

# **AN ASSESSMENT OF THE PRIMARY HEALTH CARE SERVICES AND UTILIZATION IN IGABI LOCAL GOVERNMENT AREA OF KADUNA STATE**

**BY**

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## **ABSTRACT**

This paper presents finding on the assessment of the primary health care services and utilization of existing health care services in Igabi Local Government Area (LGA). The aim of study is to assess the impact of PHC services and utilization in Igabi Local Government Area of Kaduna state. Data from the study was derived from the administration of a structured Questionnaire, Focus group discussion and data from Hospital records. A total of 516 questionnaires representing 0.12 percent of the entire population were administered with the help of some research assistants. A total of 435 questionnaires were used for analysis which was carried out through the use of computer software, SPSS version 9, entry and cleaning. This indicates a sources rate of 84.3 percent. The result represents their interaction with one another and their influences on the impact of PHC delivery system. The finding also reveals that 52.2percent of the respondents have PHC centres in their communities while a significant proportion of the respondents (47.8 percent) indicate that they have no PHC centres. A total of 83.3percent of the respondents indicate that they have dispensaries in their communities; 12.4 percent said that they have clinics in their areas, while 0.2percent of the respondents indicate that they have specialist hospitals. A total of 0.5 percent each indicates that they have herbal/traditional homes and general hospitals, a total of 0.2 percent for the “others” respondents mention that they have pharmacies, patent medicine stores and insurance hospitals. A very striking finding shows that malaria fever is the major cause of ill health in the area which represents 44.8 percent of the respondents and this is followed by typhoid fever (17.2) percent. The study also shows that 52.9 percent of the respondents are not living within the 0-4 kilometers WHO recommendation of a health care facility. Decision making among the respondents on treatment during pregnancy and childbirth shown that husbands and mother-in-law play a prominent role (44.5 percent), and 41.1 percent of the respondents indicate that antenatal patients wait for many hours (4-8) before they are attended to by a health care personnel. The correlation coefficient indicates that the observed  $r$  (0.673) is greater than the critical value of (0.195) at 433 degrees of freedom (DF) and at 0.05 level of significance. Therefore; the argument that there is no significant relationship between income status and utilization of PHC services is rejected. It therefore shows that there is a strange association between these variables. The inference from this test is that the higher the level of income the more utilization of PHC services. This shows that the rural inhabitants, as a result of their low level of the income do not utilize PHC services effectively as those with higher incomes. The mass media and government information services are the most powerful sources of information about modern health care delivery system.

Key words: Primary healthcare, Utilization, Services and Infrastructure

## INTRODUCTION

### 1.1 Introduction

Improving health throughout the world is a gigantic task requiring global cooperation. The international health care system was first recognized at the first international scientific conference in 1851 (Shunom, 2006), after which the World Health Organization (WHO) introduced a system of cooperation against the spread of diseases. A WHO conference held in Alma-Ata in 1978, proclaimed Primary Health Care (PHC), as a concept that calls for the overall promotion of health by supporting the individual, the family and the community, by defining the active participation of the community, their needs and ways to meet them (Ogbole, 1981).

Studies have shown that the problems confronting Nigeria in areas of health are many, ranging from poor finance, equipment, shortage of manpower to the unwillingness of few health professionals to work in rural areas (Brieger, 1980; Obionu, 2007). The health care delivery system which gives emphasis on erection of magnificent buildings and provision of sophisticated equipment to serve a few urban dwellers is known to be inadequate. Investing on such health delivery system will not ensure that basic health care services are made available to the masses to achieve the objectives of health for all.

In practice therefore, no government (including Nigeria) has enough financial sources needed to meet the health needs of the population. For this reason, a new strategy for health care delivery system is worth considering, for it is a determination of the government to bring health care within the reach of every one particularly the under privileged who have been left out of health (FMOH, 2004).

Igabi LGA today as in most parts of Nigeria is faced with high population growth, high poverty level accompanied by illiteracy and ignorance, poor nutrition, rampant superstitious beliefs, taboos and other related health risk and problems such as inadequate sanitation, unsafe drinking water and high rate of environmental pollution. These conditions have encouraged high prevalence cases of both infant and adult diseases such as measles, diarrhea, tuberculosis, cardio vascular diseases and other respiratory infections. Also, deadly diseases such as Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and other Sexually Transmitted Diseases/Sexually Transmitted Infections

(STDs/STIs) are particularly worrisome in Kaduna State (Laah and Mamman, 2002). There is also growing number of child mortality aged 0-4 years, maternal mortality is also high. Consequently, life expectancy is lower than expected. It is therefore necessary that we understand the vital role of health in both the curative and most especially the preventive services of our health care delivery system. It is against this background that this study on PHC in Igabi LGA of Kaduna State is being carried out. The study attempts to explore the impact and challenges of PHC delivery system with the intension of generating data for policy and planning.

