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Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities

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Quality health is a fundamental right of all Nigerian citizens. While primary health care (PHC) centers are relatively uniformly distributed throughout local government areas (LGAs) in Nigeria, the rural people tend to underuse the basic health services. This article examines some cross cutting issues in PHC and outlines strategies to enhance the utilization of health services by rural people. The responsibility for perpetuating the existing low use of PHC services should be held by PHC policy makers and LGA. Responsible health personnel can build a new social order, based on greater equity and human dignity, in which health for all by the year 2015, including that of rural populations, will no more be a dream but a reality. Capacity building and empowerment of communities through orientation, mobilization and community organization as regards training, information sharing and continuous dialogue, could further enhance the utilization of PHC services by rural populations.

Key words: Healthcare, services, strategies, use, rural.

INTRODUCTION

The goal of primary health care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade. The PHC aims at providing people of the world with the basic health services. Though PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts. About two-thirds of Nigerians reside in rural (http.//www.fao.org/countryprofiles/index.asp) areas therefore they deserve to be served with all the components of PHC.

Primary health care, which is supposed to be the bedrock of the country's health care policy, is currently catering for less than 20% of the potential patients (Gupta et al., 2004). While most PHC facilities are in various state of disrepair, with equipment and infrastructure being either absent or obsolete, the referral system is almost non-existent. 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 individuals and communities are assured of productivity, social well-being and enjoyment of living. The health services, based on PHC, include among other things: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supply and proper nutrition, material and child care, including family planning immunization against the major infectious diseases, prevention and control of locally endemic and epidemic diseases and provision of essential drugs and supplies. The provision of health care at PHC level is largely the responsibility of local governments with the support of state ministries of health

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and within the overall national health policy (Nigeria Constitution, 1999). Private medical practitioners also provide health care at this level. Although PHC was said to have made much progress in the 1980s, its goal of 90% coverage was probably excessively ambitious, especially in view of the economic strains of structural adjustment that permeated the Nigerian economy throughout the late 1980s. But many international donor agencies such as UNICEF, World Health Organization (WHO) and the United States Aids for International Development, (USAID) embraced the programme and participated actively in the design and implementation of programmes at that level (USAID, 1994). At a stage, most of the programmes were donor driven. It was not surprising that at the height of the political crisis in 1993, most of them withdrew their funding and the programme started experiencing hiccups. With the return to democracy in 1999, however, primary health care system deteriorated to an unacceptable level. The availability of basic health services provided by the PHC especially to rural areas in a country might be used as a yardstick to measure the extent of its health level of development. The aim of this article is to describe some strategies which, if implemented, might enhance the proper and timely use of PHC by Nigerian rural populations.

METHODS OF LITERATURE SEARCH

An extensive search of the Pub Med database, Medline and Google Scholar was done to retrieve literature on PHC services and strategies for enhancing the use in rural community, which were published either in English or with an English abstract (foreign-language publication). A separate search was also conducted to identify the problem areas and gaps in the implementation of PHC services in Nigeria. The time period of the search range from 1987 till 2008. Combinations of the following types of keywords were used such as issues in PHC services, strategies for improving PHC services, Nigerian rural community, etc. All keywords were first used to search for papers in Nigeria, and then papers published else where but related to PHC in Nigeria. Other countries were added to get more information. Furthermore, Pub Med, Medline and Google Scholar searches were conducted using the research title and the related articles link for key publications, and additional papers were also identified from the respective reference lists. Non-indexed literature and reports from international organizations were also accessed using Google and organizational websites (www.ngnhc.org). The following data was used from two main global sources: the WHO PHC capacity building strategies, PATH guideline for implementing supportive supervision. Due to the variability in quality of information and the broad range of values reported in published literature and reports, this paper did not attempt to provide any quantitative summary of effects of programs. Instead a review of information is being presented with analysis of overall trends and knowledge gaps. Contacts were made with colleagues with relevant information on our topic. All sources have been referenced in the text of the paper.

