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Full Length Research Paper

Challenges in accessing primary health care services for rural communities in Jigawa State, Nigeria

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In Jigawa state urban settlement pattern exhibit discrete format, while the rural setting is made up of settlements units of individual distinct villages. They have basic welfare facilities like markets, hospitals, schools and other social facilities located in them. This study examines and explains how accessibility problems affect level of utilization of the primary health care system (as measured the location hospitals) in Jigawa state. The result revealed that distribution of primary health care centres and facilities is not homogeneous because of political policy and so their location does offer equal access or uniform benefit to the rural people. It was also found out that few settlements have primary health centres and cottage hospitals located in them and they are poorly connected by road. And so, the number of people utilizing the primary health care centers and facilities declines because of the increasing distance between their places of residences and points were they obtain health services. Other reasons which have contributed to low level of utilization are user fees for services, cost of transport, non-availability of drugs, lack of good doctors and qualified nurses, long waiting time for treatment. All these encouraged people to go for options provided by traditional orthodox. It was recommended that there should be improvement in the location of primary health care centres and good roads should be constructed to link all health facilities.

Keywords: primary health care, settlement, rural people, Jigawa state

INTRODUCTION

Accessibility is defined as the ease with which a specific location can be reached from a given point, (Lowe and Moryada, 1975; Chapman, 1979 and Ingram, 1971). It has physical (spatial), time, economic and social dimensions. The physical dimension deals with road conditions, where as time dimensions refers to the time spent on a journey, the economic dimension talks about the finance, i.e. money spent on a journey and the social dimension considers the norms and values of the people, as it determines the use of particular item or a point located facility.

The facilitator of accessibility in any region or place is the transport that serves as the medium by which movement is made possible. It therefore, plays a vital role in the transfer of people to places of demand and as such it aid the patronage and utilization of basic welfare facilities, thereby, bringing changes in the use of such a facility. Hagget, et al 1955 and 1977; Jones, 1976, Kirby 1971 and 1979; Egunjobi 1979; Nutley 1980 and 1984(a) and (b), Ikporukpo and Kayode, 1995. The third National Development Plan, Nigeria also supported this by saying "the basic objective of the government in the field of transport is to develop, to move people and goods in response to public private demand at the lowest cost...." (3rd NDP: 1975-80).

But for over twenty years of organized effort by the government of Jigawa state, Nigeria at setting up modern

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primary health care centres which will address health problems. People still talk about bias in the distribution of the primary centres and nature of roads connecting them. More so there are serious complains on the access to their services and on the poor services rendered to people. There are also problems of introduction of user fees for services provided, the unfriendly openings hours, poor skill of other staff and the absence of drugs. The poor operation methods of commercial vehicles are also a contributing factor. The gap identified and that is worth studying relates to the spatial spread of primary health centres and to explain how accessibilities problems affects the level of utilization of the health facilities in Jigawa state. Figuure I, is showing the spatial distribution of primary health facilities in Jigawa state,Nigeria. This study is divided into four sections, section one is introduction and research problem, section two is the methodology, section three deals with the interpretation of result and section four is the conclusion.

Study area

Jigawa state was created out from Kano state in 1991, located between logitude7 6"W and 9 8" E and latitude 13 2 N and12 8 S, in the Northern part of Nigeria and has the characteristics of Sudan savannah regions,(administrative map of Nigeria scale 1: 2,000,000). It is bounded in the north by Niger republic, in the north east by Yobe state, in the south east by Bauchi state and in the West by Katsina and Kano, see fig.1. For a map of Jigawa state showing the local government areas and the distribution primary health care centres (as measured by the location of hospitals). The Southern part of the state is relatively more developed and densely populated than the Northern part. It is also more physically and functionally linked to Kano state. The Northern part is more physically sparse, characterized by underdeveloped transportations and communications links.

Administratively, Jigawa state is made up of twenty-seven (27) Local Government Areas and Dutse is the state capital. It has five emirates, each administered by a tradition ruler called Emir, they are: Kazaure, Dutse, Gumel, Hadejia and Ringim, which together have an estimated populations of 4, 348,649 people (N.P.C. 2006).

METHODOLOGY

The primary and secondary methods were used to obtain information for this study. In the primary method questionnaires were used to collect data from respondents who make use of the primary health centres or facilities. Jigawa state administration map on scale of 1:500,000 were used to select the first seventeen Local Government Areas, represent 62.9%, using their population in descending order. The ministry of health was also visited to collect information on types, location, facilities and staffing of the hospitals.

