



DETERMINANTS OF UTILIZATION OF PRIMARY HEALTH CARE FACILITIES IN ALKELERI LOCAL GOVERNMENT AREA, BAUCHI STATE, NIGERIA.

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ABSTRACT

Background: Primary health care in rural communities of Nigeria have come a long way but certainly still require more effort so as to achieve the goal of health for all. Few rural communities utilize primary health care services despite its long time of implementation in the country.

Objective: This study was designed to assess the level of utilization of PHC centers and also assess the determinants of utilization of primary health centers in Alkeleri LGA of Bauchi State.

Methods: Non-experimental descriptive survey design was adopted; a self structured and validated questionnaire was used to collect data from 381 respondents. The respondents were selected from the community using multistage random sampling. Data was analyzed using SPSS version 20 and descriptive statistics of frequency counts and percentages was used to answer research questions.

Results: There was seemingly low level of utilization (33.9%) reported among the respondents. majority of the respondents blamed their non utilization to proximity of the people to the health care centers, non-availability of drugs and laboratory equipments, high cost of care, long waiting time and poor health care provider-client interaction.

Conclusion: The study suggest an upgrade of the existing primary health care centers to meet with the minimum WHO standard and subsequent establishment of new Primary Health Care centers to be based on need of the service recipients and not political motivation

Key words: Determinants, Utilization, Primary health care, Alkeleri

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INTRODUCTION

Health is a major human capital and there exist substantial agreement in the literature on the relationship between health and economic development through its relationship between capability and poverty (Strauss and Thomas, 1998). It is assumed that improvement in health leads to improvement in life expectancy, which is a robust indicator of human development. A simple channel through which health affects

human development is by improving the living conditions. As living conditions improve, human longevity is expected to improve and vice-versa. Empirical evidence has shown that among poor countries, increase in life expectancy is strongly correlated with increase in productivity and income (Deaton 2003).

Health care utilization is the use of health care services by the people. The health care utilization of a population is related to availability, quality and cost of services, as well as the socio-economic structure, and personal characteristics of users (Chakraborty, Islam, Chowdhury, Bari, Akhter 2003). The under-utilization of health services in public sector has been almost a universal phenomenon in developing countries (Zwi, 2001). It is, therefore, in recognition of this fact that various Nigerian governments have made numerous great efforts towards the provision of health care facilities to its population. Notable among these efforts were the expansion of medical education, improvement of public health care, provision of primary health care (PHC) in many rural areas. However, overt concern has not been given to the need for equity in the planning and distribution of health care facilities over the years in the country. Public and private health facilities are sparsely provided in many regions within the country. Such region with difficult terrain and physical environment are often neglected (Onokerhoraye, 1999). This makes distance between the rural dwellers and the health care center far apart, given the transportation problem experience in these areas and its attendant cost.

Longer travel times and greater distance to health centers in rural areas constitute barriers to repeated visits (Buor 2003). The effect of travel time on the utilization reflects that of distance and utilization. The inadequacies in the access to health facilities have reduced the life expectancy of rural inhabitant and increased infant mortality (Ajala, Sanni, Adeyinka, 2005). Ajala et al further asserted that rural people often waste a lot of time getting to the nearest available health care centers of which they have to trek long distance on many occasion because they are often faced with problems of reliable means of transportation.

In a study conducted in Guatemala; Goldman and Heuveline (2000) found that family size and parity, educational status and occupation of the head of the family are also associated with health seeking behavior besides age, gender, and marital status. Mugisha, Bocar, Dong, Chependeno, Saver, (2004) also identified household incomes, education and expected competency of the provider as positive determinants of utilization of healthcare services in rural Burkinafaso.

There are two main health providers in Nigeria these are, Government or public health services provider and Non-Governmental health care providers which are coordinated by the ministry of health. The under utilization of these health facilities in rural area which are occasioned by inaccessibility has led to death from illness which ordinarily could have been treated and prolonged state of illness thus reducing labour and productivity from the rural areas. Ajala, Sanni, Adeyinka, (2005) asserted that the resultant affect of inadequate access to health care delivery on sustainable development can be exemplified by the number of man hour loss annually to malaria alone. In Nigeria, despite the long implementation of the Alma-ata declaration; adequate utilization of PHC centers still remain as a mirage especially in the rural settings. Empirical findings has shown that PHC which is supposed to be the bedrock of the country's health policy is currently catering for less than 20%, of the potential patient, most rural settlers which forms the remarkable part of the of population prefer to visit traditional healers over the orthodox medicine (Gupata, Gauriv, Khemani, 2004). This study was designed to assess the level of utilization of PHC centers and also assess the determinants of utilization of primary health centers in Alkaleri LGA of Bauchi State.