## **1.2 Materials and Methods**

The data for this paper was obtained through the administration of two sets of questionnaires specifically designed to obtain information among other things, on utilization of primary health care services in Igabi LGA. Igabi LGA has a total population of 430,229 with a male population of 219,269 while the female population amounts to 210,960 (National Population Commission, 2006). The whole wards in the LGA form the sampling frame for the study. After considering cost, available resources and an optimal sample size of obtaining reliable estimates on the study area, a 0.12percent sample was used as the sample frame (0.12percent of 430,229 amounts to 516 respondents).

The purposive sampling method was used. This method is characterized by the use of personal judgment and a deliberate attempt to obtain representative sample by including presumable typical areas or groups in the sample (Abiola, 2007). A residential ward study areas was selected from the north, south and central part of the study area to reflect the differing age, ethnic, income, occupation, religion and educational characteristics. In the light of the above explanations, the twelve wards in the study area were covered.

A total of 516 questionnaires were taken to the field for administration, and out of this number a total of 435 (84.3 percent) respectively were successfully administered. In most cases, questionnaires were administered in direct face to face interaction or interview by the researcher or the field assistants. The questionnaire was in English but interviewers were however conversant with appropriate ways to ask questions in relevant Nigerian languages spoken in the area or in the languages best understood by the

respondents. Respondents who could read and write were allowed to fill the questionnaire themselves, but on submission clarification on any aspect not understood were made. Also focus group discussions and in-depth interview were used.

The rank correlation was used to test if a significant difference that exists between an observed number of responses in each category and the expected number which is based on the null hypothesis (Ho).

In rank correlation, the data may be ranked in order of size and importance using the numbers 1, 2, 3..... N. If we rank two variables in such a manner, the coefficient of rank correlation given by spearman is:

$$r_{\text{rank}} = 1 - \frac{6 \sum D^2}{N(N^2 - 1)} \text{ where;}$$

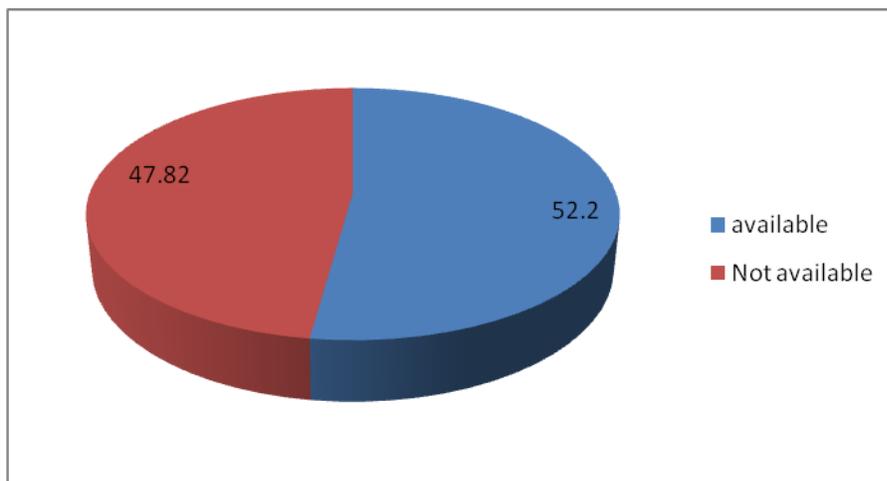
D= Differences between ranks of corresponding values

N= Number of pairs of values in the data

### 1.3 Results and Discussions

#### 1.3.1 Distribution by Availability of PHC Centres and Types

Figure 1 shows the distribution of respondents by availability of health care centres. It shows that 52.2percent the respondents have PHC centres in their communities while a significant proportion of the respondents (47.8 percent) indicate that they have no PHC centres.



**Figure 1: Percentage of Respondents by Presence of PHC centres**

**Source: Field Survey, 2011**

The distribution of respondents by type of PHC centres is shown in Table 1. A total of 83.3percent of the respondents indicate that they have dispensaries in their communities; 12.4 percent said that they have clinics in their areas, while 0.2percent of the respondents indicate that they have specialist hospitals. A total of 0.5 percent each indicates that they have herbal/traditional homes and general hospitals, a total of 0.2 percent for the “others” respondents mention that they have pharmacies, patent medicine stores and insurance hospitals.