CRITICAL ISSUES IN PRIMARY HEALTH CARE SERVICES IN NIGERIA

The Nigerian government is committed to quality and accessible public health services through provision of primary health care (PHC) in rural areas as well as provision of preventive and curative services (Nigeria Constitution, 1999). PHC is provided by local government authority through health centers and health posts and they are staffed by nurses, midwives, community heath officers, heath technicians, community health extension workers and by physicians (doctors) especially in the southern part of the country. The services provided at these PHCs include: prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health and the collection of statistical data on health and heath related events. The health care delivery at the LGA is headed politically by a supervisory councilor and technically and administratively by a PHC coordinator and assisted by a deputy coordinator. The PHC co-coordinator reports to the supervisory councilor who in turn reports to the LGA chairman (Adeyemo, 2005; Federal Ministry of Health, 2004). The different components of the LGA PHC are manned by personnel of diverse specialty. The LGA is running her primary health care services delivery in compliance with the principles / framework of the National Health Policy (Nigerian National Health Bill, 1987). The LGA is divided into various health districts/wards so as to enhance maximum benefit of the principle of decentralization of the health sector whereby people are involved, participate and mobilized in the PHC processes.

Problem areas in the implementation of PHC

The essence of health care to the local government is to make the management of PHC services more effective and closer to the grassroots. However, in view of the level of health awareness, one begins to question the extent to which health care has been taken to the doorstep of the rural people. One of the hindrances to the development of health especially in Nigeria has to do with insufficient number of medical personnel as well as their uneven distribution. The Third Development Plan (1975 to 1980) for Nigeria focused on the inequity in the distribution of medical facilities and manpower/personnel. Despite the desire by the government to ensure a more equitable distribution of resources, glaring disparities are still evident. The deterioration in government facilities, low salaries and poor working conditions had resulted in a

mass exodus of health professionals (Iyun, 1988). There has been too much concentration of medical personnel at the urban to the neglect of the rural areas. Another significant problem in the management of PHC is transportation. It has been reported in LGA PHCs that there are not enough vehicles for workers to perform their task especially to the rural areas. Immunization outreach services are inadequately conducted. The maintenance culture of the existing vehicles is poor while PHC vehicles were used for other purposes other than health related activities. To put succinctly, many of the PHC vehicles donated by UNICEF in the 1980s are totally non-functional (Wunsch and Olowu, 1996).

Access to many parts of the communities is a function of: natural topographical and weather conditions (http://en.wikipedia.org/wiki/Geography_of_Nigeria); inadequate finance; over dependence of the LGA on federal, state and international agencies for support - the internally generated revenue of the LGA is meager (Adeyemo, 2005); low level of community involvement (Omoleke, 2005), general misuse and abuse of the scarce resources by some political and administrative leadership and high leadership turnover at LGAs (Adeyemo, 2005).

Health needs and problems of rural populations

There are three health care delivery systems in Nigeria (primary, secondary and tertiary).There are innumerable problems within primary health care delivery system which affect the whole population. An assessment of these problems and needs is important to assure easy accessibility to health care services by rural people. Apparently, people living in remote areas show an adaptability that allows them to adjust to the adverse conditions. Critical observation of some groups of nomads, for example the Fulanis and fishermen from the core northern states, the migrant Tiv farmers from Benue State, reveals satisfactory physical health and increasing resistance to disease or illness, but they are not without health problems. The health and health-related problems of nomads, migrant farmers and rural people include the following:

i. Poverty associated with poor housing, unsatisfactory environmental sanitation, polluted water and food which predispose to malnutrition and infectious diseases.
ii. Uneven distribution of health services, and shortage of physicians, nurses and trained health personnel in rural areas.
iii. High mortality and low average life expectancy, due to lack of access to health services. It is unfortunate that systematically collected data are lacking about levels of morbidity and mortality in rural communities. Despite the availability of PHC services, some rural dwellers in Nigeria tend to underuse the services due to perceptions of poor quality and inadequacy of available services (Sule et al., 2008). Various reasons can be adduced for the underuse of the services provided: a) difficulties associated with transportation and communications; b) high rates of illiteracy among rural peoples ; c) traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which increase the patronage of the services of traditional healers; and d) lack of understanding of PHC among health professionals and decision-makers resulting in poor quality services; and e) heath worker attitude to work (frequent abstinence from the work place) (Adeyemo, 2005).
iv. A tendency to press older children into adult responsibilities early, resulting in psychological problems due to role conflicts.
v. Endemic diseases prevalence, such as malaria and trachoma.
vi. Zoonotic diseases as a result of their close contact with animals as part of their way of life.