METHODS AND MATERIALS

Research Design: A Non-experimental descriptive survey design was used for this study. The researchers used this design because it provides the options for respondents regarding the phenomenon being studied (Burns and Grove, 2007).

Study Setting: The setting of the study was Alkaleri Local Government Area of Bauchi State, northeastern Nigeria. The LGA has the highest land area and the fifth most populated among the twenty local governments in Bauchi State. It covers a landmark of 5,918 KM² and a projected population of 329,424 (National Bureau of Statistics, 2013). Alkaleri Local Government Area has a total of 3 Districts Areas and 19 wards, the dominant

ethnic nationalities found in the area are: Dugurawa, Fulani, Hausa, Barebari, and Jarawa. The area is one of the precious local governments in Bauchi state, that is blessed with abundant natural resources and fertile land for farming, one of the natural endowment in the area is the Yankari National Park which serves as tourist center for both foreign and indigenous tourists. Major occupation of the people in the region includes farming, livestock rearing and trade.

Sample and sampling technique: Multistage random sampling was used in sampling the 400 respondent, one Ward was selected from each of the 3 Districts in the local government area using simple random sampling and three villages were selected at random from each of the ward. National programme on immunization (NPI) house numbering was used in distributing the questionnaire to the 400 respondents. The formula

$$n = \frac{N}{1 + (e^2)}$$

was used in estimating the sample size.

Where; n= required sample size

N= total population of the study

1= is a constant

e = alpha level or margin of error at 5% (standard value of 0.05)

Substituting the formula therefore:-

$$n = \frac{329,424}{1 + 329,424 (0.05^2)}$$

$$n = \frac{329,424}{1 + 329,424 (0.0025)}$$

$$n = \frac{329,424}{1 + 823.54}$$

$$n = \frac{329,424}{824.54}$$

n = 400 approx

Instrument for data collection: The researchers use a self structured and validated questionnaire. The questionnaire consists of three sections (section A – C); section A contained the socio-demographic data, section B; utilization of primary health care facilities, section C; determinants of health facilities utilization.

Method of data collection: The researchers together with the research assistance used the period of two weeks in the collection of data. : A sampling frame of the ten council wards in the local government was drawn. The names of the council wards were written in pieces of paper and shuffled in a basket, 3 pieces of papers were picked representing the 3 wards whose' names appear in the papers picked. A sampling frame of communities in the selected wards was also collected. The communities where the study was carried out were randomized by simple random sampling (balloting). One community was selected from each ward to make a total of 3. The national population commission (NPC) house numbering was identified and used, places where there were no numbering, the houses were numbered for the purpose of the study. 50 houses were selected from each of the three communities using systematic sampling technique, i.e. every other house. Three respondents were conveniently selected and served with questionnaire. Each respondent was addressed prior to administration of the questionnaire on the essence and significance of the study stressing the importance of giving accurate data. Participants, who were able to read and write had self-administered questionnaire while those who could not, had an interview administered questionnaire.

Method of data analysis: Only 381 (95.25%) of the 400 questionnaires distributed were suitable for analysis. The information obtained was analyzed using SPSS software version 20. Descriptive statistics of simple frequencies and percentages was used to answer research questions.

RESULTS

Table 1: Demographic Characteristics of the Respondents

S/N	VARIABLE	FREQUENCY	PERCENTAGE
1	AGE		
	15-24	75	19.7
	25-34	146	38.3
	35-44	28	7.3
	45-54	31	8.1
	55-64	69	18.1
	65 Above	32	8.4
	Total	381	100.0
2	SEX		
	Male	253	66.4
	Female	128	33.6
	Total	381	100.0
3	TRIBE		
	Jar	59	15.5
	Hausa-fulani	138	36.2
	Barebari	98	25.7
	Others	86	22.6
	Total	381	100
4	MARITAL STATUS		
	Married	196	51.4
	Single	142	37.3
	Separated	13	3.4
	Divorce	17	4.5
	Widowed	13	3.4
	Total	381	100.0
5	LEVEL OF EDUCATION		
	No formal education	116	38.1
	Primary education	60	16.8
	Quranic education	63	17.1
	Junior secondary school	33	8.7
	Senior secondary school	62	16.3
	Tertiary education	44	8.7
	Bsc	8	2.1
	Others	6	1.6
	Total	381	100.0
6	OCCUPATION		
	House wife	55	14.4
	Farming	117	46.5
	Trading	59	15.5
	Student	47	12.3
	Civil servant	33	8.7
	Others	10	2.6
	Total	381	100.0
7	RELIGION		
	Islam	321	84.3
	Christianity	51	13.4
	Traditional African Religion	9	2.4
	Total	381	100.0