**Table 1: Distribution of Respondents by Types of PHC Centres**

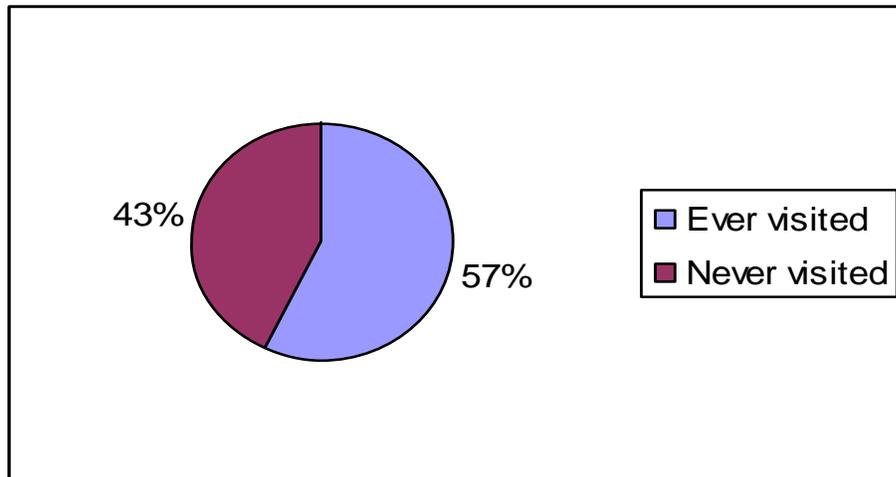
Type	Frequency	Percentage
No response	4	0.9
Dispensary	371	85.3
Clinic	54	12.4
Specialist hospital	1	0.2
Herbal/Traditional home	2	0.5
General Hospital	2	0.5
Others(Specify)	1	0.2
<b>Total</b>	<b>435</b>	<b>100.0</b>

**Source: Field Survey, 2011**

From this analysis, it is clear that there are more dispensaries in the study area. This is to be expected because the study area is largely a rural setting and the establishment of hospitals (specialist) tends to favour urban, semi-urban and local.

**1.3.2 Distribution by Ever Visited to PHC Centres**

The aim of PHC is to make people value not only health but how to achieve it. Like any other social services provided by the government, PHC facilities should be located so that people living in various communities can have physical access to them. Figure 2 gives us the distribution of respondents by ever visited to PHC facilities. About 57.0 percent of the total respondents indicate that they have visited the PHC centres in their areas, while 43.0 percent agreed that they have never visited a PHC centre. The relatively high proportion of respondents who have never visited a PHC centre does not mean that respondents in the area do not seek health care delivery as the patronage of herbal medicine practitioners could be a factor.



**Figure 2: Percentage Distribution of Respondents by Ever Visited PHC Centres**

**Source: Field Survey, 2011**

This situation explains why traditional medicine is gaining more grounds especially in the rural areas (Datong, 1988).

### 1.3.3 Distances to PHC Centres from Home

Table 2 reveals that 47.1 percent of the respondents are within 4 kilometers of a health care facility. The World Health Organization (WHO) has recommended that a health care facility shall be within 0-4 kilometers (WHO, 1978), while 52.9percent are living within the radius of five to seventeen kilometers (5-17 km) and above. This implies that majority of the people in the study area are not within easy reach of a health care facility.

**Table 2: Distribution of Respondents by Distance to PHC Centres**

Distance	Frequency	Percentage
< 2 km	95	21.8
2-4 km	110	25.3
5-7 km	85	19.5
8-10 km	65	15.0
11-13 km	50	11.5
14-16 km	20	4.6
17km+	10	2.3
<b>Total</b>	<b>435</b>	<b>100.0</b>

**Source: Field Survey, 2011**

From the FGDs, discussants revealed this situation, as one of them comments thus;

*“The government should know that we are human beings like them, who need hospitals, good roads and portable drinking water, they should provide our villages with hospitals that would be closer to us or provide us with good roads so that we can have easy reach to the hospitals they have built in other communities”.*

### 1.3.4 Types of Diseases Prevalent In the Area

Table 3 shows the distribution of respondents by types of disease prevalent in the area. On the whole, 44.8percent of the total respondents suffer from malaria fever, ranking the highest in the study area. This is followed by typhoid fever with a proportion of 17.2percent. A total of 11.5 percent, 8.7percent each indicate that they suffer from hypertension and diarrhea respectively, while 6.9percent of the proportion said they are suffering from ulcer. Cholera and diabetes represent 4.6percent and 4.1percent of the respondents respectively. Other types of illness include dracunculiasis, headache and cough, each representing 0.5percent of the respondents. The “others” category has 0.7 percent and this includes those who suffered from nose bleeding, body pains, accident and eye problem.

**Table 3: Distribution of Respondents by Disease Prevalence**

Disease	Frequency	Percentage
Malaria Fever	195	44.8
Typhoid Fever	75	17.2
Hypertension	50	11.5
Diarrhea	38	8.7
Ulcer	30	9.6
Cholera	20	4.6
Diabetes	18	4.1
Headache	2	0.5
Dracunculiasis	2	0.5
Cough	2	0.5
Others (specify)	3	0.7
<b>Total</b>	<b>435</b>	<b>100.0</b>

