choice of health care services made by the patient seeking treatment for the first time, while retention refers to follow-up visit to the same health care services in order to seek treatment for the same period of illness.[40] an example is the proportion of children at risks who are immunized. Proportion of pregnant women who received antenatal care or have their deliveries supervised by trained birth attendants, etc.

The Index of Medical Under-service (IMU) is a scale of 0 to 100, where 0 represents completely underserved and 100 represents best served areas. A least underserved, any region or area with a score of less than 62.0 is undeserved. [41]

The trio of acceptability, availability as well as accessibility have an overall effect on the utilization of PHC services, availability is viewed in public health as the ratio of the population as a function of the health assigned to it, e.g. population per health centre, number of doctors per patient, ratio of women who delivered under care of trained traditional birth attendants, etc. [42]. Accessibility on the other hand implies the kind of care that is geographically, financially, culturally, and functionally within each reach of the whole population/community. The accessibility can be geographical, which means that distance, the travel time, the location of the health centre, the kind of people employed as staffs are acceptable to the people. Technically, accessibility can be defined as the number of people of a given population that can be expected to use specific facilities and personnel assigned to it.[42]

Financial or economic accessibility is the ability of the individual or community to be able to cover the financial health care is via, out of pocket payment, presently out pocket payment constitute (75%) of the payment system (43%). If a service is available, but neither the individual nor the community can afford it, then it is not accessible.

Dislocations along the referral chain could also serve as a potential barrier to the utilization of services, even though there is paucity of information on linkages between levels of care in Nigeria. For instances in 2004, 92.9% of cases seen at University of Ilorin Teaching Hospital (a tertiary referral facility) within a four week period were

without referrals. [89] Patients referred from primary health centers and comprehensive health centers were 5.2% and 2.3% of the cases respectively with the bulk from private clinics (34.3%) and the General Out-Patient Department of the hospital (41.9%).[89, 90]

Social and cultural accessibility refers to the process of providing health care in keeping in keeping with the social, cultural and religious peculiarities of the community, while functional accessibility refers to the right kind of care if available on a day-to-day basis to those who need it, whenever they need it and that it is provided by the right people at the right location.

2.4 Barriers to the Utilization of PHC Services

Nigeria is one of the few countries in the developing world and has systematically decentralized the delivery of basic services in the country including health, to locally elected governments, states, and community based organizations, as a result of this, the entire health system is not insulated from the myriad of problem affecting the nation, that is why simple or increase in allocating greater public resources to basic health services is not enough to ensure that quality services are made available to the vast majority of poor citizens in the country.

Even though, the states and local government are assigned primary responsibility for the delivery of basic primary health care service, they are not equipped with adequate resources in terms of revenue to fulfil their expenditure obligations. There is therefore the need for increased funding as well as better fiscal responsibility on the part of the administration and other stakeholder involved in the health sector. It is believed if the

spending by local government is properly coordinated and monitored. It will effectively translate into better basic health and infrastructure at the grass root.[44]

There is also a need for clear and explicit demarcation of roles and responsibilities in the management of health care in Nigeria, the roles and responsibilities of the three tiers of government need to be clearly explained and interpreted within the concept of the constitution. Numerous attempts by the government in the form of national health policies, nation health bill, various health sector reform initiatives have all attempted to do this, but they could not see the light of the day.

Lack of community participation and ownership of health care at the grass root is also a barrier to the utilization of health. In a study, it was found that there is a comparatively little or no community engagement in setting and monitoring prices and charges for drugs as was envisioned in the Bamako initiative and also the community plays a negligible role in disciplining staff, which is also overwhelmingly indicated as the responsibility of local government development committees.[45]

Neglect of staff welfare leads to staff demoralization and bad attitude with concomitant reduction in productivity and utilization of health services. There is also a global shortage in virtually all primary health centres nationwide.[46] This translates into diminished utilization and inefficiency. Poor staff community relationship is also a barrier to the utilization of health services nationwide.[5,3,54,55,56] The characteristics of facilities and services provided perhaps constitute one of the major barriers to utilization in primary health care services.[47] Usually, facilities that are well equipped proximate to a much

higher density of population and referral centre, better provided with public amenities such as water and electricity are more likely to be utilized than otherwise.[48]

The presence of alternative sources of care also serves as an impediment to publicly provided primary health care. [49] In areas where there is availability of alternative sources of care like private clinics, secondary or tertiary health clinics, traditional medical practice, etc. The utilization of primary health services is usually low, and in areas with relative shortages of alternative sources of care, pressure is usually high on the hospital and the staff.

The shortages of essential drugs and basic equipments are a generally a characteristics of virtually all health facilities nationwide. In a study, it was found that majority of health facilities nationwide. In a study, it was found that majority of health centres lack basic equipments, 95% did not have microscopes, 59% did not have sterile gloves, 98% did not have a malaria smear and 95% lack a urine test strip. [46] This deficiency in critical infrastructures tend to undermine service delivery and hence, utilization of PHC.

Socio-cultural and religious factors are one of the greatest determinants of health care utilization. [50,57,58] Primary health care facilities should therefore be provided in line with the social, religious, cultural, and other peculiarities of the people. Other factors that determine health care utilization include economic factors like per capita income, cost of health care and method of payment.[51] Socio-economic status, health literacy, level literacy, educational level, ownership of livelihood assts irrespective of wealth, and health seeking behaviour.[15,52] All these factors and practices go a long way in determining how health is utilized at the primary level. The barriers to the use of primary

health care are therefore multiple, multi-dimensional and complex and will need a thorough understanding and appreciation of the local peculiarities of the people before they could be properly understood.

CHAPTER THREE

METHODOLOGY

3.0 Study Area

The study was conducted in Batsari local Government Area which is one of the seven hundred and seventy four local government areas in the country, with a population of 256,666 (two hundred and fifty six thousand, six hundred and sixty six) according to the 2006 census result, it is bordered by Zamfara state in the west , Dutsinma Local Government in the east , Katsina Local Government in the south and Jibia Local Government in the north, the LGA is divided into 11 eleven political wards viz, Ruma, Karare, Dan Alhaji/Yangayya, Manawa, Kandawa, Madogara, Abadau/Kagara, Darini Magaji Abu, Wagini, Batsari and Yau Yau Mallamawa.