Clearly most of the problems and needs of rural areas are multifactoral in origin and require multidisciplinary interventions (Abiodun et al., 2010).

CURRENT STATUS AND GAPS IN PHC SERVICES IN RURAL COMMUNITIES

PHC centers are filtering units for those who require specialized services at the higher levels of care. Specialized medical services such as radiotherapy, orthopaedic procedures and surgeries are completely absent. There are many variations in the ways that medical care is given to rural people. The psychosocial health of rural dwellers is a neglected aspect of services provided. Gap remains in the knowledge of rural health workers to respond satisfactorily to identified problems.

This gap needs to be addressed because patients' satisfaction with health care is an important health outcome which has implications for capacity utilisation. And, in health systems that emphasizes the cooperation and involvement of the community, both in terms of resources contribution and management, satisfaction with health care assumes an important dimension in terms of its implication for success of public health programmes (Hegazy et al., 1992).

Some of the health workers are untrained and the trained ones lack the modern concept of PHC practice. Although, in principle, PHC requires intrasectoral and intersectoral coordinations and community participation, they are often lacking when put into real practice. Most of the services rendered lack community linkage and because of this, most community members are unaware of some available services. In general, nomadic women and children especially in the northern part of the country are the most underprivileged and chronically neglected segment in rural areas. Study has shown that rural women especially nomads, when compared with the

urban population, significantly underuse maternal and child health services (Abiodun et al., 2010).

STRATEGIES FOR ENHANCING THE USE OF PHC SERVICES BY RURAL COMMUNITIES

Operational strategy

A comprehensive baseline survey using rapid appraisal techniques should be planned in the initial stages to collect information about the health status, socio-demographic variables, civic amenities, existing health facilities as well as the attitudes and beliefs of the target population towards PHC services.

Reviewing and restructuring of PHC services

Public health goals at all levels of government are influenced by demographic and background variables. In view of this, information about community felt needs becomes paramount. These needs should be properly evaluated and coordinated with different sectors and incorporated into existing PHC services. In addition, new programmes should be developed to meet their unfulfilled needs. Some PHC centers are badly located in terms of physical accessibility. Accessibility can be improved by either relocation of the existing PHC centers, or adding more centers at the village level to bring the services within walking distance of the population of the catchment area. It is essential that PHC personnel are trained and re-trained to orientate people towards the concept and principles of PHC. Likewise, the skills of traditional birth attendants and voluntary village health workers should be enhanced by adequate and pertinent training.

Mobile health services intended to meet the needs of the remotest population have proved ineffective and rather too costly. In summary, such mobile services are not cost-effective. The establishment of health centers to serve remote populations would be a better strategy. If need be, working hours of the PHC centers should be adjusted and more emphasis be placed on the care of specific groups, such as mothers, children and the elderly. Therefore, PHC services should be based on fixed structures with a reasonably wide coverage, sufficient flexibility and adequate mobile capacity to fulfill their obligations to all sectors in the population, especially the highly migrant population. Legislation should be enacted for special services like immunization and reproductive health. Family health file/card should be prepared with all information related to health, so that they can be taken by families on the move from one place to another for quick acceptance, greater access and prompt management. Village health committee should be restructured and revitalized to include health personnel, community members, including nomadic people, and women.

Periodic evaluation of PHC centers with regards to the impact of new health programmes and policies. Secondary-level health care facilities should be empowered to monitor and supervise PHC services. The secondary health facilities should also have some disciplinary authority on erring PHC centers.