Table 1: Shows that majority of the respondent 146 (38.3%) were within the age range of 25-34 years, 75(19.7%) of the respondents were within the age of 15-24 years, 31(8.1%) within age range 45-54 years, 69(18.1%) within age range, 55-44 years and 32(8.4%) was above 65 years, least of the respondent 28(7.3%) where within the age range of 35-44 years. 253(66.4%) were males and 128(33.6%) were females. Greater proportion of the respondents 138(36.2%) were Hausa-fulani by tribe, 59(15.5%) were Jar by tribe, and 98(25.7%) were Barebari, while 86(22.6%) were of other tribes. Most of the respondents 196(51.4%) were married, 142(37.3%) were single, 17(4.5%) were divorcee, 13(3.4%) widowed. and least of the respondents 13(3.4%) were separated, Greater percentage of the respondent 116(38.1) had no formal education, 60(15.7%) had primary education, 63(16.5%) Quranic education, 33(8.7%) junior secondary education, 62(16.3%) senior secondary education, 33(8.7%) tertiary education, 8(2.1%) Bsc, 6(1.6%). 55(14.4%) were house wife. Majority of them 117(46.5%) were farmers, 59(15.5%) were traders, 47(12.3) students, 33(8,7%) civil servant, 10(2.6%) were of other occupation. Majority of the respondents 321(84.3%) were Muslims, 51(13.4%) were Christians.

Table 2: Utilization of Primary Health Care Facilities

Question	Frequency	Percent
When was the last time you took ill?		
This year	318	83.5
Last year	41	10.8
Two years back	19	5
More than 5 years back	3	0.8
Total	381	100.0
Were you in Akaleri local government area when you took ill?		
Yes	330	86.6
No	51	13.4
Total	381	100.0
If yes to question above where did you receive medical care during the last episode of illness		
General Hospital	30	9.1
Primary health care centre	112	33.9
Private Hospital	16	5.5
Traditional healer	90	27.3
Church/prayer house	71	21.5
Others	9	2.7
Total	330	100.0
How many times have attended primary health care centre located in your area?		
1-2 times	146	38.3
3-4 times	121	31.3
5 and above	89	23.4
None	25	6.6
Total	381	100.0
Supposing you are in need of health services like treatment of malaria, headache, routine immunization, child delivery will you use the primary health care facility in your area?		
Yes	262	68.8
No	119	31.2
Total	381	100.0
If yes to question above why do you prefer to use the primary health care facility in your area? (n=262)		
Better care services	63	24.0
Availability of skill health personal	64	32.1

Good patient staff relationship	55	21.0
Shorter distance from my house	60	22.9
Total	262	100.0
If no to the question above where did you prefer to seek for health care services? (n=119)		
Traditional healers	64	53.8
Prayer house	37	31.1
Home	14	11.8
Others	4	3.4
Total	119	100.0
Why do you prefer to seek for health care services in the place of choice in question 14 above? (n=119)		
Services are not expensive	32	26.9
Shorter waiting time before you are attended to.	23	19.3
I prefer the prayer house for spiritual reasons	32	26.9
I don't believe in modern health care facilities	22	18.5
Others	10	8.4
Total	119	100.0