The LGA has 21 twenty one functional health facilities, these comprise 1 comprehensive health centre, 3 maternal and child health centres, dispensaries and health outposts, three additional clinics are currently under constructions. The LGA also has a total of 201 and one staffs working in the health department, 42 of which work in the Local Government health department, this figure excludes other staffs who have moved to the recently created water and sanitation department, the rest of the staffs are scattered across the 21 functional health facilities mentioned above.

It is inhabited predominantly by Hausa Fulani Moslems, and the people in the LGA are primarily agrarian in nature engaging mostly in subsistence farming, the headquarters of the LGA has pipe borne water and electricity but no other village in the LGA has pipe borne water, even though some have electricity they are still rural in nature.

The managerial structure of the PHC department is similar to that of all other LGA s in the state, with the PHC coordinator as the head of department with 6 other sub departmental heads, under him these are disease control, monitoring and evaluation, essential drugs, health education and maternal and child health, the recent creation of water and sanitation department has altered the managerial structure of the PHC department and it has the department of environmental sanitation, water quality, vector control and engineering, the two departments are meant to work in close collaboration with each other for the overall good of the people.

The LGA also has a functional central LGA development committee headed by the traditional head, this committee coordinates the affairs of the various village development committees, the structure is fairly organized and working properly as a result of the efforts of a USAID funded programme that operated in the LGA, various other village development committees are in various stages of formation, the committees regularly meet and make the decisions that facilitate the running of the affairs of the LGA, the LGA also utilizes the services of traditional birth attendants, ulamas and influential members in the utilization of the community to accept health services.

3.1 Study Population

The study population involves all households assessing primary health care services in the selected villages in the LGA, the inclusion criteria were that one must be a resident of that town, must be a head of a household and must be a willing to voluntarily participate in the study, excluded from the study are all non resident of the villages, non household heads and those who object to participation in the study.

3.2 Study Design

The study was a cross sectional descriptive study

3.3 Sample size determination

At the household level a cross sectional descriptive study was carried out and sample size was determined using the following formula

$$n = \frac{Z^2PQ}{d^2}$$

Where n = minimal sample size determined

Z = standard normal deviate taking as 1.96

P = proportion of utilization of health services from previous study

P = 89% (gotten from pilot testing of questionnaires)

Q = 1-P=0.11

d = margin of error at 95% confidence interval

d = 0.05

$n = 1.96^2 \times 0.89 \times 0.11 / 0.05^2$

=150

But a total of 180 households were selected for the study to balance for attrition and those who may voluntarily opt out of the study.

3.4 Sampling Technique

A multi stage sampling technique was used, in the first stage the LGA has a total of eleven political wards, and from the list of this ward six were randomly selected. Second a village was selected from the list of these six wards giving a total of six villages, to obtain the participating households equal allocation of 30 households per village was done, giving a total of 180 households, in each village the first 30 houses were interviewed.

3.5 Data collection technique

Data collection technique was both qualitative and quantitative, the quantitative technique involved the administration of close ended interviewer administered questionnaire to the heads of households, these questionnaires were used to assess the demographic characteristics of households, the existence or otherwise of primary health care facility within a defined vicinity of the households, the distance to the facility, the common health care problems, the preferred places of treatment , the ease of access to these services, the predominant barriers to the utilization of the services and their perception of the solutions to these barriers, the existence or otherwise of village and ward development committees and how these contribute to the utilization of PHC services

At the facility level a close ended self administered questionnaire was issued to the various in charges of the health facilities to access information on the basic characteristics of the facilities and services offered, the existence or otherwise of facilities within the neighbourhood, hours and types of services offered, with emphasis on those

within the purview of primary health care, availability and use of basic resources (equipments and staffs).

At the LGA level and in depth interview guide was issued to the head of the PHC to assess PHC infrastructures, manpower and utilization as well his perception on the barriers to the use of the services and their solution. A focus group discussion was conducted in 6 randomly selected communities to access the people's perception of the primary health care services, the barriers to the utilization as well as their perceived recommendation, the pilot testing of the household questionnaire was done in these wards; the interviewers were given two days training on the content, intent and the modalities of filling the questionnaires, the training was done by me.

3.6 Data Analysis

Quantitative data collected was be sorted manually cleaned and analysed using SPSS statistical software packages, all data was analysed in line with the overall aims and objectives of the study.

Qualitative data was also transcribed and utilized to further widen the scope and dimension of the study.

3.7 Ethical Considerations

An introduction letter was gotten from the head of department of community medicine Ahmadu Bello University and a similar introduction letter was gotten from head primary health care development agency in the state, all addressed to the LGA PHC department

authorising the study, verbal consent of the people to be interviewed before the study was also gotten prior to commencement of the study.

3.8 Inclusion and Exclusion criteria

The inclusion criteria were that one must be a resident of the town, must be a head of household, must be willing to participate in the study, and excluded from the study are all non residents of the villages, non household heads and those who object to participation in the study.

3.9 Limitations of the Study

The creation of department of water and sanitation out of the present PHC department distorted the architecture of the PHC department and made it difficult for the services to be assessed comprehensively.

CHAPTER FOUR
RESULTS

Table 4.1: Showing socio-demographic characteristics of the households (n=180)

Age (yrs)	Frequency	Percentage (%)
15-24	31	17.2
25-24	16	8.9
25-29	21	11.7
30-34	25	13.9
40-44	24	13.3
45-49	14	7.8
50-54	20	11.1
55-59	10	5.5
60-64	7	3.9
65-69	6	3.3
70-74	3	1.7
75-79	3	1.7
Total	**180**	**100**
Sex		
Male	177	98.3
Female	3	1.7
Total	**180**	**100**
Educational status		
No formal education	11	6.1
Adult literacy	13	7.2
Quranic education	70	39.0
Primary school	13	7.2
Secondary school	33	18.3
Tertiary education	40	22.2
Total	**180**	**100**
Occupational status		
Farmer	103	57.2
Trader	39	21.7
Civil servant	38	21.1
Total	**180**	**100**

Comment: The age (yrs) range between 15-24yrs had the highest households with 17.2%, while 70-74 and 75-79 had 1.7% and 1.7% respectively. The household heads are mainly males (98.3%) with females accounting for only 1.7% of household heads. Majority of the population have only Quranic education (39.0%), while 6.1% have no formal education at all. Households in the LGA are predominantly agrarian in nature (57.2%), while others are traders and civil servants with 21.7% and 21.1% respectively.

