Primary Healthcare and Rural Development in Dekina Local Government Area of Kogi State

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Abstract
The ultimate goal of primary healthcare as envisaged in Alma-Atta Russia in 1978 is to guarantee sustainable livelihood for families and communities by achieving the highest level of health and the least level of inequality. This is in conformity with the needs of rural Nigeria consigned to socio-economic and political squalor against the backdrop of a relatively urban squander in Nigeria. This paper is an attempt to elucidate the in-built symbiotic relationship between the PHC (aims and goals) and the rural communities (needs) in Nigeria as well as the obvious constraints of the PHC in selected rural communities in Dekina Local Government. This study is heavily relied on secondary data across health and development literature corroborated by a qualitative primary data. The primary data was collected from 11 randomly sampled rural communities and the management of the Department of Health, Dekina Local Government using the in-depth Interview Guide (IIG). The data was collated and analyzed by the use of content analysis. Findings of the study reveals an in-built symbiotic relationship between the PHC and rural communities in Nigeria but the goal of development through the PHC is constrained by poor human resource for PHC both in qualitative and quantitative terms, administrative lapses by government, and ignorance on the part of the rural citizens. Recommendations generated from these findings include: in-service training and capacity building for health workers by government and non-governmental organizations, re-introduction of the drug revolving scheme by the Federal Ministry of Health, enhanced monitoring and supervision by health management officials and intensive health education for rural citizens using the Behaviour change communication (BCC) strategy.

Key words: Health; Primary healthcare; Rural; Rural poverty; Development and rural development.

INTRODUCTION
Rural areas in Nigeria continue to yearn for sustainable development as a result of the dualism that inadvertently characterizes the Nigerian geo-political space. The word “rural” means different things to different people. According to the National Bureau of Statistics NBS (2009), the American Bureau of Census classifies a group of people living in a community having a population of not more than 2,500 people as rural, whereas in Nigeria, the Federal Office of Statistics defines a community with less than 20,000 people rural. In addition to demographic features, Afolayan (2005) posits that other marks of rural identity are: level of infrastructural development (water, sanitation, electricity, health facility, communication and road network), occupational differentiation (characterized by subsistence agriculture) housing (the one that conforms to human health standard), etc.. Against the backdrop of several rural development policies and programmes in Nigeria, Ijere (1999) and Ball (2007) posits that rural areas is another Nigeria characterized by poverty linked characteristics which include illiteracy, low income, superstition, poor family planning, high morbidity and mortality especially for women and children, extended family and caste system often with cultural underpinnings (Afolayan, 2005). The statement is further reinforced by Ekwureke (2005) who avers that
rural/remote dwellers have higher morbidity and mortality rates than urban dwellers, and restricted access to health Services. The report also added that access is impeded by limited availability of services, higher costs of services, workforce shortages and transport problems, coupled with a disintegrating rural infrastructure. The level of development of any society whether rural or urban is inextricably contingent on the health status of the people; lending weight to the popular aphorism that “health is wealth”.

The failure of several rural development policies in Nigeria to achieve set objectives clearly show that the challenge of rural transformation is multifaceted and multi dimensional in nature and requires a multidisciplinary and multi-sectoral intervention. The adoption of the Primary Health Care by the Federal Government of Nigeria in 1987 was in tandem with the basic requisites for sustainable rural transformation in consideration of its egalitarian, integrated, collaborative and above all bottom-top approach to development. Hence, (WHO / UNICEF 1976) defined primary health care as the health approach which integrate at community level, all the elements necessary to make an impact upon the health status of the people, an approach which is an integral part of the national health care system, which takes in to account the fundamental human needs necessary to improve living condition of individuals, families and communities. These needs according to Alakija (2007) include preventive, promotive, curative and rehabilitative health measures and community development activities. Health care in this regard is not an end in itself but a means to greater social end expressed as both means and goal of development. It is defined as not just an output of socio-economic development but more importantly an input for socio economic transformation.

The nexus between health and other indices of development can never be over emphasized. First, the Ottawa Charter for Health Promotion held in Ottawa Cannada in 1986, declares: “The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity”. On the other side of the coin, the ultimate goal of peace, social justice, stable eco-system, shelter, education, food and income overtly manifest in a state of complete physical, social and mental well-being of the citizenry. The current health policy of Nigeria is embodied in the National Health Policy and Strategy to achieve health for all Nigerians, introduced in 1988 and subsequently revised in 2004 was founded on egalitarian principles. The policy seeks to improve the health of all Nigerians by devising a sustainable health system based on primary healthcare (PHC), that is promotive, protective, preventive, restorative and rehabilitative and which will ensure a socially and economic productive and fulfilling life to every individual (FMOH, 2008).