Community participation and involvement

It is almost universally acknowledged by national and international health planners that community participation is the key to the successful implementation of primary health care (PHC). The 1978 Declaration of Alma-Ata 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, 1978). Nigeria is one of the few countries in the developing world that has systematically decentralized the delivery of basic services in health to locally elected governments and community based organizations. Community participation has been institutionalized through the creation of village development committees and district development committees that are grass-roots organizations expected to work closely with local governments in monitoring and supporting primary health care services. Recently, there have been several governmental initiatives to strengthen these institutions of community participation to improve health services (World Bank, 2003). The National Health Policy in Nigeria emphasizes active community engagement in the provision of PHC services in the spirit of the Bamako Initiative of 1987, when Health Ministers from various African nations adopted resolutions for promoting sustainable primary health care through community participation in financing, maintenance, and monitoring of services. Community participation was institutionalized in Nigeria through the creation of District Development Committee (DDC) and the Village Development Committee (VDC) (World Bank, 2003). There is a large and growing body of evidence (Mike, 2010) that certain types of service delivery are enhanced with the active participation of the communities they serve. As end-users of the services, communities have a stake in ensuring that services are well-provided, and are also well-positioned to monitor the quality of services. With the benefit of local information, they can assess the specific obstacles facing facilities in providing services and they can seek to ensure that facilities have the necessary infrastructure, supplies and staff motivation to provide the services they are supposed to provide. Some of this can be done through volunteer efforts, such as donations for buying supplies, but most of the benefits of community participation can only be harnessed if there are specific mechanisms in place to enable them to do so. For example, whether or not they are allowed to raise local resources will affect their ability to ensure a smooth

flow of supplies. Similarly, whether or not they have a say in the evaluation and rewards/sanctioning of facility staff will affect the extent to which they are able to translate their observation of staff behavior into improved staff responsiveness to local needs.In planning the community participation aspects of primary health care, the collaboration of an anthropologist or rural sociologist with field experience is recommended. Promoting community participation is a skill which must be taught to community health workers, and backed up with support services. The genuine commitment of medical staff to community self help is crucial to the motivation process. Motivation within the community quickly breaks down if materials, expertise, and salaries fail to arrive when promised. Community activities are most successfully promoted with reference to the people's own ideas of purity/pollution, cleanliness/dirtiness, and health/illness. Guidelines for successful community participation include: projects undertaken should be ones that the community has identified as a priority; demonstrations and activities to promote health might be linked with agricultural initiatives, adult literacy campaigns, or programs from other sectors; and it is necessary to make sure the community fully understands all the costs in labor, time, money, and materials. If projects or long term community health programs fail, a quick, simple analysis should be made of constraints that may be operating. Apart from providing health care services based on their expertise, community also help in ensuring professional commitment to achieving the goal of health for all. In the last three decades, there has been an increasing demand for a shift of emphasis from acute care to the prevention of disease and promotion of health, education and research. Health workers should try to achieve the maximum possible while trying to solve other deep-rooted problems so as to make health the right of every individual. Professionals working in outreach areas need to develop confidence and expertise in making decisions, even under extreme conditions. It is advisable to accord suitable rewards and recognition for work under difficult and rigorous conditions to boost the morale of the workers. In rural areas, PHC centers are assisted and manned by local people who are selected and trained in addition to the trained medical personnels from outside the locality. In order to strengthen the interest of these people and ensure their retention in the rural areas special incentives should be given, for example, financial inducement of trained nurse aides or midwives to migrate to rural areas and thereby be permanently available to work. Increased awareness of the public, but especially of nomads and rural communities, about health problems, as a result of encouragement and stimulation from health professionals, leads to the mobilization of community resources and greater control over the social, political, economic and environmental factors which affect global health. This is necessary because health begins at home and in the work place. It is where people live and work that health is made or neglected. So the involvement of the community in devising health plans cannot be over-emphasized. The participation of the public in defining problems, planning, implementation and evaluation of community resources makes them feel responsible, not only for their own health, but also that of others. All members of the community can be involved in some aspects of the health programmes. In rural areas espe-cially, the cooperation of local people is fundamental. Their participation can be encouraged by disseminating relevant health information, increased literacy and making the necessary institutional arrangements. Mutual support between the community and the government is highly needed. Planners should realize that individuals need not feel they are obliged to accept solutions unsui-table for them. The approaches to the delivery of PHC for rural populations should, therefore, be practical and feasible.

Women from nomadic and rural communities constitute a major health risk group. So, in PHC programmes, if women are actively involved and treated as responsible and concerned members, they can play an enormously effective part, not just in improving the overall health status, but in achieving greater social justice within their own communities as well. PHC, being people-oriented, should make use of all channels through which people express their concerns over health and health supportive policies and programmes. A social climate can be crea-ted in which various groups in society accept the health practices recommended, and thereby help individuals make wiser choices. An enlightened community (that is, a public that knows its rights and responsibilities, supported by political will and awareness at all levels of govern-ment) holds the key to making health for all a reality.