Table 4.2: Showing the common health care problems of the households in the last one month

Common health care problems	Frequency	Percentage (%)
Fever	53	29.4
Cough	48	26.7
Diarrhoea	37	20.6
Others	42	23.3
Total	180	100

Comment: The predominant health care problems in the community are mainly preventable ones, fever 29.4%, cough 26.7% and diarrhoeal diseases 20.6%, these depicts the disease pattern of a typical underdeveloped society.

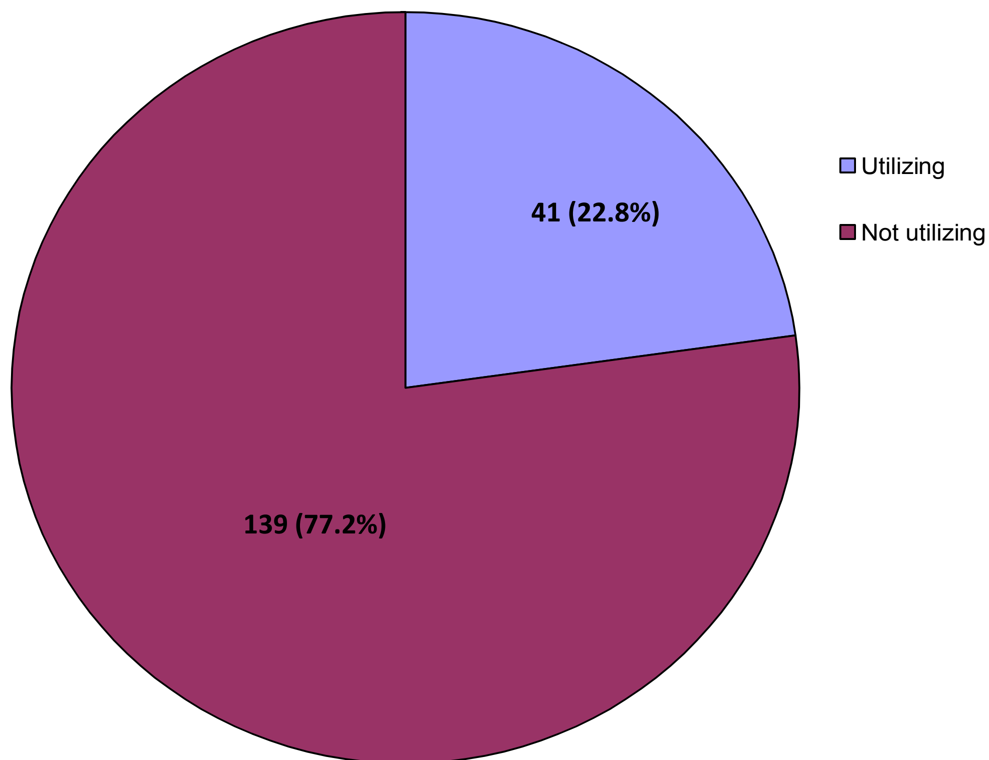

Figure 4.1: Showing the utilization of primary health centers among households

Comment: Less than twenty three percent (22.8%) of the household heads utilize the PHC facilities while 77.2% utilize other alternative services.

Table 4.3: Showing the preferred place of treatment for households

Preferred place of treatment	Frequency	Percentage (%)
Traditional medicine	33	18.3
Village health facility	39	21.7
Pharmacy/patent medicine store	62	34.5
Spiritualist	11	6.1
Private health facility	27	15
Secondary health facility	8	4.4
Total	180	100

Comment: The community preferred to use the pharmacy/patent medicine store 34.5%, the village health facility 21.7% and then traditional medicine 18.3%.

Table 4.4: Showing the outcome of treatment by place of treatment

Outcome of treatment	Preferred place of treatment						Total
	Traditional medicine	Village health facility	Pharmacy/ patent medicine store	Spiritualist	Private health facility	Secondary health facility	
Cured	15	21	23	4	18	4	85
Not cured	13	14	35	5	7	2	76
Death	5	4	4	2	2	2	19
Total	33	39	62	11	27	8	180

Comment: The private health facility showed a higher cure rate when compare with the village health facility attendace with reasonable figure not cured, and the traditional medicine had highest death rate with almost half not cured.

Table 4.5: Showing reasons for non utilization of health facility by households

Reasons for non utilization	Frequency	Percentage (%)
Lack of staff	28	15.6
Lack of essential drugs	49	27.2
Distance	13	7.2
Poor community development	17	9.4
Negative attitude of staff	15	8.3
Cost of services	46	25.6
Lack of basic infrastructures	12	6.7
Total	180	100

Comment: Lack of essential drugs (27.2%) and cost of sevices (25.6%) where the major reasons for the non utilization of health facility.

Table 4.6: Showing the solution to health facility problems from the perception of households

Solution to health facility problem	**Frequency**	**Percentage (%)**
Recruit more staff	41	22.8
Reduce cost of services	50	27.8
Involve the community the more	18	10.0
Provide essential drugs	47	26.1
Reduce distance of facility	13	7.2
Others	11	6.1
Total	**180**	**100**

Comment: In agreement with the reasons for non utilization of health facilities, provision of essential drug (26.1%), reduction in cost of services (27.8%) and recruitment of more staff (22.8%) were seen as the most important solutions to the problems affecting the health facility.