1. STATEMENT OF THE RESEARCH PROBLEM

Akinyele (2009) reports that about 70% of the people of Nigeria live in rural areas. Unfortunately, sustainable development continues to be elusive to this teeming population owing to the failure of several rural transformation programmes. The challenge of Rural transformation is multifaceted and multi dimensional yearning for a multidisciplinary approach. The introduction Primary Healthcare for the people of the world aims at promoting the highest level of health and the least difference in health status are the hallmark of development in human populations. It takes in to account the fundamental needs necessary to improve living conditions of individuals families and communities. In view of this vision, it is expected that the PHC will serve as the antidote for the resilient rural squalor and underdevelopment through its liberal, integrated and collaborative approach to development. However, after three decades of primary health care in Nigeria, development literature has revealed that the rural development problem remains undaunted manifesting extant lack of social amenities- safe water, road, sanitation, housing, medical services but high level of ignorance, superstition, malnutrition, fertility, as well as morbidity and mortality mostly among women and children (UNICEF, 2007; Ball 2007).

The NDHS (2008) also reveals that more than half of the population live in severe deprivation with many households being food insecure and unable to meet other basic needs of life. Similarly, UNICEF (2010) reveals that a survey of 25 rural communities in Nigeria by Water Aid shows that only 25% of the rural population have access to safe drinking water while 5% have improved sanitation. These reports are not unconnected with the nation’s reported low Human Development Index (HID) owing the teeming but deprived rural nature of her population. The overt manifestations of these are the high infant, child and maternal morbidity and mortality which is rated second highest in the world (UNICEF, 2012, CIA, 2013), and the general decline in life expectancy. On the other side of the coin, the PHC requires the support of the benfitting communities to deliver its goods which aim at transforming the lives of individuals, families and communities. The relationship between lack of social services and poor health outcome on one side and poor health outcome and underdevelopment on the other side abounds in literature. The unyielding poor standard of living of the rural dwellers as reported above inevitably calls for a scientific enquiry in to the activities and performances of the PHC in Nigeria’s rural communities. This study is therefore, moved to probe in to the contents and approach of primary healthcare in order to determine whether (a) the PHC has the levers to deliver on mandate; and (b), rural societies are fertile grounds for
the pragmatic application of the theories and principles of primary health care in Nigeria.

1.1 Research Questions
Are there in-built mechanisms in the primary healthcare Scheme that can trigger rural development?
Are there inherent features in rural communities that encourage the success of primary healthcare?
What are the basic constraints of PHC in Dekina Local Government Area?

1.2 Objectives of the Study
The general objective of this study is to investigate the link between Primary Health Care and rural development policies in Nigeria. Specific objectives are as follows:
To examine whether there are in-built mechanisms in the PHC that can trigger rural development.
To highlight the existence of rural features that can lead to the success of the PHC.
To investigate the basic constraints of PHC in Dekina Local Government.

2. CONCEPTUAL CLARIFICATIONS AND LITERATURE REVIEW
This section reviews relevant literature on Primary Healthcare, rural and rural development, community ownership and participation, health education and PHC financing.

2.1 Primary Health Care: A Historical Approach
Alakija (2000), traced the origin of Primary Healthcare back to 1920 in England when lord Dawson reported on “first contact medical care and the promotion of primary health care”. In 1926, the term was used in Britain to denote general practice. Sorungbe (1989) tracing the origin of PHC in Nigeria argues that primary healthcare service became a dream come true for the first time in Nigeria in 1975, when Yakubu Gowon, the then president of Nigeria announced the Basic Health Service Scheme (BHSS) as part of the Third National Development Plan (1975-80). The objectives of the scheme were: to increase the proportion of the population receiving health care from 25 to 60 percent, correct the imbalances in the location and distribution of health institutions and provide the infrastructures for all preventive health programmes such as control of communicable diseases, family health, environmental health, nutrition and others; and establish a health care system best adapted to the local conditions and to the level of health technology. These objectives are in consonance with the present world approach to health equity and development tagged “Primary Healthcare”.