Advocacy and political support/ commitment for health equity

A concern for health equity is not new in global health. Equity was central to the World Health Organization (WHO) 1946 constitution, and to the work that culminated in the Declaration of Alma Ata in 1978. Despite this, the health agenda has mostly focused on securing progress on priority challenges. This has contributed to substantial advances in average life expectancy in most parts of the world. Yet the global health community has often seemed unable to counter the widening inequities brought by uneven progress.

The World Health Assembly has the potential to be a turning point in addressing health inequities. Two resolu-tions should be passed, and they should fundamentally have concern for equity and social justice – one on ‘primary health care, including health systems strengthening’ and another on ‘reducing health inequities through action on the social determinants of health. It can seem a long way from a high-level policy review to action

that makes a difference on the ground. Three points are important here. First, health inequities are associated with social inequalities. Health outcomes are linked to position in social hierarchies, described by income, occupation and education, by ethnic group or by gender and to geographic location, for example, rural or urban. In particular, poor health outcomes are likely where social inequalities intersect, for example, for children of women with no education in poor households in rural areas. Studies (Lucas and Gilles, 1984) in low and middle income countries in Africa and Asia show a stepwise increase in under-five mortality across households by wealth, with children from the poorest fifth of households more likely to die before their fifth birthday than the next poorest and so on across the distribution. This pattern is seen for a number of health outcomes and is known as the social gradient in health, meaning that health outcomes are associated with people's position in the social hierarchy. The social gradient has important implications for policy as it means that policies and programmes must not only target the worst off in society, but must also address the conditions of the whole of society in order to tackle the gradient in health. Second, and crucial to the social determinants of health approach, is that where differential health outcomes are linked to social inequalities, then action to improve health outcomes must include action to reduce social inequalities. Seen in this light, every sector is, in effect, a health sector, because every sector, including finance, business, agriculture, trade, energy, education, employment, and welfare, impacts on health and health equity.

Thirdly, health workers at the heart of communities have a pivotal role to play in raising awareness and calling for action on social determinants and in the process of developing and evaluating action at local and national level. A clear political commitment to health for all and to equity in all sectors is essential to tackle the existing inequalities in the provision of health. Health policy makers and planners should note that health and its maintenance is a major social investment. Formal support from the government and community leaders is required to re-orientate national health strategies, especially the transfer of a greater share of resources to underserved populations. Authority should be given to local administrations regarding decisions about matters related to local needs. Those in power need to go to the people in order to receive and hear their complaints and take the necessary steps to solve them, especially in rural and nomadic settlements. Political commitment is a crucial factor in the process of policy formulation and implementation to ensure adequate services to the neglected sections of society (World Health Organization, 1991).

Political environment plays a significant role in making accessible to every person the complete range of health, psychological and social services, including prevention and rehabilitation, thus meeting the needs of underserved individuals, families and special groups. Unfortunately/ surprisingly, health planners in Nigeria have not realized this need.

Government must first make the PHC centers attractive by putting up clean structures and equipping them with the right tools, personnel as well as drugs. There is need for total turn around of many of the PHCs. In a bid to strengthen the primary health care, the government should also pass the National Health bill. The bill should aim to establish a framework for the regulation, development and management of the national health system and underpins primary health care as the entry point into the national health system. The bill should also establish a Primary Healthcare Development Fund, which shall see to the provision of basic health care to as many as possible through the National Health Insurance Scheme. The fund should be administered by the National Primary Health Care Development Agency (NPHCDA). The bill should also provide that funding for the Primary Health Care Development Fund should come from "an amount not less than two per cent of the value of the Consolidated Revenue Fund as well as grants from international donor partners."

The bill should stipulate a sharing formula in the utilisation of the fund to the effect that "fifty percent of the amount in the fund would be expended on basic health care for all citizens," while 25% of the fund would be used to provide essential drugs for primary healthcare and 15% of the fund should be used in providing and maintaining logistics used under the primary health care system. The remaining 10% of the fund should be utilized in building human capacity used under the primary healthcare system. The bill should also set guidelines for states and local governments to benefit from the fund. The bill should authorize the state to provide at least ten percent of the cost of the project envisaged while local governments should contribute 5% of the cost of the project.