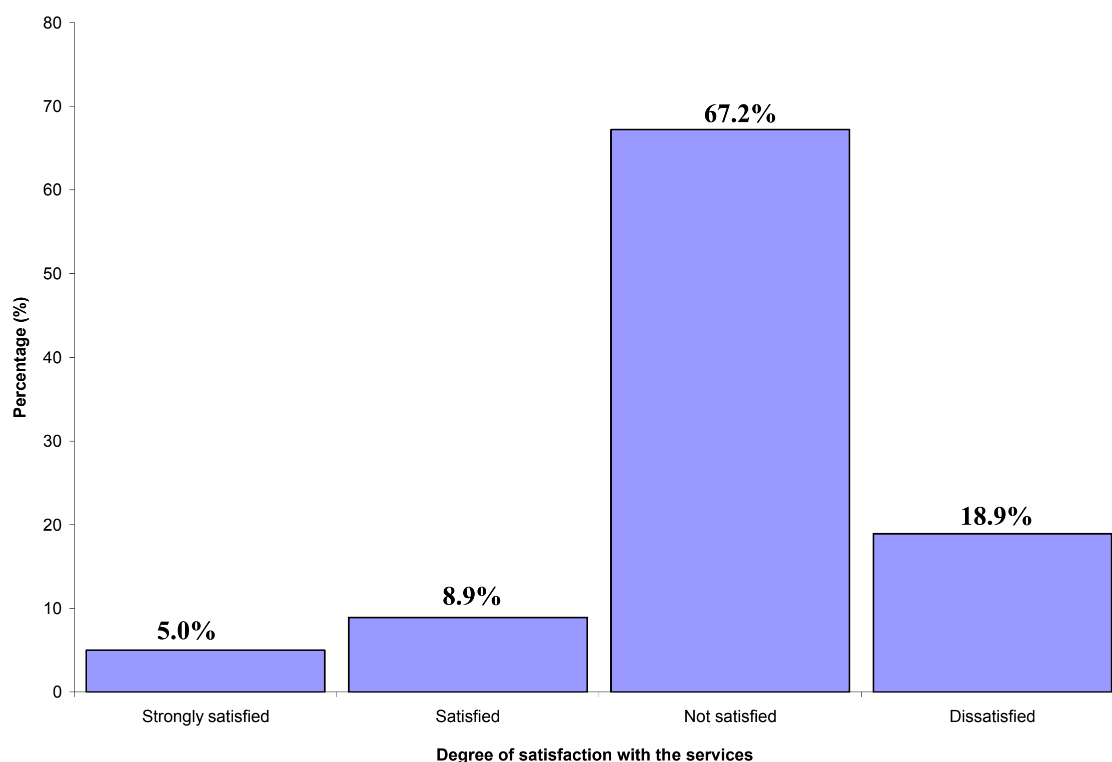

Figure 4.2: Showing the degree of satisfaction with the services in the facility by respondents

Comment: Majority of the population expressed dissatisfaction (not satisfied and dissatisfied strongly with 67.2% and 18.9% respectively), with the services in the PHC and only a few expressed satisfactions (strongly satisfied and satisfied with 5% and 8.9% respectively), with the services.

Table 4.7: Showing the distribution of health facilities in the wards of LGA as well as the health facility to population ratio

Ward	Population	Number of Health facilities
Batsari	40,025	5
Abadau	20,543	2
Wagini	23,005	2
Dan Alhaji	19,815	3
Yau Yau	26,380	2
Ruma	14,567	3
Kandawa	22,789	1
Darini/Magaji abu	21,654	1
Madogara	19,642	1
Karare	24,513	1
Manawa	23,733	2
Total	**256,666**	**23**

Comment: As depicted from the above table the number of health facilities is grossly inadequate compared to the population, the health facility population ratio is 1:11,159.

Table 4.8: Showing distribution of personnel by profession in the facilities

Profession	Number		Total
	Male (M)	Female (F)	
Medical Practitioner	1	0	1
Pharmacist	0	0	0
Registered Midwife	0	2	2
Registered Nurse	3	1	4
CHO	1	1	2
SCHEW	19	0	19
JCHEW	6	3	9
Total	**30**	**7**	**37**

Comment: The LGA faces gross man power problems especially with respect to skilled manpower e.g. Doctors and midwives, as the entire PHC systems is been managed by the community health extension workers as depicted in the ratios above.

Table 4.9: Showing availability of clinical services in the facilities

Service	No. offering	No. not offering	Total	Percentage offering
Antennal care	8	13	21	38.1%
Deliveries	8	13	21	38.1%
Essential Obstetrics services	2	19	21	9.5%
Post natal care	7	14	21	33.3%
Family planning	4	17	21	19.0%
Growth monitoring and child welfare clinic	12	9	21	57.1%
Immunization	21	0	21	100%
Health Education	21	0	21	100%
General outpatient services	21	0	21	100%

Comment: Majority of the facilities only offer immunization, health education and General outpatient services which have 100%, few of the facilities offer essential obstetrics care 9.5% and family planning 19%, these are essential services needed by the LGA.

Table 4.10: Showing the relationship between educational status and use of PHC facility

Educational status	Uses of PHC facility		Total
	Yes	No	
No formal education	10	1	11
Adult literacy	13	0	13
Quranic education	70	0	70
Primary school	13	0	13
Secondary school	30	3	33
Tertiary education	34	6	40
Total	**170**	**10**	**180**

Comment: There is no significant relationship between educational status and the uses of PHC facility (P □ 0.282). But the ratio of the uses of PHC facility compared with non usage is 1:18.

Table 4.11: Relationship between distance of facility to household and use of PHC facility

Distance of facility to households	Uses of PHC by household		Total
	Yes	No	
30mins – 1hr	70 (38.9%)	15 (8.3%)	85 (47.2%)
More than 1hr	95 (52.8%)	0 (0%)	95 (52.8%)
Total	**165 (91.7%)**	**15 (8.3%)**	**180 (100%)**

Comment: There is a significant relationship between distance of facility to household (given in time) and the uses of the PHC facility by household (P □ 0.009). Majority of the households uses PHC facility irrespective of the distance.

THE RESULT OF THE FOCUS GROUP DISCUSSION

The study examined the PHC system in Batsari Local Government using stakeholder analysis approach, which is an approach for understanding a system by identifying the key actors or stakeholders in the system and assessing their separate interests in that system.[73] To assess the perspective of the households a focus group discussion was done in 6 randomly selected wards to identify problems and issues from the point of view of the people involved .

Participants were asked a set of questions concerning primary health care as a system of health of health care in the locality, the percieved barriers to the utilization of the services and their solutions, transcribed materials by me whose first language was the same as the interviewees, after transcription data was described and broken down into sequential themes and a subsequent interpretative analysis was done to deduct emerging themes and extract quotable quotes, thes quotes were then related to existing literature, confidentiality was assured to all participants and has been maintained throughout this study as has anonymity.

Results

A total of 60 household heads participated in the six focus groups, participants are of different ages with variable degree of perceptions to the utilization of the services in the LGA.

On how the current PHC system performs with respect to meeting their demands for comprehensive health care, the issue of availability, affordability of primary health care services were the central issues identified by almost all the participants.

"The only thing we can be sure of about this facility is that it is easy to acesss, but no service is available for free"

"We do have regular house to house immunizations, but every other thing we have to purchase"

The above quotes demonstrate the degree of variable factors affecting these services and the re echo of cost as a common feature of the PHC system goes to cast a shadow of doubt on the effectiveness of the states free maternal and child health services.