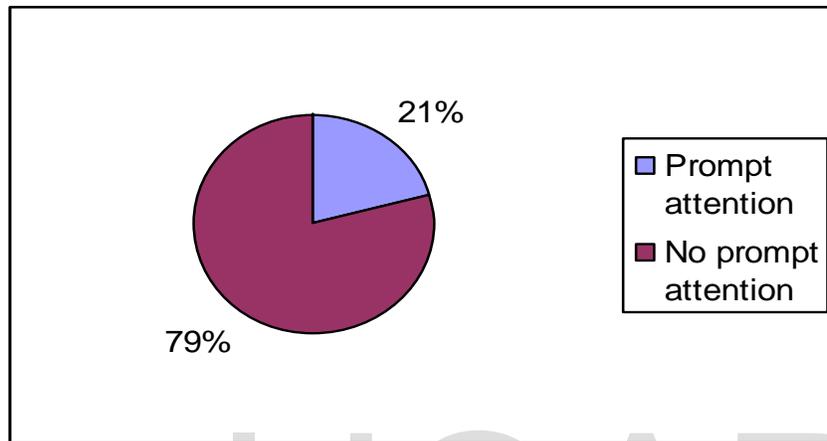
**Source: Field Survey, 2011**

These findings confirm what is known from other sources on the endemic and epidemic nature of malaria, and being one of the major causes of ill-health and death in sub-Saharan Africa (WHO/UNICEF, 2009). Typhoid fever, cholera and diarrhea are common in the area, this is partly because of inadequate

access to safe drinking water, because majority of the inhabitants in the area depend on unhygienic sources of drinking water from rainfall, shallow wells, ponds, and streams.

### 1.3.5. Distribution by Availability Prompt services at PHC Centres

To understand the level of attention given to patients at PHC centres, respondents were asked to reply to the question “Do you receive prompt attention at the PHC centre?”



**Figure 3: Percentage Distribution of Respondents by Attention Given to Patients at PHC Centres**  
 Source: Field Survey, 2011

It is obvious from figure 3 that prompt services at PHC centres in the area are low. A total of 79.0percent of the whole respondents do not receive prompt services at the PHC centres by the medical workers, while 21.0 percent of the respondents indicate that they are accorded with prompt services.

Table 4 shows the distribution of respondents by reasons for lack of prompt services at the PHC centres. It shows that 66.7 percent of the whole respondents indicate that there is shortage of health care personnel in the area. A total of 17.5percent of the total respondents interviewed are of the opinion that health care staffs are hostile to the patients at the health centres.

**Table 4: Distribution by reasons for Lack of Prompt Services**

Reason	Frequency	Percentage
Shortage of staff	290	66.7
Hostility of staff	76	17.5
Shortage of equipment	32	7.4
Shortage of drugs	25	5.7
Others (specify)	12	2.7
<b>Total</b>	<b>435</b>	<b>100.0</b>

Source: Field Survey, 2011

The table shows that 7.4 percent of the respondents believe that the hospital experience shortage equipment, and as such, workers cannot perform their duty effectively, while 5.7 percent of the sampled survey are of the view that there is shortage of drugs at the facility centres. The 2.7 percent for the “others” category comprises of respondents who mention high cost of available drugs, lateness of health care staff to work, lack of enough privacy during consultation as reasons why patients do not receive prompt attention at the PHC centre. Studies on health care delivery system by Alakija (2004), Obionu (2007) has confirmed these reasons as some of the problems of PHC delivery system in Nigeria.

Most discussants from various groups during the FGDs and in-depth interviews revealed that institutional factors at the health care centres such as hospital procedures, staff attitudes to patients, long waiting time, lateness of medical staff to work, slow medical records and cumbersome protocol among others are some of the reasons for the delay in receiving treatment at the health care centres. The major complaint was the attitude of the health care nurses; some of the discussants described them as “harsh and inconsiderate”.

### 1.3.6 The Perception of Patients to the Quality of Treatment

Treatment of patients at a health facility is an important dimension of the patient’s assessment of the quality of care (Annis, 1981). If the facility has a reputation of unfriendly staff, rude service providers and humiliating treatment, patients may even delay their decision to seek for medical care until the seriousness of their condition necessitates over-coming all barriers, or may rather seek for alternative medicines.

The study therefore considers the perception of patients on the quality of treatment of patients by the medical personnel in the study area.

**Table 5: Distribution of Respondents by Quality of Treatment by Health Care Staff.**

Perception	Frequency	Percentage
Very Good	70	16.0
Good	110	25.3
Average	65	15.0
Poor	170	39.1
Very Poor	20	4.6
<b>Total</b>	<b>435</b>	<b>100.0</b>

**Source: Field Survey, 2011**

Table 5 shows that 16.0 percent of the respondents are of opinion that the quality of treatment by health care providers. A total of 25.3 percent are of the opinion that the health care personnel treat their patients well, while 15.0 percent indicate that the quality of treatment is average. The (Table 5) also shows that 39.1percent of the total respondents agreed that the patients have poor perception about the Quality of treatment by health care workers, while 4.6 percent of the respondent said that the quality of treatment by is very poor.