As a global approach to dealing with health problems, the world leaders in 1978, under the auspices of the World Health Summit (WHS) endorsed Primary Healthcare as the means to guarantee health for all people of the world irrespective of color or creed by the year 2000. At the conception stage of Primary Healthcare (PHC), the World Health Organization/United Nations, International Children Emergency Trust Fund (WHO/UNICEF) committee on health policy in 1976 regarded primary healthcare to mean the health approach which integrate at community level, all the element necessary to make an impact upon the health status of the people, an approach which is an integral part of the national health care system, which takes in to account the fundamental human needs necessary to improve living condition of individuals, families and community. These needs include preventive, promotive, curative and rehabilitative health measures and community development activities (Alakija, 2000, p.7).

Primary Healthcare is defined as essentials basic healthcare which is based on practical, scientifically sound and socially acceptable methods and technology which is universally accessible to individuals and families in the community through their full participation and at a cost the community and their country can maintain at every stage of their development in the spirit of self reliance and self determination (FMOH, 1988). The 1978 Alma–Atta declaration on the role and contents of primary health care indicates that it constitutes the fundamental bottom-top strategy for delivering public health to the people at their door steps. As the declaration noted, PHC ‘forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social economic development of the community’. The pre-eminence of the Primary Healthcare system suggests that how the health needs of the population are met and the level of community development largely depends on the overall effectiveness and performance of the Primary Health Care system (FMOH, 2008).

Importantly, the adoption of the PHC coincides with the structural adjustment programme (SAP) which focused on reducing government spending on social infrastructure but encourages community development through self-help. It is therefore community-based and closest to the people. The goal of the National Health Policy (1987) is to bring about a comprehensive health care system, based on primary health care that is promotive, protective, preventive, restorative and rehabilitative to all citizens within the available resources so that individual and communities are assured of productivity, social well-being and enjoyment of living through the instrumentality of the following services, namely: health education; adequate nutrition; safe water and sanitation; reproductive health, including family planning; immunization against five major infectious diseases; provision of essential drugs; and disease control (NDHS, 2004; Gupta, Gauri, & Khemani, 2004; FMOH, 2008).

Primary health care therefore goes beyond the narrow clinics, hospital, or clinical perceptions to include all allied beliefs and practices and technologies that contributes to health and well-being.
In spite of the perceived contributions of the PHC to health and development, critical observers in recent times have argued that the scheme still suffers from inadequate awareness and mass mobilization for increased involvement of the citizenry in PHC activities. Metiboba (2005) observes that till now for instance, a greater proportion of the rural population in many communities does not seem to know what the Primary Healthcare is all about, nor are they aware of the various services under the PHC scheme.

2.2 Rural Development in Nigeria
The word “rural” means different things to different people. The American Bureau of Census classifies a group of people living in a community having a population of not more than 2,500 people as rural, whereas in Nigeria, the Federal Office of Statistics defines a community with less than 20,000 people rural. In addition to population description, Afolayan (1995) posits that other measures of identity are: level of infrastructural development (poor access to water, sanitation, electricity, health facility, communication and road network) occupational differentiation (characterized by subsistence agriculture) housing which is below human health standard etc.. These negative features best describes the rural environment. Unfortunately, UNICEF (2010) contends that, inadequate access to safe drinking water, nutritious food and safe sanitation coupled with poor hygienic services kills and sickens thousands of people especially children everyday and leads to diminished opportunities for thousands more.

William (1993) categorized rural transformation strategies in Nigeria in to three broad folds which are: agricultural development strategy, agricultural extension strategy and community development strategy. Unfortunately, these policies have failed to meet targets. Available data from the National Bureau of Statistics (2003) and the National Demographic Health Survey (NDHS) (2003) reveal that more than half of the Nigerian population, especially women and children, live in severe social deprivation, especially in rural areas with many households being food insecure, with poor access to resources to meet basic needs, resulting in nutritional deficiencies. The incidence of poverty in Nigeria using food-energy intake reveals that: Nationally, the food-energy poverty incidence is higher among the poor totalling 54.7% than the non-poor recorded at 45.3%. When disaggregated by different sectors, food energy poverty incidence was higher among the rural poor given at 63.8% than the rural non-poor which stood at 36.2%. The challenge of access to health care services as reported by the World Bank /FMOH (2007) reveals that in 2005, 80% of households in urban areas were within 5 kilometers of a PHC, compared to 66% in rural areas. The challenges of inadequate staffing and low capacity, equipment, and essential drugs, were consistent among the rural PHCs. This also corroborates the report of Ekwureke (2005) that remote rural dwellers in Nigeria have more illnesses and getting treatment is more difficult.