The perception of the participant with respect to major barriers affecting the utilization was further probed as well as the percieved solutionsto the problems were asked, majority believed the most fundamental barriers are non availability of essential drugs and cost.

"We are tired of telling our problems, there is nobody to hear our voice and no place to complain, no drug, no doctors and no equipments"

"We are not involved in any program planning everything just comes from the government, nevertheless we keep waiting and accepting, after all that is all we can do"

The above quotations highlight further the role of cost as well as the lack of community participation and involvement in the affairs of their health, this top down approach to issues further undermines the ability of the communities to participate in the planning and implementation of PHC services and to accomplish inter sectoral action .

CHAPTER FIVE

DISCUSSIONS

Batsari Local Government is one of the 34 LGAs of Katsina, it was carved out of the present Dutsinma Local Government in 1989, and has since its inception inherited an existing PHC structure, with a primary health care department under the leadership of a PHC coordinator who is assisted by six other unit heads. The LGA has a total of 11 Political wards these are Karare, Batsari, Wagini, Abadau, Manawa, Madogara, Dan Alhaji/Yangayya, Yau Yau/Mallamawa, Ruma, Kandawa and Darini/Magaji, the LGA distributes facilities to these wards based on political, population and geographical considerations.

5.1. Socio Demographic Characteristics of the Households

In terms of occupation the LGA is primarily agrarian in nature with 57.2% of its population been engaged in agriculture and have farming as their principal occupation, while others engage in trading (21.7%) and civil service (21.1%), as shown in table 4.1. The choice of place of treatment and the utilization of the PHC facilities is not in any way related or affected by the occupational status, other occupations the people engage in are blacksmithing and House wife, though the population of households is principally male in sexual orientation 98.3% still 1.7% is female in nature and these have house wife as their major occupation. Educationally, the LGA as found in this study can be said to be literate in nature if one takes the UNESCO definition of illiteracy as the inability to read and write in any language, as 39% of the population have Quranic education as their main source of knowledge while only 6.1% of the households have no any form of education that is either Quran or western education, there is also a growing need for western

education in Northern Nigeria as evidenced by the massive compulsory primary education system been put in place by the LGA, this perhaps explains the 7.2% level of those who have adult literacy and 18.3% and 22.2% (secondary and tertiary education respectively) with education above primary level, the educational distribution of households in the LGA is following a similar pattern as observed in most LGAs in Northern Nigeria, and education been an index of socioeconomic development one will expect it to have some major of influence on the utilization of PHC services, but as shown in Table 4.10 the study found no relationship between educational status of household heads and health care utilization, it is however expected that the growing awareness on the need and importance of western education will have an effect on the health status of the community in long run.

The role of socio demographic factors in determining the utilization pattern of primary health care services cannot be overestimated, as the utilization of maternal, and childhood services is affected by socio-demographic, household, community and state factors.[74] The variations in the indicators of maternal health service utilization by selected results show that for each of the indicators, there are significant differences by education, age at last birth, and ethnicity. Household socio-economic status is positively related with use of antenatal services such that the odds of reporting use are almost six times as high among women from the richest households compared to their counterparts from the poorest household attitudes towards family planning, and ideal family size.[75] There are also significant variations in the indicators by household socio-economic status, urban residence, community media saturation, prevalence of the small family norm in the LGA of residence, and the ratio of PHC to the population in the state of residence.[76,77]

5.2 Distribution of Health Facilities in the LGA

As shown in table 4.7 the 11 political wards have no enough PHC facilities with some wards having only one PHC facility to cater for at least 20,000 people, Batsari ward which has a population of 40,025 has only 5 health facilities while Kandawa and Darini magaji which are the most hard to reach in terms of terrain have only 1 health centers each, this translates to a ratio of 1 facility to 20,000 people as said earlier, and this has an overwhelming negative effect on the people as it limits their choices and places undue overbearing pressure on scarce health commodities.

5.3 Manpower in the Health Sector

The pattern of male predominance in the households is also replicated in the health sector as only 7(18.9%) of the health facility staffs are females while the remaining 30(81.1%) are males, even though the LGA has a high number of staff in the PHC department, these are mainly auxiliary staff, night watchmen and clerical officers, there is a serious shortage of skilled manpower as shown in table 4.8, where it can be seen that there is only one doctor in the services of the LGA , based on this findings the doctor patient ratio is put at 1:256,666 , The LGAs doctor-patient ratio is far below the standard set by the World Health Organisation (WHO) or that of other African nations. Statistics indicate that the doctor-patient ratio in Ghana is 1:13,000, a figure far below the WHO global standard pegged at 1:5,000.[58,59,60] The LGA also has 2 qualified midwives in its services which hypothetically means a ratio of 1 midwife to 128,333 patients this is not comparable to the globally accepted standards and has the potential of demoralizing both staffs and patients and therefore affecting the utilization of this services, The situation in the country has been worsened by the exodus of health professionals, particularly

doctors, to seek greener pastures in more developed economies.[60,61,62] Every year Africa losses 1/3 of its health professionals- costing $4 billion to replace – about 23,000 African health professionals migrate to developed countries every year.[62,63,64] In Tanzania the average nurse patient ratio is 160/100,000 but 6/100,000 in rural districts.[65,89]

The variations in the skilled man power availability across different zones of the country are also obvious, for example, while the South-West has about 7,300 doctors, the North-East has only 639.[84] The average health facility in Kogi state had 7.85 health workers, but the average for health posts was 2.3 workers.[78]

The bulk of the staff in the PHC department are CHEWS and JCHEWS, with only one CHO in the services of the LGA, This over emphasis on CHEWS and JCHEWS have placed the nations PHC system in mortal danger as it has the potential of converting these cadre of staff into potential "doctors", making them do more harm than good.

5.4 Health Care Problems of the Community

The major health care problems of each of the households were assessed in the last one month to minimize recall bias and 29.4% of the households said fever was the major reason why they utilized the facility, while cough and other respiratory tract infections accounted for 26.7% of the reasons for the use of PHC services and diarrhoeal diseases 20.6%, others accounted for only 23.3% and this include malnutrition, ear and eye infections as well as HIV/AIDS, the pattern of ailment is in agreement with the level of development of the area and is a reflection of the poor socioeconomic status of the LGA as well as the bad sanitary condition of the area. Studies elsewhere have also revealed a similar picture where fever was the leading complaint for most household especially US,

then cough and diarrheal diseases, Other health problems reported during the period under review included vomiting and skin diseases[79].