Table 2: shows that large percentage of the respondents 318(83.5%) took ill this year, 41(10.8%) last year, 19(5.0%) two years back, and 3(0.8%) more than 5 years back. 330(86.6%) were in Alkaleri when they took ill and 51(13.4%) were not in Alkaleri when they took ill. 30(9.1%) receive medical care from General Hospital, 112(33.9%) receive care from Primary health care centre, 16(5.5%) from private hospital, 90(27.3%) from traditional healer, 71(21.5%) from church/prayer house, 9(3.2%) receive medical care from other sources. Majority of the respondents 146(38.3%) had attended the primary health care centre 1-2 times, 121(31.3%) 3-4 times, 89(23.4%) 5 times and above While the least of the respondents 25(6.6%) had never attended the primary health care centre. Most of the respondents 262(68.8%) agreed that they will utilize the primary health care facility when the need arise and 119(31.2%) said they will not utilize the primary health care facility. Most of them 63(24%) prefer to use the primary health care facility because of better care services, 64(32.1%) because of availability of skill health personal, 55(21.0%) good patient staff relationship and 60(22.9%) shorter distance from their house. 64(53.8%) prefer to seek for health care service from traditional healers, 37(31.1%) from prayer house, 14(11.8%) from home and 4(3.4%) from other sources. 32(26.9%) prefer health care service from either traditional healers, prayer house or home because services are not expensive, 23(19.3) shorter waiting time before you are attended to, 32(26.9%) prefer prayer house for spiritual reasons, 22(18.5%) don't believe in modern health facilities, 10(8.4%) for other reasons.

Table 3: Determinants of Health Facilities Utilization

Item	Frequency	Percent
Traditional healers give better care services than hospital /primary health care centre		
Strongly agree	71	18.6
Agree	13	3.4
Undecided	21	5.5
Disagree	138	36.2
Strongly disagree	138	36.2
Total	381	100.0
the church or prayer house gives better health care service because they can handle or conduct spiritual deliverance		
Strongly agree	113	29.7
Agree	27	7.1
Undecided	31	8.1
Disagree	174	45.7

Strongly disagree	36	9.4
Total	381	100.0
there is no need to use health care facilities/centre except a sick person is prone to complication		
Strongly agree	102	26.8
Agree	68	17.8
Undecided	67	17.6
Disagree	133	34.9
Strongly disagree	11	2.9
Total	381	100.0
The health facility is too far from my house		
Strongly agree	210	55.1
Agree	31	8.1
Undecided	33	8.7
Disagree	59	15.5
Strongly disagree	48	12.6
Total	381	100.0
Means of transportation to health care centre is difficult.		
Strongly agree	179	47.0
Agree	54	14.2
Undecided	51	13.4
Disagree	75	19.7
Strongly disagree	22	5.8
Total	381	100.0
Drugs are not always available in the health facility		
Strongly agree	191	50.1
Agree	121	31.8
Undecided	37	9.7
Disagree	16	4.2
Strongly disagree	16	4.2
Total	381	100.0
Materials and equipment for laboratory investigation are not readily available in the health facility		
Strongly agree	176	46.2
Agree	87	22.8
Undecided	47	12.3
Disagree	58	15.2
Strongly disagree	13	3.4
Total	381	100.0
Cost of care is very high hence discourages me from using the primary health care facility		
Strongly agree	89	23.4
Agree	98	25.7
Undecided	73	19.2
Disagree	79	20.7
Strongly disagree	42	11.0
Total	381	100.0
the unfriendly attitude of health care providers to patients discourages me from using these services		
Strongly agree	38	10.0
Agree	140	36.7
Undecided	39	10.2

Disagree	131	34.4
Strongly disagree	33	8.7
Total	381	100.0
health care provider -client interaction in the health care is very poor		
Strongly agree	231	60.6
Agree	94	24.7
Undecided	20	5.2
Disagree	27	7.1
Strongly disagree	9	2.4
Total	381	100.0
health provider in the healthcare centre are not patient to listen to clients complain or properly explain information during consultation		
Strongly agree	97	25.5
Agree	124	32.2
Undecided	47	12.3
Disagree	62	16.3
Strongly disagree	51	13.4
Total	381	100.0
Long waiting hours to see the doctor and nurses discourage me from using the health facility		
Strongly agree	169	44.4
Agree	98	25.7
Undecided	53	13.9
Disagree	44	11.5
Strongly disagree	17	4.5
Total	381	10.0
primary healthcare centre is meant for the poor and low class people in the community		
Strongly agree	98	25.7
Agree	84	22.0
Undecided	73	19.2
Disagree	102	26.6
Strongly disagree	24	6.3
Total	381	100.0
Diseases of natural causes are best treated in the primary healthcare facility		
Strongly agree	199	31.2
Agree	125	32.8
Undecided	44	11.5
Disagree	25	6.6
Strongly disagree	68	17.8
Total	381	10.0
Diseases of spiritual causes are best managed by the traditional healers and religious healers		
Strongly agree	215	56.4
Agree	94	24.7
Undecided	28	7.3
Disagree	42	11.0
Strongly disagree	2	0.5
Total	381	100.0
acute disorder are best treated in the primary healthcare facility		
Strongly agree	78	20.5