Aslam (1981) defines the concept of rural development as a process aimed at developing the rural poor, their economy and institutions from a state of stagnation or low productivity equilibrium into dynamic process leading to higher levels of living and better quality of life. Similarly, Schumacher (1983) conceived rural development as “developing the skill of the masses to make them self-reliant through instruction which supplies appropriate and relevant knowledge on the methods of self-help”. These activities are corollary to the aims of Primary Healthcare.

2.3 Primary Healthcare and Rural Development
Primary healthcare as the cornerstone of health policies is imbued with several programmes aimed at ensuring the achievement of stated objectives. It is a bottom-top approach to health and development of shrouded by community participation which takes in to account the norms, values, special needs which guarantee enabling environment for effective healthcare delivery and overall socio-economic transformation of communities. In corroboration, Metiboba (2009) posits that the PHC embodies the basic needs approach, a shift towards the front line of day-day activities carried out within the community using the auxiliary health personal.

2.4 Community Ownership and Participation
The philosophy of PHC was grounded in the idea that the programme is not only community based; for it to be effective, it must function with the ‘full participation’ of the community. The success of Primary health care is therefore shrouded in the practical logic of community participation. The 1978 declaration in Alma-Atta identified community participation as ‘the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their community’s development (World Health Organization [WHO], 1978). Community participation in health is essentially a process whereby people; both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the condition for sustained better health and in supporting empowerment of communities for health development (WHO, 1991).

In corroboration, Metiboba (2012) argues that community participation is premised on the view that people should have a sense of responsibility and control over promoting changes in their health status leading to two desirable outcomes which are: democratic process and a better targeted, more delivered public service.

2.5 Health Education
Health education is a core component of the PHC which serves to increase community people’s knowledge about
the factors responsible for health problems. An increase in the level of knowledge will help them to develop positive attitude towards health matters and this will lead to positive behavior change (Abayomi, 2003). The Federal Ministry of Health (2007) also argues that health education is very important in achieving the objectives of primary health care. The health seeking behavior of any given population is dependent on a wide range of socio-economic and environmental factors which influence knowledge, attitude and practices. In many cases, morbidity and mortality are blamed on ignorance, environmental, and cultural practices, taboos and misconceptions that reduce the scope for independent decision making within the population cumulatively referred to as the social determinants of health (SDOH).

This requires a positive behavior change by creating awareness on health status and other allied health related issues such as unhealthy cultural practices, nutrition, sanitation and hygiene which play significant roles in morbidity, mortality and under development. Lending credence, Inem (2007) argues that health Education is to get the people to realize that health is a community asset essential to economic growth and social progress, to motivate them to make efforts to contribute to improving their own health, and get their cooperation and participation in public health programmes. The ultimate goal of this is the achievement of the inseparable connection between healthy people and wealth creation corollary to development.

2.6 The Bamako Initiative

The Bamako Initiative (BI) was a formal statement adopted by African Health Ministers in 1987 in Bamako Mali to implement strategies designed to increase availability of essential drugs and other healthcare services for Sub-Saharan African countries (Hordon, 1990). Hordon further describes the initiative as the World Health Organization’s / United Nation’s International Children Emergency Fund (WHO / UNICEF) initiative aimed at solving the problems in the financing of primary healthcare. The initiative advocated for the decentralization of decision making as well as encouraged a realistic national drug policies to enhance the availability of essential drugs in primary healthcare centers. To this end, community participation and drug revolving scheme were cited as means for generating revenue for the sustainability of primary healthcare. It was believed that if the primary healthcare can provide enough revenue, accountable to the community, the money will have a multiplier effect on the creation of allied health infrastructures such as education, water and sanitation for disease prevention, health promotion and sustainable well-being. By this connection, the Bamako Initiative aims at generating funds in communities through the sale and administration of drugs relatively higher above the cost price on the basis of consensus agreement of all stakeholders for the sustainability of primary healthcare.