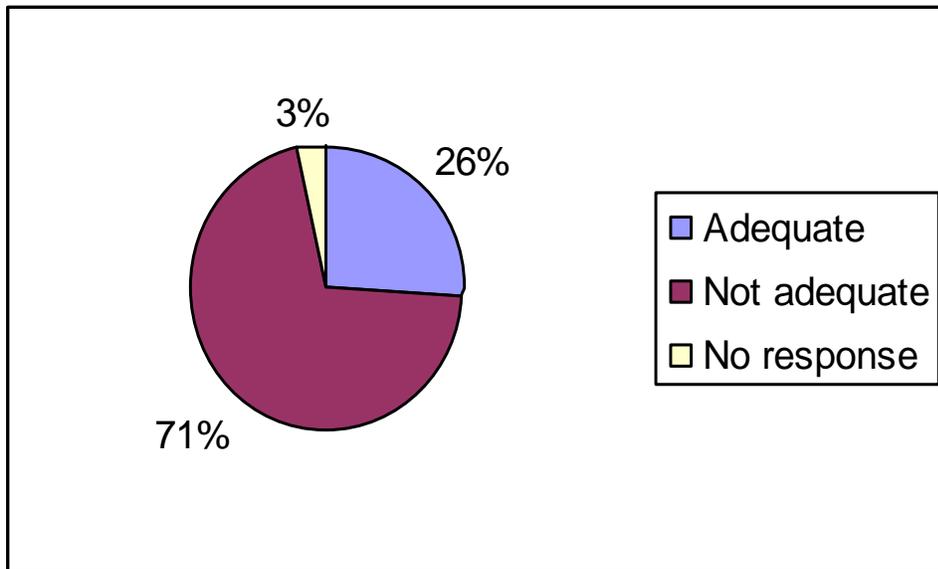
On the average, the patients have a good perception on the quality of treatment by health care workers in the study area. This was confirmed during the in-depth interviews conducted with some of the community leaders and household heads. The question was asked, “What is your perception on how health care workers treat their patients”? A community leader in Rigasa explains thus;

*“Some of the doctors are good to their patients while others rush the work. The relationship between the nurse and the people in our community is good, she is even part of our community, she lives and knows what most of the people’s situations are like”.*

This statement indicates that there is a good relationship between health care staff and their patients.

**1.3.7 Adequacy of Health Care Facilities**

Respondents were asked to indicate whether the health care facilities are adequate in the health care centres. Figure 4 shows the distribution of respondents by their perception on the level of adequacy of health care facilities. It shows that 26.0 percent of the respondents agreed that health care facilities are adequately provided while 71.1 percent indicate that there is no enough facilities at the health care centres. A total of 3.0 percent of the respondents did not reply to the question.



**Figure 4: Percentage Distribution of Respondents by Adequacy of Health care Facilities**

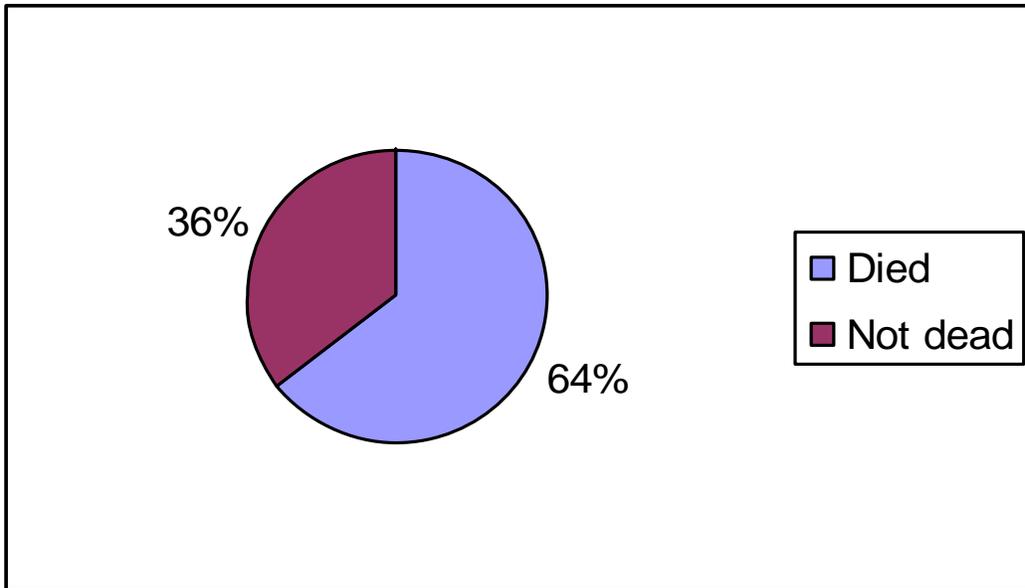
**Source: Field Survey, 2011.**

It is obvious from figure 4 that there is serious shortage of health care facilities in the study area. This finding again confirms earlier studies by Ademola (1981), Bisallah (2002) on poor state of health care services in developing countries.