5.5 Accessibility of Health Facilities

The fundamental aim of PHC is to ensure universal access to available resources in order to provide adequate coverage of the most important health needs of the people.[80] Factors that determine pattern of utilization of health care services include geographical and economic accessibility, literacy level and perceived derivable benefits.[79,81] Access represents the fit between characteristics and expectations of the providers and clients, these characteristics are actually grouped into the 5 as of access viz accessibility, affordability, availability, accommodation and acceptability, while affordability is an index of how the providers charges and cost of care relates to the willingness to pay for services, availability denotes the extent to which providers poses the requisite resources, such as personnel and technology to meet the needs of clients, accessibility refers to the geographical dimension of access, which tends to explain how easily the client can physically reach the providers location, accommodation reflects the extent to which the providers operation is organized in ways that meets the constraints and preferences of the client, of great concern are hours of operation and the ability of patient to access care irrespective of status or prior appointment, and acceptability captures the extent to which the client is comfortable with the nature of services with respect to his culture, religion and other social dimensions, these chains intertwined, and they aid in determining the accessibility or otherwise of a health commodity this include geographical factors, financial and economic factors, manpower and logistical factors as well as socio-political factors, as enumerated above it can be seen that not only are the facilities not widely

distributed they are also not evenly distributed, there is also the issue of gross man power shortages, For example, only 38.9% of these facilities are within the National health policy guideline of 5km or 30 minutes walking distance range of a health facility this means that 52.8% of the facilities are not within this range, this distance is a potential impediment to utilization as will be shown later, but as shown in table 4.11 there is a significant relationship between distance of the facility and preferred place of treatment., period of work is also very important and in this study it is found majority of the facilities do not operate 24 hours. This time lag limits the utilization of the facilities especially in critical hours of night.

5.6 Utilization of PHC Services

Numerous type of primary health centres abound this include comprehensive health centres, maternity clinics, health centres and dispensaries, there is also a functional secondary health facility in the local government headquarters as well as one private clinic, there are also various patent medicine vendors and other unorthodox practices like traditional medicine and spiritual practices, despite the availability of options the people still prefer one form to the other, this study attempted to find those places where people prefer to seek treatment, those factors that make the household to choose one from the other as well as their own perception of how they think this services can be improved, Bearing in mind that in Ghana, Mali, Nigeria and Zambia, herbal medicines are the first line of treatment for 60% of children with high fever from malaria.[63] About 65% of births delivered in Nigeria especially the rural areas are conducted by traditional birth attendants and these take place outside the health facility.[64,65]

Utilization is an index of the proportion of people in need of a service who actually received it at a given period of time, in the case of Batsari LGA not only are the facilities not available, the man power also is inadequate, these factors aid in no small way in making the health care system in the LGA rudimentary and difficult to access. This study found that majority of the people prefer to utilize the patent medicine vendors and pharmacies (34.5%) as the major source of care and this agrees with findings elsewhere.[66,67,68] Only 21.7% utilize the PHC centres in the villages, after which is the traditional medicine (18.3%) and private health facility had 15%, the preference for patent medicine vendors and pharmacies is an indication that people utilize primary health care for curative services and not for preventive ones. In rural Burkina Faso modern health care facilities are only consulted by 19% of the population, others choose home treatment 52%, traditional healers 17%, or local village health workers 5%; this translates to in a utilization of government services as low as 0.17% consultations per capita.[62] There is also the belief that some ailments are the exclusive preserve of traditional medical care and not orthodox care, this may perhaps explain the high utilization rate of traditional medical practice, in Africa up to eighty percent of people use traditional medicine for primary care, while in Nigeria as much as 85% use and consult traditional medical care for health care, social and psychological benefits.[59,60,61] In layin Zomo community of Zaria Patent medicine stores were the major source of treatment for majority of the illnesses.

Public health facilities facilities were used in 31.2% of the cases while 16.7% sought treatment from private clinics. Traditional healers were also utilized in 5.2% of the instances while. Some do not seek for any form of treatment.[79]

Numerous reasons were found as the reason for the non utilization of the PHC facility but the most common were non availability of essential drugs (27.2%) while 25.6% blamed cost as the reason for the non utilization of the services, 7.2% attributed their non use to distance while 15.6% blamed lack of staff, poor community involvement accounted for 9.4% non utilization while negative attitude of staffs had 8.0% and lack of basic infrastructures (6.7%) , other reasons are lack of medical practitioner to mention but a few.

The study also sought from the households their own view of what they think are the solutions to the problems affecting the PHC services and 26.1% of them suggested essential drugs should be provided while 27.8% are of the view that the cost of services should be reduced , while 22.8% think recruiting more staffs is the solution to the problem and 10% are of the view that involving the community the more in the affairs of the PHC will serve as a way to solve the problems of the services only about 7.2% attributed their non use of the PHC services to distance and are of the opinion that bringing the health facility closer will make them utilize the services.

5.7 Satisfaction of the Households with the Services

Households opinion was sought from those who utilize the facility there level of satisfaction with the services offered using the Liker's 5 point scale and on this scale 67.2% of the population said they were not satisfied and 18.9% said they were

dissatisfied with the services, and only 8.9% of the population said they were satisfied with the services offered, finally 5.0% were strongly satisfied.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Conclusions

The study aims to highlight those barriers affecting the utilization of primary health care services in Batsari Local Government Area of Katsina State, the study exposed the gross shortages and deficiencies in both number of facilities, their unequal distribution as well as the dearth of skilled and unskilled man power in the facilities, these factors have led to the non utilization of at the LGA level with the people preferring to utilize alternative sources of care like patent medicine vendors and pharmacists which this study found are the most utilized ,other sources of care include traditional medicine, private health facilities as well as spiritualists.

Utilization which is an index of the proportion of people who need services and are able to get those services at the right time, this study found the utilization of these PHC services to be poor (22.8%) and the perspective of both staff and households was sought and it was found to be due to the following reasons viz:

1. Lack of essential drugs and absence of effective drug revolving fund in the facilities.
2. Negative and uncomplimentary attitudes of staff.
3. Increasing cost of health care services.
4. Lack of basic infrastructures.
5. Socio-cultural and religious barriers leading to misconceptions and over reliance on alternative sources of care like traditional medicines.