Agree	71	18.6
Undecided	72	18.9
Disagree	120	31.5
Strongly disagree	39	10.2
Total	381	100.0
Chronic disorders are best managed by the traditional healers and religious healers		
Strongly agree	69	18.1
Agree	70	18.4
Undecided	101	26.5
Disagree	123	32.3
Strongly disagree	18	4.7
Total	381	100.0

The data in table 3: Indicates that 71(18.6%) of the respondents strongly agree(SA) that traditional healers give better care services than hospital, 13(3.4%) agree(A), 21(5.5%) were undecided(U), 138(36.2%) disagree(D) and 138(36.6%) strongly disagree(SD). 113(29.7%) strongly agree(SA) that church or prayer house gives better health care, 27(7.1%) A, 31(8.1%) U, 174(45.7%) D and 36(9.4%) SD. About 102(26.8%) strongly agree (SA) that there is no need to use health care facility except a sick person is prone to complication, 68(17.8%) A, 67(17.6%) U, 133(34.9%) D and 11(2.9%) SD. Most of the respondents 210(55.1%) strongly agree that the health facility is too far from their house, 31(8.1%) A, 33(8.7%) U, 59(15.5%) D and 48(12.6%) SD. 179(47.0%) strongly agree that means of transportation to the health care is difficult, 54(14.2%) A, 51(13.4%) U, 75(19.7%) D and 22(5.8%) SD. 191(50.1%) Strongly agree (SA) that drugs are not always available in the health facility, 121(31.8%) A, 37(9.7%) U, 16(4.2%) D and 16(4.2%) SD. 176(46.2%) Strongly agree (SA) that materials and equipment for laboratory investigation are not readily available in the health facility, 87(22.8%) A, 47(12.3%) U, 58(15.2%) D and 13(3.4%) SD. 89(23.4%) Strongly agree that cost of care is very high, 98(25.7%) A, 73(19.2%) U, 79(20.7%) D and 42(11.0%) SD. 38(10.0%) Strongly agree unfriendly attitude of health care providers discourage them from using the services, 140(36.7%) A, 39(10.2%) U, 131(34.4%) D and 33(8.7%) SD. 231(60.6%) Strongly agree health care provider-client interaction in the health care is very poor, 94(24.7%) A, 20(5.2%) U, 20(5.2%) D and 27(7.1%) SD. 97(25.5%) Strongly agree health care providers are not patient to listen to client complain, 124(32.2%) A, 47(12.3%) U, 62(16.3%) and 51(13.4%) SD. 169(44.4%) Strongly agree that long waiting hours to see the doctor and nurses discourage them from using the health facility, 98(25.7%) A, 53(13.9%) U, 44(11.5%) D and 17(4.5%) SD. 98(25.7%) Strongly agree primary healthcare centre is meant for the poor, 84(22.0%) A, 73(19.2%) U, 102(26.6%) D and 24(6.3%) SD. 199(31.2%) Strongly agree that diseases of natural causes are best treated in primary health care facility, 125(32.8%) A, 44(11.5%) U, 25(6.6%) D and 68(17.8%) SD. 215(56.4%) Strongly agree diseases of spiritual causes are best managed by traditional healers, 94(24.7%) A, 28(7.3%) U, 42(11.0%) D and 2(0.5%) SD. 78(20.5%) Strongly agree that acute disorders are best treated in the primary healthcare facility, 71(18.6%) A, 72(18.9%) U, 120(31.5%) D and 39(10.2%) SD. 69(18.1%) Strongly agree that chronic disorders are best managed by traditional healers, 70(18.4%) A, 101(26.5%) U, 123(32.3%) D and 18(4.7%) SD.