2.7 Primary Healthcare and Rural Societies

Rural areas are structured in to family units with the family heads wielding significant authority over family members. The larger rural community is also integrated through a face-to-face intimate and interpersonal relationship among members. Communal life and adoption of simple but effective technologies to overcome personal and group challenges are predominant (Olayinka, 2007). These features encourage easy mobilization of members to participate in; support and utilize community projects such as the Primary Healthcare Project. In rural societies, heads of families and the extended clan that permeates the communities represent their families in the Council of Elders’ meetings where decisions are taken to regulate and promote the general interest of citizens and to administer the affairs of their communities. They use to play leadership roles in the society and were seen as repositories of wisdom (Olayinka, 2007).

Torimiro, Kolawole, and Adeogun (2005) posits that rural communities in Nigeria constitute the bedrock of the nation’s culture. Hence, the most authentic and unadulterated aspects of the Nigerian culture can only be found in rural areas. At the conception stage of Primary Healthcare (PHC) The World Health Organization/United Nations, International Children Emergency Trust Fund (WHO/UNICEF) committee on health policy in 1976 regarded primary health care to mean the health approach which integrate at community level, all the element necessary to make an impact upon the health status of the people, an approach which is an integral part of the national health care system, which takes in to account the fundamental human needs necessary to improve living condition of individuals, families and community (WHO/UNICEF, 1976). Indigenous medicine is rooted in the cultural gem of the people mostly practiced in the rural areas. The efficacy of traditional medicine can be enhanced using the Primary Health Care approach of health education. Similarly, some of the cultural practices of the people that are deleterious to health mostly prevalent in rural areas can be cushioned through the instrumentality of health education.

2.8 Review of Relevant Theories

This study adopts three theories in triangulation to explain the relationships between Primary Health Care and rural development. These are: the Participation Action Research Model (PAR) the Health Belief Model (HBM) and the Structural Functionalism Theory.

2.9 The Participatory Approach Model

This model is usually associated with Rahman and Unyonyi (Olayemi, 1995). The basic philosophy of this approach according to Rahman (1981) is that a self conscious people, who are currently poor and oppressed will
progressively transform their environment by their praxis. Rahman argues that the two elements of participatory model are: autonomous democratic organization of the people and the restoration and promotion of proper knowledge. He contends that the role of government, NGOs and other professionals are to act as catalysts and to play supporting but not dominating roles. Lending credence, Nyomi (1981) argues that the very notion of participation implies that nothing should be hidden from the people and the major objectives is to empower the poor to self reliance and freedom. PAR places emphasis on the people’s initiative to seek to improve their own conditions in the generation of indigenous knowledge which takes off from their traditional culture and seeks to preserve the physical environment with which they have organic association.

This theory is often criticized for its marginal perception of the rural populace. Rural dwellers are characterized by endemic poverty, associated with illiteracy and ignorance which constrains an individual from initiating and living a live he desires. However, the theory is relevant to this study because it accords recognition to the need for rural transformation and advocating a bottom-top style approach which is the hallmark of true development.

2.10 The Health Belief Model (HBM)

The Health Belief Model (HBM) is one of the most widely used frameworks for trying to understand health behaviour. Developed in the 1950s by Godfrey Hochbaum 1958 and Irwin Rosenstock 1974. The model has been used successfully for many decades to promote health seeking behaviour of the people (Becker, 1974). Health Belief Model is initially encapsulated in four key concepts of perception which are: perceived susceptibility, perceived severity, perceived benefits and perceived barriers. The concepts of cues to action and self efficacy were added to stimulate action. Lending credence, Metiboba (2012) posits that the Health Belief Model articulates the role of culture in disease prevention and health promotion. The perception of the people about the disease is also dependent on the knowledge of the etiology and course of diseases which are a function of their socialization. Unfortunately, rural dwellers are associated with high level illiteracy, ignorance and superstition. In another dimension, the overt perception of susceptibility, severity, barriers and benefits of illness and health behavior differs from one individual to another even in the most culturally homogenous society. This is consequent on the different level of exposure, adaptability and response largely determined by individual biological, psychological and economic factors (Shaibu, 2012).

2.11 Functionalism

Functionalism is the oldest, and still the dominant, theoretical perspective in Sociology and many other Social sciences. The theory is associated with Emile Durkheim 1858-1917 and more recently with Talcott Parsons 1902-1979 (Haralambos & Heald, 2006). Functionalists believes that the theory is based around a number of key concepts. First, society is viewed as a system — a collection of interdependent parts, with a tendency towards equilibrium. Second, there are functional requirements that must be met by a society for its survival and third, phenomena are seen to exist because they serve a function. Third, Functionalists believe that society is held together by social consensus, or cohesion, in which members of the society agree upon, and work together to achieve, what is best for society as a whole.