### **1.3.8 Distribution by Friends/Relatives Who Died From Pregnancy and Child Birth and Reasons for Death**

Pregnancy and child birth are well recognized as being hazardous in most developing countries including Nigeria (Annis, 1981). Death during pregnancy and puerperium has continued to be a public health problem in Nigeria (Alakija, 2004).

Figure 5 shows the distribution of respondents by friends/relatives who died from pregnancy and childbirth. It shows that 64.1percent of the respondents interviewed indicate that their friends and relatives had died from pregnancy and childbirth as against 35.9 percent who reported that none of their relatives has died from such situations.



**Figure 5: Respondents by Friends/Relatives who Died due to Pregnancy and Childbirth.**

**Source: Field Survey, 2011**

Other findings on maternal mortality by the Federal Bureau for Statistics (2008) has confirmed the severity of maternal mortality ratios in Nigeria, putting the country as having the highest rate in sub-Saharan Africa.

A test of the understanding why women die due to pregnancy and child birth was conducted by simply asking the respondents “what was the cause of her death?” Table 6 shows the distribution of respondents by causes of death from pregnancy and child birth. It shows that 57.5percent of all the respondents indicate that their friends and relatives died due to prolong labour, 9.2 percent admitted their relations died from miscarriages, while 25.3percent agreed that they died as a result of obstructed labour. Those who died from pregnancy induced hypertension rank 5.3percent while the “others” respondents mentioned induced abortions, malaria, anemia and stillbirth as some of the causes, representing 2.5 percent.

**TABLE 6: Distribution of Respondents by Causes of Death during Pregnancy and Child Birth.**

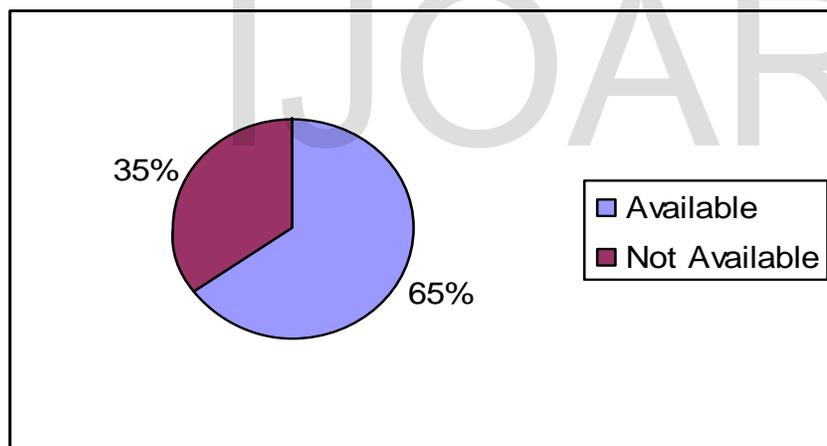
Cause of death	Frequency	Percentage
Prolong labour	250	57.5
Miscarriage	40	9.2
Obstructed labour	110	25.3
Pregnancy induced hypertension	23	5.3
Others (specify)	12	2.5
<b>Total</b>	<b>435</b>	<b>100.0</b>

Source: Field Survey, 2011

Studies in maternal mortality also reported that over 500,000 women die annually due to pregnancy complication from obstructed labour, hemorrhage, sepsis and eclampsia (Adesegun, 2004).

**1.3.9 Distribution by Availability of Maternal Clinics and Utilization.**

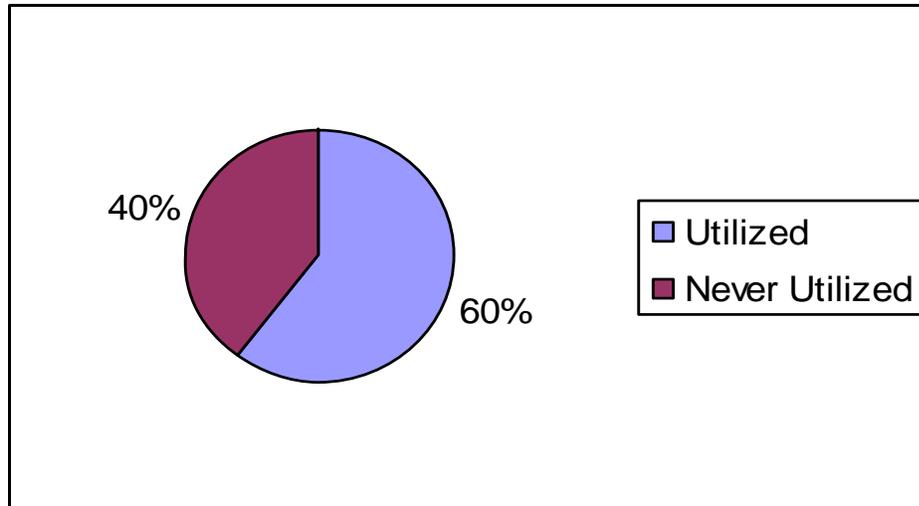
Respondents were asked to mention whether there are clinics for pregnant women in their areas and the level to which these clinics are utilized. Figure 6 shows the distribution of respondents by availability of maternal clinics. It shows that 65.0percent of the total respondents indicate that there are clinics for pregnant women in their communities, while 35.0percent have none.