DISCUSSION OF FINDINGS

The analysis revealed that greater percentage of respondents 318(83.5%) took ill within the year under investigation of which most of them 330(86.6%) were in Alkaleri Local Government Area when they took ill; however only 112(33.9%) received medical care from Primary health care centers. This seemingly low level of utilization is in consonant with a study conducted in South-Eastern Nigeria, by Uzochukwu and Ohwujike (2004) which reported that private health facilities were the initial point of call for majority of the respondents. Furthermore, low rates of utilization of PHC facilities was also reported in some rural communities in Africa, for example literatures from rural areas of Orange Free State in South Africa and Changwe district of Zambia had shown rates of 37% and 42.8% respectively (Hazemba and Siziya, 2009). The under utilization may possibly be as a result of expensive services, longer waiting time before they are attended to, spiritual reasons and lack of

believe in orthodox medicine. Although it is clear from the analysis that a great majority 262(68.8%) of the respondents were willing to use PHC centers subsequently, however it can be deduced that one plausible reason aside from availability of skill health personnel's, may not be because the PHC centers are meeting the community's health needs but simply because poorer households are encouraged to attend PHC centers because of the free products dispensed during the visits, e.g. ITNs, iron supplements, and malaria prophylaxis tablets. The free distribution of these products recently introduced by the government may have served as a strong incentive to utilization for low income households, who cannot easily afford to purchase them on the private market.

One other determinant that shows a contributory effect on the utilization is the perception of the respondents toward the causes of diseases. Majority of the respondents were of the opinion that diseases of natural causes are best treated at the orthodox health care centers and diseases of spiritual causes should be treated by the traditional healers. This findings is in consonants with the report of Kyomuhendo (2003), Mrisho et al (2007) in Tanzania and Amoti-Kugana (2000) in Uganda; in their studies on the impact of women's status, traditional beliefs and limited resources which revealed that majority of respondents prefer to seek for cure and health care services at the traditional healers and prayer houses because of their ability to approach the services holistically. Other factors that were found to affect the utilization of PHC facilities in the area include: proximity of the people to the health care centers, non-availability of drugs and laboratory equipments, high cost of care, long waiting time and poor health care provider-client interaction. This finding is partly in consonant with what was obtainable in Uganda and Nigeria (Khalid, Daniel and Lale, 2006, Bakeera, 2009, Moore, Alex-Hart and George 2011). Bakeera pointed out that, inadequacy of health services, unprofessional approaches of health care providers, lack of supplies and equipments, lack of trust in the health worker qualifications and demand for unofficial fees are some of the factors that hamper the patronage of PHC facilities. Sahm (2008) in Tanzania also synchronized that the quality of medical care in terms of technical efficiency as proxied by availability of drugs has been cited as a key determinants of demand for health care.

CONCLUSION

In view of the finding from this study it is evident that there is a gross underutilization of PHC facilities in this locality and this is predisposed by proximity to the health center, unavailability of drugs and other medical equipments, negative attitude of health care providers, poor socio-economic background in the presence of rising cost and preference of traditional healing to orthodox medical care in managing some diseases conditions.

Recommendations

Based on the findings, the following recommendations were made:

- 1) There is the dere need for the Local government as well as all the other tiers of government to increase their allocation to the health sector. Local governments on the other hand should be more inward-looking and aggressive in the area of internally-generated revenue. This will reduce the dependence on the federation account in financing health programmes.
- 2) Priority should be given to improved living condition of the people beyond the present poverty level, so as to enhance better healthy living. To this end, intensive and effective health education of the public must be of necessity and reinforced their willingness to patronize PHC centers in other to eliminate such diseases as malaria, typhoid and other infectious diseases.
- 3) Drug Revolving Fund Scheme (DRFS) should be instituted and implemented under the supervision of competent chairmen from the communities. This will ensure availability of subsidized drugs and other medical equipments
- 4) Poor leadership and political instability have been the basis for unsuccessful implementation of most government policies and programmes on health care delivery. Therefore, good leadership and political stability is desirable to provide enabling environment for the implementation of the PHC programmes. This will invariably reduce the problem of abandoned projects in the health sector.

- 5) There is the need to put a stop to unnecessary responsibilities being given to LGA's by the state governments. It is a common occurrence for federal and state governments to shift part of their responsibilities to LGA, such as purchase of nonfunctioning generator, fridges, ice liners and solar fridges and imposition of sponsored programmes. All these are drains on the lean purse of the local governments with its attendant effects on health services delivery.
- 6) Adequate supervision, monitoring and evaluation of programmes should be pursued with vigor and required manpower provided. The Nigerian health policy makers should give priority to the training of more rural health workers. This is to prevent the drift of rural health workers from the rural communities to the urban centers.
- 7) Establishment of PHC centers should be based on need and not political motivation.

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