The house listing list was obtained from national population commission was used to select houses and the purposive sampling method was used to select responding household heads. The author and eight trained assistants directly interviewed those who agreed to be interviewed in their houses. Generally, respondents were asked to provide answers to questions on utilization of primary health care centers and facilities. The type of questions asked, covered suitability of the location of health facility, availability of equipment and cost of using them, prompt availability of service, availability of drugs, preference for using a health centre, distance and cost of trip, affordability and availability of options. The responses were summarized, tabulated and explained using the percentage method. This method was adopted from a similar studies conducted in Lagos state by Federal Office of Statistics on patronage of hospitals, in 1999 and by Bok et al, (1999) in their study on situation assessment and analysis of the state of health system in Kaduna. In this study one percent of the population representing a total of forty three thousand four hundred and eighty-six were people were interviewed in Jigawa state. This means that one thousand six hundred and ten respondents were directly interviewed at home by trained research assistants in each local government area. The result obtained is used for analysis and the result is presented below.

INTERPRETATION OF RESULT

Distribution of Health Institutions in Jigawa State:

This study found out that primary health centres (as measured location of hospitals) are grouped in five zones, namely, Hadejia, Gumel, Kudu, Jahun and Kazaure, to enable effective control and management. In each zone, there is a general or specialist hospital and other categories of health centres including either cottage hospital or the primary health care centre. Added to these are the private hospitals, the clinics and patient medical stores, which were not covered in this study. Table 1, shows location, staffing and number of beds in the general hospitals and table 2 presents information on the cottage hospitals, while table 3 presents the sub-classification of primary health care centres in Jigawa state.

The general hospitals are managed by the state government and are located in the local government headquarters. They provide both preventive and major curative service and also the specialized curative rehabilitative and reconstructive services.

Table 1. Distribution of General Hospitals

Names of the Cottage Hospital	Location	Staff Strength	No. Of Bed
General Hospital, Birnin Kudu	Birnin Kudu	88	160
General Hospital, Dutse	Dutse	114	180
General Hospital, Hadejia	Hadejia	98	145
General Hospital, Kazaure	Kazaure	62	120
General Hospital, Jahun	Jahun	56	108
General Hospital, Babura	Babura	34	68
Total		556	961

Source: Fieldwork: 2005

Table 2. Shows the Characteristics of Cottage Hospital in Jigawa State

Name of the Cottage Hospital	Location	Staff Strength	No. Of Bed
Cottage Hospital, Gwaram	Gwaram	38	50
Cottage Hospita, Ringim	Ringim	21	40
Cottage Hospital, Birniwa	Birniwa	18	30
Cottage Hospital, Bulanga	Bulanga	18	36
Cottage Hospital, K/Hausa	K/Hausa	32	20
Total		127	170

Source: Fieldwork: 2005

Table 3. Shows Distribution of Primary Health Facilities by Type and Location in Jigawa State

General Hospital and their location	Cottage Hospital and their Location	Primary Health Centre and their Location
Hadeji	Gwaram	Garki
Birnin Kudu	Birniwa	Basirki
Gwaram	Kafin Hausa	Old Gwaram
Kazaure	Ringim	Maitagari
Jahun	Kiyawa	Roni
Babura	-	-
Dutse	-	-

Source: Fieldwork: 2005

The cottage hospitals and the primary health centres are managed by state government. They provide basic preventive and health promotion services as well as simple curative services. Specifically, this includes health education, immunization and management of simple malaria, diarrhoea and teaches nutrition. The result reveals that cottage hospitals provide upgraded services to people than the primary health centres in Jigawa state.

It was found out that the primary health centers are managed by the local government councils; they are sometimes assisted by multinational organizations with drugs and equipments. It was also found out that increase in demand for health care and the problems of accessibility (physical and economic dimensions), have encouraged the active involvement of community based organizations and private individuals in provision of health services. This is appearing in the establishment of more private hospitals and pharmaceutical chemists in urban areas and their branches in rural areas.