**Figure 6: Percentage Distribution of Respondents by Availability of Maternal Clinics**

Source: Field Survey, 2011

Figure 7 shows the level of utilization of maternal clinics in the area. About 60.0 percent of the respondents indicate that they have attended maternal clinics in their areas as against 40.0 percent who said they have never attended maternal clinics.



**Figure 7: Percentage Respondents by Maternal Utilization.**

**Source: Field Survey, 2011**

Lack of clinic attendance by pregnant women is partly because of lack of money, distance of the clinic from home coupled to transport and treatment cost as well as cultural prescription and severity of restrictions on mobility of women generally in the area (Harrison, 1978).

### **1.3.10 Distribution who Decides Treatment during Pregnancy and Child Birth**

In this study, only female respondents were asked to give their responses on who is responsible for taking decisions for their treatment during pregnancy and childbirth. In many parts of Africa including Nigeria, pregnancy and childbirth are ambiguous events, though acknowledged as potentially risky, pregnancy and delivery are commonly considered natural, and normal for women (Auerbach, 1982). This means that death during labour and childbirth may sometimes be considered normal. Such fatalistic views can lead to the perception that the condition is not amenable to treatment, and can thus act as an effective barrier for timely decision to seek for health care.

Table 7 Show the distribution of respondents by who is responsible for taking decision for treatment of women during pregnancy and childbirth. On the whole ,26.8 percent of the respondents indicate that they take decision on the their own treatment during pregnancy and childbirth, while 35.1 percent and 12.4 percent agreed that only their husbands and mother-in-laws respectively take decision on their treatment during pregnancy and childbirth. About 20 percent of the proportion indicates that both

of them (husband and wife) take decision on their treatment, and 5.7 percent for the “others” category comprises respondents who say decision for their treatment is affected by cultural and religious beliefs.

**Table 7: Distribution of Respondents by who Takes Decisions on Treatment during Pregnancy and Childbirth**

Decision	Frequency	Percentage
Only you	71	26.8
Only your husband	93	35.9
Your mother-in law	33	12.4
Both of you	53	20.0
Others(specify)	15	5.7
<b>Total</b>	<b>265</b>	<b>100.0</b>

**Source: Field Survey, 2011**

This findings show that treatment of most of the women in the study area is decided by husbands and mother-in-laws. Harrison (1978) in his study on child bearing in Zaria confirms this finding.

### 1.3.11 Distribution by Waiting Time

The time it takes a patient to be attended to by the health care providers at the centre is very important. In the analysis of access to health care delivery. The study considers the waiting time by patients as an important parameter, and the time given for diagnosis by the health care personnel very crucial. Table 8 shows the distribution of respondents by how long it takes to be attended to during visits to the health care centres in all 61.1 percent of the respondents indicate that antenatal patients have to wait for a long time (4-8hrs) before they are attended to by the health care personnel, while 38.9 percent of the proportion agreed that antenatal patients spent only few minutes or hours (30min-3hrs) at the health care facility before they are attended to by a health care personnel.

**Table 8: Percentage Respondents by Waiting Time during Antenatal days**

Waiting Time	Frequency	Percentage
30 minutes	8	3.8
30 minutes -1hr	32	16.2
2 - 3hrs	39	18.9
4 – 5hrs	112	54.7
6 – 7 hrs	8	3.8
7 – 8 hrs	4	1.9
> 8 hrs	1	0.7

<b>Total</b>	<b>204</b>	<b>100.0</b>
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**Source: Field Survey, 2011**

This analysis shows that there is long waiting time for pregnant women during antenatal days. Long waiting hours in hospital could be as a result of lateness to work by the medical personnel, registration procedure, organization of waiting hall and waiting at pharmacy stores (Olumide and Ajayi, 1999). This situation is explained by one of the market women during the in-depth interviews;