Functionalism is therefore very relevant to this work because it describes the all important role of benefiting communities in achieving the sustenance of the Primary Health care through their participation. This theory is often criticized for failing to specify the beneficiary of the outcome of social functionality. Hence, critics claim that the perspective justifies the status quo as well as motivates complacency on the part of members of the society. Functionalism does not encourage people to take an active role in changing their social environment, even when such change may benefit them. This is therefore a minus to aims of primary health care which rests on community participation in programme design and implementation.

2.12 The Triangulation Approach

No single theory can effectively account for all variables inherent in a social problem (Metiboba 2012). This is also true of human health and sustainable livelihood especially in marginalized rural settings. A triangulation approach therefore becomes indispensable to absorb the limitation of these theories with the strength of the other.

Using the triangulation approach, the Participatory Action research Model focuses on the people’s initiatives to improve their own conditions in the generation of indigenous knowledge which takes off from their traditional culture and seek to preserve the physical environment with which they have organic association. However, this model is limited by the fact that meaningful and sustainable development in consonance with changing social circumstances can hardly evolve from an illiterate and superstitious population mostly found in rural areas. In the same token, the Health Belief Model with its focus on factors constraining utilization of health services failed to generate the solutions to the problem.

Importantly, functionalism is most appropriate for this study because of its inclination to the contributions of parts to the whole. Structural Functionalism contends that the social importance attached to any part is contingent on its contribution to the success of the whole. The contributions of the PHC to overall wellbeing are evident in the concepts of community ownership and participation, health financing through the drug revolving scheme and health education. These are essential units of
the PHC imbued to give a sense of belonging to the local people; educating and mobilizing them for community development activities that are health relevant. On the part of the rural communities, the rich cultural artifacts, the use of simple technologies and face-to-face interpersonal relationship with rich extended family system are great assets for the success of the PHC. The education component of the PHC aims to gradually nurture the illiterate local people in to an informed group on disease prevention and health promotion through informed decisions. The PHC is therefore a system that is dependent on the contributions and functional adequacy between the government, health program designers and benefiting communities to bring about health equity and sustainable livelihood in human communities. The functional input of these variables both in the PHC and in rural communities are effective drivers of disease prevention and health promotion which are central to primary health care.

2.13 The Research Process
This survey research was conducted in Dekina Local Government area of kogi State Nigeria. Dekina Local Government as found in kogi East Senatorial District of kogi State; share borders with Bassa local government to the North Omala and Ankpa to the South, Ofu to the East and Ajaokuta to the West.

The study utilized both primary and secondary data using theoretical and scientific approaches. The secondary data was sourced from printed materials such as textbooks, Journals, Newspapers and Magazines, etc. as well as internet materials.

The primary data for this study were collected using in-depth interview Guide from the three salient functionaries of the PHC- Health Management Officials, health workers and health committee members. A total number of 11 rural communities representing 20% of 55 functional PHC centers in Dekina Local Government Area were sampled using the simple random approach. Administrative staff of the Health Department, Health workers and community members were purposively recruited for in-depth interview.

2.14 Data presentation and Analysis
Key informants which includes: health management officials, health workers and health committee members from a total of 11 sampled rural communities were interviewed on Key variables of primary health care such as: Community ownership and participation, health education, human resource problems, availability of essential drugs and equipments, health accountability and health education to corroborate the theoretical foundations of this study.

(a) Human resource for health situation
The availability of effective and highly motivated staff is essential for health policy implementation. The management staff were unanimous about extant shortage of health workers on the government pay role.

One of them armed with records had this to say:

Shortage of health workers is one of the major problems besetting the PHC. In fact, we have closed down many centres for want of qualified staff. Another problem is that of lack of motivation as health workers are owed several arrears of salary. Most of the workers also need to update their knowledge about current disease trend as they have remained stagnant in knowledge for so many years. Most of them have been in the service for more than 25 years without updating their knowledge.

(b) Motivation
There is a poor level of staff motivation arising from erratic payment of staff salaries and other emoluments.

One of the management staff reports:

The government is to be blamed for the failure of Primary healthcare programme. the cold commitment of the government to the welfare of health workers is very unfortunate. Health workers are owed several arrears of salaries leading to lack of commitment and motivation. Most health workers engage in other business to make ends meet as a result of non payment of salaries.