As part of efforts to revitalize the PHC sector and to facilitate the establishment of the Ward Health System, the federal government through the National Primary Health Care Development Agency should complete the construction of model health centers in various needy political wards across the country. There should be also be a 5-year developmental plan to construct model health centers in all political wards in the country

Awareness creation

There is a need for a national approach to health education/promotion/behavior change. Currently, the unit within the PHC responsible for health promotion needs to be supported and strengthened to discharge her responsibilities effectively. Community-based activities should support increased family participation in their own health care. This should include educating them on what

services they should expect from PHC, as well as activities/messages on promotion of healthy lifestyles and prevention and early treatment of common illnesses.

The PHC should address several aspects of communications/health promotion linked to building awareness and achieving behavior change. It should include communications approaches directed at the family and community level.

To enhance the utilization of the health services by people, it is most important that they should recognize the need for such services. This need will only be felt if they start to value health as a worthwhile asset (Morley et al., 1983). For this, they need adequate, relevant, scientific information and education about health, disease and hazardous environments (Lucas and Gilles, 1984). Maximum efforts should be made to study the beliefs and practices about health and disease prevailing among different tribes and population groups. Traditional healers serve as the best source of information in this regard. Practices should be categorized into those that are clearly beneficial or clearly harmful.

The information provided should be expressed in simple but quantitative form (Morley et al., 1983), starting from simple matters, such as personal hygiene, and gradually progressing towards more comprehensive health education, fostering behavioural changes and community action for health. The language for communication should be the same as that of the local people, audiovisual aids used must be produced locally and be appropriate, and finally the educational programme should be carried out by trained and experienced personnel from the locality (World Health Organization, 1991).

Health personnel must be aware of the harmful effects of rapid intervention. It is easier to change practices rather than beliefs because the latter are deep rooted, especially among the rural people. The commitment of rural people to religion can be utilized to support the health messages through quotation from the Quran and *hadith* and Bible. Local beliefs can be interpreted to fit in with the desired health practices (Last, 1984). Traditional media, such as folk songs and drama shows, are very useful in educating illiterate people, especially rural women, who need a rigorous campaign to utilize effectively the maternal and child health services provided at the PHC centers. Health information should be available to the public in the communication media they know and use regularly (World Health Organization, 1991). Adequate knowledge and desirable attitudes about health are necessarily accompanied by appropriate practices.

Collaboration and partnership with other agencies

Collaboration in PHC focuses on how to create conditions for health care providers every where to work together in the most effective and efficient way with the aim of producing the best health outcomes. Collaboration with other related sectors in the improvement of PHC as part of total socioeconomic development is very important. It has been emphasized that no sector involved in socioeconomic development, especially the health sector, can function properly in isolation (Hegazy et al., 1992). Many social factors such as education, housing, transport and communications influence health (Last, 1984), and so does economic factors too. Therefore, collaboration with the relevant sectors is especially important for worthwhile mutual benefits. Collaborative efforts focused on economic development and progress leads to better health.

Educational institutions play an important role in the health status of the community, especially in the field of prevention. Teachers can help in the early detection of ill health in students. Students are used as messengers of health to the community. Literacy programmes have been shown to have a great impact on equity-oriented development in rural areas (World Health Organization, 1991). The educational status of the mother plays a pivotal role in the health of the family. As maternal education among rural and nomadic groups is relatively lacking, adult educational programmes would be of great help. The mass media can contribute effectively to the dissemination of health messages to the population at large. The health sector must play a leading role in health supportive public policies. Health activities should be undertaken concurrently with such measures as the improvement of nutrition, particularly that of children and mothers.