Six different types of treatments for ill health persons were identified out of which three are standard and the others are discretional. The level of utilization of these treatment methods are affected by income of people, types and nature of services, distance travelled and cost of the services rendered. They are:

1) Government hospital treatment
   a. General hospital
   b. Cottage hospital
   c. Primary health centres
2) Treatment from private hospital
3) Self medication
4) Use of chemist or patent medicine stores
5) Traditional medication
6) Did nothing

Private hospital in this work refers to places owned by individuals to render health services with intention of

Table 4. Determinants of utilization of Health Facility

S.No	Determinants	Frequency	Percentage
1	Distance to service place	4943	11.1
2	Income of respondent	4259	9.5
3	Prompt Availability of service	3631	8.1
4	Non-availability of drugs	5432	12.2
5	Lack of good doctors/ other staff	4322	9.6
6	Cost of transport	4618	10.3
7	Payment for service rendered	5132	11.4
8	Affordability of service rendered	2625	5.9
9	Long waiting hours	5269	11.7
10	Time spent on trips to hospital	4401	9.8
	Total	44659	99.6

Source: Fieldwork 2005. The total figures for frequency appears to be large because some responded tick more than once

making profit. The amount of fees charged varies with the type of sickness. They are mostly located in towns or urban areas, but of recent the proprietors' are establishing branches in rural areas.

This category is closely followed by the chemist or pharmaceutical or patent medicine stores, individually or jointly owned and is purely for profit making. It is normally a one or two room's kind of treatment place that does not admit but rather offer immediate onsite treatment in the form of drugs and injection. Another treatment method is the self-medication where an individual buys non-prescribed drug from a chemist or any other source to affect cure on himself or others. The last is where a sick person is refused or refuses himself any form of medication voluntarily due to prevailing cash flow problems or beliefs.

Table 3 shows the distributions of primary health facilities by type and places of location in Jigawa state. It could be inferred from the table that location of primary health care centres is bias in favour of local government headquarters and or few settlements. The reasons for this include political agenda and preference for locating in urban areas due to availability of basic welfare facilities. The result shows that only few settlements (Garki, Basirka, Old-Gwaram, Maigatari and Roni), have primary health care centres located in them. Others like Birniwa, Kafin-Hausa, Ringim and Kiyawa have cottage hospitals. This settlements exhibit poor road connectivity and the location pattern does not offer equal or uniform access due to poor physical and low economic accessibility, meaning that it has negative effects on the level of utilization of health facilities. Added to these the rural areas where primary health centres are located have poor welfare facilities. It was also revealed that people in these areas are left with the primary health centres which lack bed space, have low and unskilled staff strength and the also lack equipment and drugs. It was found out that the payment for every services obtained, distance traveled and personal low income levels is forcing people to go for other options, which are found in the traditional orthodox healings.

In this study rural settlements which have primary health centres were categorized into three. They are (a) rural settlements which have primary health centres and are connected with road (b) rural settlements which do not have primary health centres but are not connected by road and (c) rural settlement which do not have primary health centres and are not connected by road. The results shows 119km as the total distance traveled to get to the primary health centres for the 37 households interviewed in the first category. This means that the mean distance to reach the health centers for houses in the first category is 3.2km. The total distance for settlements that do not have primary health centres but are connected by road is 213km and the mean distance is 5.7km. Whereas those settlements which do not primary health centres and are not connected by road have a total of 389km, covering a mean distance of 10.5km before reaching the health facility.

The results obtained shows that respondents in category (c) cover more distance to obtain health services. It means the number of people using primary health care centers decline as distance increase from their places of residence or towns. While level of utilization of the primary health facilities reduces as a result of distance and cost of transport, the payment for services introduced, long waiting time hours for doctors or treatment. Others reasons includes, lack of qualified doctors, nurses and drugs. Fig 4, present summarises the responses of those interviewed in Jigawa state, Nigeria.

The results revealed that 12.2% of the respondents complained of non-availability of drugs, 10.3% reported that of cost of transport, 11.1% claimed of distance, 11.4% complained on the payment of services rendered and 11.7% talked about the long waiting hours for doctors and services. This is substantiated by the fact that only 5.9% of the people interviewed can instantly afford the services rendered by the hospitals. Generally, these results on table 4, revealed that all the factors have good

fit with the exception of affordability of services. It could be interpreted to mean that accessibility problems have reduced the utilization of primary health centers and facilities in Jigawa state, Nigeria.

CONCLUSION

In Jigawa state, Nigeria, primary health care centres are unevenly distributed and the reasons responsible for these include political policy and the desire to locate in urban areas. Three types of health institutions (general or specialized, cottage and primary health care centres) provide services to the people and six different treatment methods were identified. Reasons like cost of transportation and low income level, distance, user fees, cost and non-availability of drugs were considered as factors of poor accessibility which have affected the utilization of the primary health facilities in Jigawa state, Nigeria. It was recommended that more roads should be constructed to link primary health care centres at desirable points and there should be improvement in the location and distribution of new health care centres in Jigawa state, Nigeria.

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