(c) Knowledge of ownership and community participation
Knowledge of ownership and community participation are salient issues in Primary Health Care. Regrettably, this study records poor knowledge of ownership and low level of community participation.

A man, member of the health committee, educated, 50 years of age reports:

Primary Health care facilities are cited by the government for the community to own. However, it is very difficult to own anything you don’t have control over. The community has no contribution on how the facility is run. The business is between the health workers and their boss at the Local Government. We virtually do not take part in the decision about the cost of treatment. Our participation is either when the PHC environment is bushy and need to be cleared or when one of the equipments is bad and needs replacement or repair. So it is very impossible to own what you can not decide for.

(d) Level of accountability to the community
The primary healthcare by its contents is expected to be the health business of the community being managed by the health workers and the health committee. They are to be accountable to the community and evolve health mediating projects such as portable water, sanitation services etc. however, in general terms, there seems to be a gap between the expected and observed.

The committee chairman in, one of the sampled communities reports:

The health workers decide unilaterally on drug procurement and service charges. The cost of services is very high that the people cannot afford to pay at all times. We are only contacted when there is a need for equipment to be bought or fixed when damaged but he does not account for the gains accruing from the services. No body can challenge them either from the community or the Local government. We are aware that they make a lot of money from us but the PHC has neither initiated nor contributed to any project of health importance in our
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communities. That is why some people have made up their mind neither to patronize nor support and you can never blame or force them.

(e) Availability of essential drugs and equipments
The Bamako initiative was aimed at overcoming the problem of essential drugs and health financing to ensure sustainability of the PHC for improved standard of living. Majority of health centers visited were in extant lack of essential drugs and laboratory equipments.

One of the health workers reports:

We normally buy drugs when we have patients, most of the equipments such as clinical thermometer and stethoscope are bad and there is no replacement. We also have no laboratory staff and equipments but we can identify diseases quickly whether typhoid, malaria, dysentery measles by their symptoms.

One of the health workers also reports that:

The drugs we use here are not supplied by the government. But the villagers usually want to access services without payment. If you provide services for them on credit, they will fail to pay for the cost of the services, this may delay for months even to outright refusal to pay. Indeed this has caused dangerous conflicts between health workers and community members. In fact, most health centers operate on payment before service or at least partial payment to avoid conflicts.

(f) Health education
Health education is one of the components of Primary Healthcare. It educates members of the community on the basic knowledge of family and personal hygiene, sanitation, family planning, nutrition; and also on the need for community to evolve health mediating services such as portable water, road maintenance and the maintenance of the health facility and equipments. Majority of the health workers in the study area however reveal the level of health education in their areas of influence.

A health worker in one of the sampled reacted in this way:

Health education is part of our job as community health workers. But it is very difficult if not impossible to organize the members of the community to educate them on important issues such as nutrition, family planning, sex education, and sanitation and timely treatment of diseases. In fact most members of the community do not even want to hear about sex education and family planning and mostly engage in commercial agriculture.

DISCUSSION OF FINDINGS
The success of PHC rests on three basic things: community ownership and participation, the availability of essential drugs and other equipments and more importantly, the skill, and resourcefulness of the health worker. Evidence from this study and the larger Nigerian rural society shows that these essentials are grossly lacking.

First, the findings of this study show that rural communities have unwittingly handed over the PHC to the health workers undermining their essential roles and benefits of ownership and participation which have two basic desirable outcomes. First, it ensures the sustainability of the health care delivery system and second, it encourages the initiation of other health mediating social services through informed decisions and accountability. This gap created by poor knowledge of ownership and community participation has led to what most scholars regard as the death of primary health care, and by implication the continued want for infrastructure development and the poor standard of living. This finding is in consonance with Metiboba (2005) who argues that till now, a greater proportion of the rural population in many communities do not seem to know what PHC is all about, nor are they aware of the various services under the PHC scheme.

Second, the sustainability of the PHC is first of all dependent on the quality of services expressed in the availability of essential drugs and equipments. The African health ministers initiative- BI which aims at ensuring the availability of drugs through the drug revolving scheme has been replaced by the personal initiative of the health workers in sampled communities for their own personal gain. Consequently there exist what could be termed as private commercial enterprise in public facilities. The BI aims to generate funds for the community through the sale of drugs above cost to enhance the performance and sustainability of the PHC. The ignorance of the rural dwellers and the craftiness of the health worker have played to consign the rural dwellers to perpetual poverty. This failure has led to the UNICEF (2010) report which reveals that a survey of 25 rural communities in Nigeria by Water Aid shows that only 25% of the rural population have access to safe drinking water while 5% have improved sanitation. The relationship between lack of these essential services is expressed in what most scholars termed as the cyclical nature of poverty. Lack of infrastructures leads to health, poor productivity, under development and poor health.