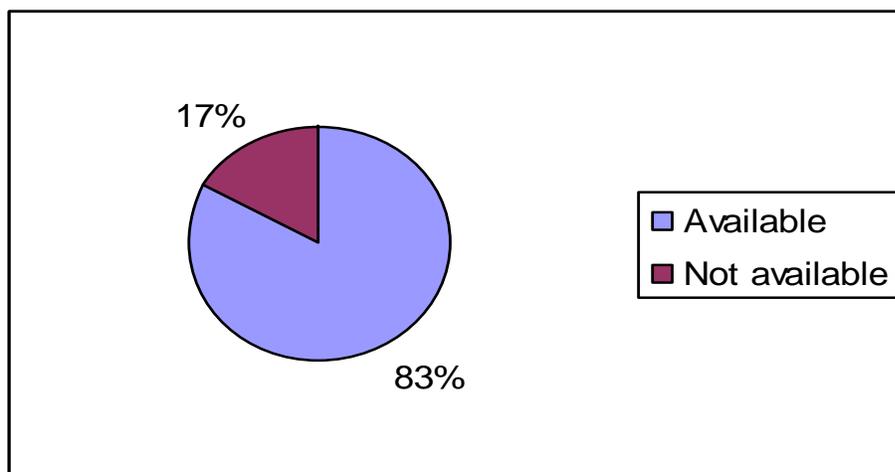
*“A very busy women like me is embittered about the time I would be wasting while in waiting hall or at the pharmacy, because I have lost economic time on several visits to the hospital while waiting to see the doctor on antenatal days, and sometimes end up not seeing him.”*

Long waiting period therefore has implications on access to health care services.

### **1.3.12 Availability and Cost of Drugs**

The provision of drugs form an integral part of the overall health care delivery system, and the rating of the entire PHC delivery system is a function of the availability of drugs in the facility centres, for without drugs; a health care centre has no substance and credibility.

Figure 8 shows the distribution of respondents by availability of drugs. It reveals that majority of the respondents (83.0 percent) indicate that drugs are available in the PHC centres, as against 17.0 percent who agreed that there are no drugs in these facility centres.



**Figure 8: Percentage Respondents by availability of Drugs**

**Source: Field Survey, 2011**

Though majority of the respondents agreed that drugs are available in most of the PHC centres, the survey further considers whether these drugs are affordable as enshrined in the Alma-declaration in 1978.

Table 9 shows the distribution of respondents by how costly the drugs are sold in the centres. It shows that 49.9 percent of the whole respondents indicate that drugs are expensive at the PHC centres. The proportion of the respondents who indicate that the prices of drugs are moderate ranks 33.3percent of the total respondents, while 5.7 percent agreed that the drugs are cheap, 11.0 percent of the proportion did not respond.

**Table 9: Percentage Distribution by Perception of the Cost of Drugs**

Cost of Drugs	Frequency	Percentage (percent)
Expensive	217	49.9
Moderate	145	33.3
Cheap	25	5.7
No response	48	11.0
<b>Total</b>	<b>435</b>	<b>100.0</b>

**Source: Field Survey, 2011**

With the above analysis, it is obvious that drugs are expensive in the study area; which implies that drugs are not easily affordable for the majority of people in the area.

**Hypothesis: There is no Significant Relationship between Income Status and their Utilization of PHC Services.**

**TABLE 10: Relationship between Income and Utilization of PHC services.**

Variables	N	Mean	S-D	R	Degree of freedom	P	r-critical
<b>Income</b>	435	1.8713	0.8783	0.673	433	0.000	0.195
<b>Utilization</b>	435	1.2276	0.6043				

**Source: Field Survey, 2011**

The correlation coefficient as shown in table 10 indicates that the observed r (0.673) is greater than the critical value of (0.195) at 433 degrees of freedom (DF) and at 0.05 level of significance. Therefore; the argument that there is no significant relationship between income status and utilization of PHC services is rejected.

It therefore shows that there is a strange association between these variables. The inference from this test is that the higher the level of income the more utilization of PHC services. This shows that the rural inhabitants, as a result of their low level of the income do not utilize PHC services effectively as those with higher incomes.

This study is in line with Datony (1987) who reported that majority of the people in the lower socio-economic status are not aware of health facilities in areas, let alone use them, and even within this group some of them claim to be aware of such services but lack the financial resources to seek such services

#### **1.4 Summary and Conclusion**

The study provides a good representation of PHC programme in Nigeria and Kaduna state particular. The failure to provide an efficient, functional and sustainable health care system has led to a situation where access to health care is no longer a right for the majority of the populace as proclaimed by the WHO/UNICEF in 1978, but as a privilege. PHC has failed in the study area because there was no serious interaction between formal management structures and local resident. This led to absence of local mechanisms for ensuring adequate financial allocation to the PHC centres.

Because the local communities were not allowed to take full charge of their own health (lack of community participation), in policy making and implementation with regards to PHC delivery system in the area, they did not see formal management structures in the area as particularly relevant to their existence.

The operation of the PHC programmes at the facility level staggers so much that it has become too per functioning to invoke receptivity from the community. A couple of scintillating facts brought out by the analysis shows that the impact made by the PHC programme on the general health conditions of the people is very insignificant. These facts include; inadequate personnel, expensive nature of drugs, lack of location of many centres within reasonable distance, inadequate infrastructural facilities and logistic support and high rate of infant, child and maternal mortality in the area. As a result the facilities available

in the LGA can only offer outpatient treatment, rudiment antenatal care services and occasional vaccination. The quality of services whatever offered has been deteriorated so much that the beneficiaries prefer to seek medical care outside the facility centres through referral or seek for alternative non- PHC agencies or visit quacks.

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