6.1 Recommendations

In the light of this findings it can be deduced that the PHC system as it is been implemented in Batsari LGA is not in its right shape, frame and direction to deliver affordable, qualitative and accessible health care services in line with the goals and objectives of the Alma Ata declaration, in the long run the PHC services presently operating in Batsari LGA can best be described as rudimentary and fall short of all the expectations needed for an effective and efficient PHC system.

The following recommendations are highlighted:

1. To ensure consistency and continuity of projects and policies the LGA should evolve a strategy that will improve budgetary expenditure on health as well as ensure accountability and transparency in the health sector.
2. Provision of basic and critical infrastructures', while making efforts to rehabilitate existing ones and at the same time put in place a mechanism, for continuous monitoring and evaluation to ensure adequate maintenance of equipments.
3. Provision of essential drugs and strengthening of the drug revolving fund.
4. Integration of locally available resources into the PHC e.g. the use of traditional birth attendants into the health care delivery system, they should be updated for example with knowledge of danger signs in pregnancy, conduct of normal labour and hygiene in pregnancy.
5. Harmonization of the PHC system with other vital sectors of the nation e.g. the National poverty eradication programme, National Youth service corps and the National Health insurance Scheme. With a view to addressing critical resource and man power challenges of the system.

6. Model PHC facilities should be built that will serve as a guide for other facilities in terms of service and health care management.
7. Regular campaign and health education involving all stake holders on the need to support and monitor the continuous day to day activities of the PHC system.
8. There is need to conduct a more extensive study to research into the problems affecting this fragile system.

I do hope these recommendations will receive the attention of the authorities concerned.

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APPENDICES

APPENDIX I

AN ASSESSMENT OF THE BARRIERS TO THE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN BATSARI LOCAL GOVERNMENT OF KATSINA STATE

Community Level Questionnaire

To be filled by head of household.

SECTION A

1. Socio demographic characteristics of the household.

(a) Name of local government area...

(b) Name of ward ....

(c) Name of Village...

(d) Name of nearest PHC facility...

(e) Household number ....

(f) Sex of head of household...

(h) Age of head of household...

(I). Educational status of head of household .

(i) No formal education ( )

(ii) Adult literacy ( )

(iii) Quranic education ( )

(iv)Primary school ( )

(v) Secondary education ( )

(vi) Tertiary education ( )

(viii)What is the occupation of the household head.

(a) Farmer ( )

(b) Trader ( )

(c) Civil servant ( )

(d) Others, specify ....

(ix) How many people live in the household?

(a) Total women ( )
(b) Total children U5years of age ( )
(c) Other age groups ( )

SECTION B

Assessment of health care problems in the community

1 .In the past one month or at present has any member of the household been sick enough to seek medical care.

(a) Yes ( )
(b) No ( )
(c) Not sure ( )

2. What is/was the problem?

(a) Fever ( )

(b) Cough ( )

(c) Diarrhea ( )

(d) Others, specify..

3. What is the duration of the ailment?

(a) Less than a week ( )

(b) One week to one month ( )

(c) Above one month ( )

4. Where was treatment for the ailment sought?

(a) Traditional medicine ( )
(b) Village health facility ( )
(c) Pharmacy/patent medicine vendor ( )
(d) Spiritualist ( )
(e) Private health facility ( )
(f) Secondary health facility ( )
(g) Others, specify..

5. What was the outcome of the treatment?

(a) Cured ( )

(b) Not cured ( )

(c) Dead ( )

SECTION C.

Assessment of the level of Primary healthcare utilization.

1 .Do you and your family members make use of the PHC facility?

(a) Yes ( )

(b) No ( )

(c) Not sure ( )

2. If yes, does the facility open 24hrs a day?

(a) Yes ( )
(b) No ( )
(c) Not sure ( )

3. What is the distance of the facility to you?

(a) 30 minutes to 1hour journey (}

(b) More than 1 hour journey ( )

(c) Not sure ( )

4. What kind of services are offered at the hospital

(a) General outpatient services ( )

(b) Antenatal care ( )

(c) Immunization services ( )

(d) Delivery ( )

(e) Post natal clinics ( )

(f) Health education ( )

(g) Others specify...

5.Has any staff of the health facility ever visited your household to give you a health talk?

(a) Yes ( )
(b) No ( )
(c) Can't remember ( )

6. Are you aware of the existence of a functional Village or ward development committees?

(a) Yes ( )
(b) No ( )
(c) Not sure ( )

7. How satisfied are you with the level of services offered in the facility?

(a) Strongly satisfied

(b) Satisfied

(c) Not satisfied

(d) Dissatisfied strongly

(e) Moderately satisfied

SECTION D

Assessment of the barriers to the utilization of PHC services.

1. If you don't utilize the facility please give reasons why

(a) Lack of staffs ( )

(b) Lack of drugs ( )

(c) Distance ( )

(d) Poor community involvement ( )

(e) Negative attitudes of staffs ( )

(f) Cost ( )

(g) Lack of basic infrastructures ( )

Others please specify…….

2. What do you think can be done to make you utilize the facility?

(a) Recruit more staffs ( )

(b) Reduce cost of services ( )

(c) Involve the community the more ( )

(d) Provide essential drugs ( )

(e) Reduce distance of facility ( )

(f) Others please specify……

3. Do you think you have a say in the running of this facility?

(a) Yes ( )

(b) No ( )

(c) Not sure ( )

APPENDIX II

AN ASSESSMENT OF BARRIERS TO THE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN BATSARI LOCAL GOVERNMENT

HEALTH FACILITY LEVEL QUESTIONNAIRE

To be filled by in-charge of health facility

SECTION 1: BASIC CHARACTERISTICS OF THE HEALTH FACILITY

SECTION A

(a) Name of health facility: --

(b) Village: --

(c) Ward: ---

(d) Local Government Area: ---

(e) Name of In-charge: --

(f) Sex: (a) Male [ ] (b) Female [ ]

(g) Age: --

(h) Educational qualification: --

(i) Years spent as In-charge: ---

(j) Working experience (in years): --

SECTION 2: BASIC CHARACTERISTICS OF SERVICE OFFERED AT THE HEALTH FACILITY

(i) When was the facility built? --

(ii) Who built the facility: ---

(iii) Any other facility in the neighbourhood? (a) Yes [ ] (b) No [ ] (c) Not sure [ ]

(iv) How long does it take to reach the facility from a nearby village? (a) Less than 30 minutes [ ] (b) 30 minutes – 1 hr [ ] (c) More than 2 hrs [ ]