Third, this study has revealed that the element of democracy in PHC expressed in accountability is grossly non-existent. The PHC is expected to be accountable to the community to ensure the provision of health mediating social services such as portable water, environmental sanitation services, etc. The PHC through the health worker has the mandate of “developing the skill of the masses to make them self-reliant through the instrumentality of the Behaviour Change Communication (BCC) strategy which supply appropriate and relevant knowledge on disease prevention, health promotion and methods of self-help”. However, Klitgaard (1988) argues that opportunities for corruption are greater in situations where the government agent (health worker) has monopoly over his clients, has a great deal of discretion or autonomous authority to make decisions without adequate control on that discretions and there is not enough accountability for that decision or results. Funds
generated from the sale of drugs, are to be used for the growth and sustainability of the PHC as well as to evolve health mediating social services. The overall process of development especially the health mediating services rest on the PHC. Conversely, the extant lack of such social services are favourable conditions for high morbidity, diminishing opportunities, productivity and mortality. This finding lends credence to UNICEF (2010) report which indicates that, inadequate access to safe drinking water nutritious food and safe sanitation coupled with poor hygienic services kills and sickens thousands of people especially children everyday and leads to diminished opportunities for thousands more.

Finally, the most important component of the PHC germane for the achievement of rural transformation is health education. Unfortunately, the seeming shortage of health personnel and low capacity as a result failure to update knowledge to meet up with current trends is a serious omission for the success of the PHC. The health worker is expected to be highly skilful and resourceful in clinical practice as well as social relations. He has the duty to enlighten the rural populace on the health and illness behavior which includes hygiene, sanitation, nutrition education etc, as well as modifying cultural attitudes and practices that are injurious to health, initiating health mediating social services. The poor social relations between the health workers and community members create is a minus on the goals of the PHC. This finding is in consonance with Gupta, Gauri and Khemani (2003) who reported poor availability of human resource for health (HRH) for the delivery of PHC services.

CONCLUSION

This study is an attempt to link Primary Healthcare with the all-important rural transformation through in built elements such as community ownership and participation, health care financing through the drug revolving scheme and health education. On the other side of the coin, rural features such as the high level of family integration and rich cultural values and technologies are fertile grounds for the application of Primary Health Care services. Health care in this regard is not an end in itself but a means to greater social end defined as not just an output of socio-economic development but more importantly an input for socio economic transformation. Unfortunately, these existing rich backgrounds were not transformed in to enhance standard of living for the rural populace. The implications are: rural areas in the near future will continue to be other Nigeria characterized lack of social services (safe water, road, and sanitation); malnutrition, high fertility and general poor standard of living, high incidences of preventable morbidity and mortality and poor health and illness behaviours. This will also aggravate the problem of rural urban migration mostly among the rural working population thereby compounding the problem of urban unemployment and its ancillary challenges.

In general terms, this study has revealed that the PHC and rural societies are symbiotic assets for the sustainability of the PHC and all-round rural development. Unfortunately, the PHC is constrained by low human resource for health capacity both in qualitative and quantitative terms, the government has failed in its responsibility of effective supervision and monitoring of PHC activities. Findings of this study are yet another eye opener on the gap between health policies and policy implementation in Nigeria.

RECOMMENDATIONS

In line with the findings of this study, the following recommendations are indispensable for policy direction.

In-service training opportunities should be provided for PHC health workers by the State and Local Governments as well as regular capacity building on the all important social aspects of their jobs towards enhance knowledge and performance for effective social relations between the health workers and the community members. Similarly, the mass media should educate communities on their rights of ownership and privileges in the Primary Health Care project towards self reliance, sustainability and increased utilization. The Federal and state governments should ensure the re-introduction the drug revolving scheme for availability of essential drugs and prevention of criminal private business by health workers towards quality service delivery. Finally, government and non-governmental organizations should initiate monitoring and evaluation schemes on the activities of the health workers for effective accountability.

REFERENCES