(v) Does the clinic offer 24 hours services? (a) Yes [ ] (b) No [ ] (c) I am not sure [ ]

SECTION 3: ASSESSMENT OF MANPOWER STATUS OF THE HEALTH FACILITY

3.1 What is the number of the following staff in your local facility?

	Male	Female	Total
Doctors			
Pharmacists			
Registered Nurses			
Registered Midwives			
Community Health Officers			
Community Health Extension Workers			
Junior Community Health Extension			
Workers			
Pharmacist Technicians			
Lab Technicians			
Auxiliary Staff			

SECTION 4: ASSESSMENT OF SERVICES OFFERED IN THE HEALTH FACILITY

4.1 Does the Clinic offer the following services?

	Yes	No
(1) Antenatal care		
(2) Deliveries		
(3) Essential obstetrics care		
(4) Postnatal care		
(5) Management of abortion and post-abortal care		
(6) Family planning		
(7) Growth monitoring and child welfare services		
(8) Immunization services		
(9) Health education		
(10) General Outpatient Services		

4.2: Is there a functional drug revolving fund in the facility? (a) Yes [ ] (b) No [ ]
(c) I don't know [ ]

(i) Is there a functional referral system? (a) Yes [ ] (b) No [ ]
(c) I don't know [ ]

(ii) Are there functional vehicles in the health facility?

	Yes	No	Number
Car			
Motorcycle			
Bicycle			

Others, specify: ---

SECTION 5.1: ASSESSMENT OF THE LEVEL OF COMMUNITY INVOLVEMENT AND PARTICIPATION IN THE HEALTH FACILITY?

(i) Do you offer community visits to community? (a) Yes [ ] (b) No [ ]
(c) Not sure [ ]

(ii) Is there a functional village health committee? (a) Yes [ ] (b) No [[
(c) Not sure [ ]

(iii) If yes, how often do they meet? (a) Frequently [ ] (b) Occasionally [ ]
(c) Never [ ]

(iv) If not functioning, what are the reasons for it?
(a) It has not been formed [ ] (b) Apathy on the part of the community [ ]
(c) Can't say [ ]

(v) What are the alternative sources of care in the village? (a) Private clinics [ ]
(b) Pharmacy [ ] (c) Traditional medicine [ ] (d) Religious/Spiritualists [ ]

(vi) Do the people utilize these services? (a) Yes [ ] (b) No [ ]
(c) I don't know [ ]

(vii) Why do you think people don't utilize these services?
(a) Cost [ ]

(b) Distance [ ]

(c) Lack of confidence in the PHC facility [ ]

(d) Lack of equipment/staff [ ]

(e) Lack of community involvement [ ]

(f) Others, specify ---

(b) Do you have a functional cold store for vaccines? (a) Yes [ ] (b) No [ ]

(c) Family Planning services [ ]

(d) How satisfied are you with the services offered in this facility?

(a) Strongly satisfied [ ]

(b) Satisfied [ ]

(c) Moderately satisfied [ ]

(d) Not satisfied [ ]

(e) Strongly dissatisfied [ ]

APPENDIX III

PROJECT TITLE-

ASSESSMENT OF BARRIERS TO THE UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN BATSARI LOCAL GOVERNMENT AREA OF KATSINA STATE

METHODS-

FOCUS GROUP DISCUSSIONS GUIDE

DATE.

RESPONSIBLE PERSONS-KURFI ABUBAKAR and ABDULKADIR YASORE

Instrument Title: Discussion Guide: Focus Group I: Topic Generation

Total Participant time required: 1 hour + 10 minutes – 1 hour + 50 minutes

Total Person 10-15

OVERALL QUESTION TO ANSWER IN FOCUS GROUP DISCUSSIONS:

The purpose of the study is to conduct evaluative research to determine (in order of priority):

- The factors affecting the utilization of primary health care services in Batsari Local Government Area of Katsina state.

The specific objectives are

1. To determine the pattern of utilization of primary health care services among the people in the community
2. To determine the common health care problems of the people of the community
3. To determine the utilization pattern of PHC services in the community
4. To assess the barriers to the utilization of PHC among the members of the community.

Before the group begins, conduct the informed consent process, including compensation discussion.

I. Introduction (10 m)

- Welcome participants and introduce yourself.
- Explain the general purpose of the discussion and why the participants were chosen.
- Discuss the purpose and process of focus groups
- Explain the presence and purpose of recording equipment and introduce observers.
- Outline general ground rules and discussion guidelines such as the importance of everyone speaking up, talking one at a time, and being prepared for the moderator to interrupt to assure that all the topics can be covered.
- Review break schedule and where the restrooms are.
- Address the issue of confidentiality.
- Inform the group that information discussed is going to be analyzed as a whole and that participants' names will not be used in any analysis of the discussion.

Read out the protocol summary.

Discussion Guidelines:

We would like the discussion to be informal, so there's no need to wait for us to call on you to respond. In fact, we encourage you to respond directly to the comments other people make. If you don't understand a question, please let us know. We are here to ask questions, listen, and make sure everyone has a chance to share.

If we seem to be stuck on a topic, we may interrupt you and if you aren't saying much, we may call on you directly. If we do this, please don't feel bad about it; it's just our way of making sure we obtain everyone's perspective and opinion is included.

We do ask that we all keep each other's identities, participation and remarks private. We hope you'll feel free to speak openly and honestly.

As discussed, we will be tape recording the discussion, because we don't want to miss any of your comments. No one outside of this room will have access to these tapes and they will be destroyed after our report is written.

(If assistants present) Helping are my assistants ______ and _______. They will be taking notes and be here to assist me if I need any help.

- The initial question:
- Today we are here to talk about primary health care services in this community , What comes to your mind when you hear primary health care .?
- Probe to make sure the people understand what primary health care is

- ➢ The next question
- ➢ What is your perception of the services in the Primary health center
- ➢ With the following issues in mind
- ➢ Availability

- Affordability
- Accessibility
- Common health care problems in the locality
- Pattern of utilization of these services

The next question

- What are the major barriers to the use of these primary health care services in your locality?
- Probe further by clearly extracting the individuals perception of what constitute a barrier,

The next question

- How best do you think these barriers can be overcome?

The next question

- What is your level of satisfaction with the primary health care services in the community

The next question

Conclude by thanking the audience and asking if any one has any clarifications or questions