Coordination of health-related activities should be devoid of duplication (Hegazy et al., 1992). To make intersectoral coordination a reality, concerted efforts should be made to demonstrate how ill health and disease are closely related to illiteracy, poverty, poor sanitation and environmental conditions, etc. (World Health Organization, 1991). PHC lay emphasis on health care that is essential, practical, scientifically sound, coordinated, accessible, appropriately delivered, and affordable. One route to achievement of improved health outcomes within these parameters is the formation of partnerships. Partnerships adopting the philosophy and five principles of primary health care (PHC) focus on health promotion and prevention of illness and disability, maximum community participation, accessibility to health and health services, interdisciplinary and intersectoral collaboration, and use of appropriate technologies such as resources and strategies.

Appropriate technology

Technical appropriateness means that whatever policies and procedures are used in the delivery of health care, they should be acceptable to all concerned. When introducing any new technology, the authorities must be assured that it will not contravene the beliefs and practices of the local culture. The whole health system

should be used in a rational way to satisfy the essential health needs of rural people, by using methods acceptable to them such as the use of oral rehydration fluid in place of intravenous fluid; and standpipes which are socially acceptable and financially more feasible than house-to-house connections, etc.

Supervision

The word “supervision” literally means “to over-see”. It implies that someone higher up the scale is watching to see that someone lower down is performing their job properly. As early as the Egyptian pyramid builders, supervisors oversaw teams of slaves pulling huge building blocks into place. Since then, those in power, including colonialists, exerted their influence over others by appointing supervisors and inspectors. This form of supervision was most often focused on outcomes and was usually not open to dialogue and consultation about the process. It often favoured ridicule and discipline to push individuals and communities to perform their duties. And it has not fulfilled its promise to improve primary health care delivery.

The more traditional supervisory visit focused on inspection and fault finding. Health workers often received little guidance or mentoring on how to improve their performance. They were “frequently left undirected, with few or no milestones to help assess their performance, until the next supervisory visit, and motivation was hard to maintain in such an atmosphere” (Guidelines for Implementing Supportive Supervision, 2003). While most primary health care services acknowledge the need for some form of supervision, we maintain that effective (traditional) supervision has been an abject failure in most primary health care settings in developing countries.

For instance, inadequacy in the quality of primary health care facilities in Nigeria was felt to be the product of failure in a range of quality measures – structural (lack of equipment and essential drugs), and process (not using the national case management algorithm and lack of a protocol for systematic supervision of health workers). This study recommends that efforts should be put in place to improve the quality and use of primary health care in Nigeria by focusing not only on providing better resources, but also on low-cost, cost-effective measures that address the process of service delivery such as supervision (Ehiri et al., 2005).

From a feeling of dissatisfaction with the old model of supervision (that is, traditional supervision) emerged a new paradigm for supportive supervision. The maximizing access and quality initiative (MAQ) described supportive supervision as “a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources-promoting high standards, teamwork, and better two-way communication (World Health Organization, 1991).”

By 2001, the move away from traditional supervision had begun. Decisions were made by WHO to re-write the training modules (World Health Organization, 1991). This guideline clearly laid out the new principles of supportive supervision. While we believe these guidelines provide the basis for improving supervision in most of the developing world, there is also scope for yet more innovative approaches to supervision. Independence, autonomy, community participation and empowerment without the cultural or political climate to ensure that supervision can be conducted may not create an environment conducive to improving outcomes. Health workers at the periphery are faced with complex problems over which they may have little control, scarce resources, and few problem-solving skills. No amount of traditional supervision will overcome this situation. However, the new paradigm of supportive supervision might – where supervisors sit along side the health worker and attempt to solve the problems together.

Our observation and data collection during the supervisory visits to some PHC centers revealed that they were being operated erratically a situation leading to non use by the communities.

Worryingly, those placed in the role of supervisor have often lacked the technical, managerial, or supervisory skills needed to carry such a task out well – making it unlikely that supervision would be truly supportive. Therefore, for the supervision to be supportive, the supervisors need to be regularly trained.

CONCLUSION

While the PHC centers are relatively uniformly distributed throughout Nigeria, rural people tend to under-use the basic health services. Although there is no single solution to this problem in Nigeria, some strategies have been outlined which could result in enhancing the use of health services by the rural communities. Capacity building and empowerment of communities through orientation, mobilization and community organization as regards training, information sharing and continuous dialogue, could further enhance the utilization of PHC services by rural populations. Quality of care and service delivery must be assured by those in management positions. In situations of scarce resources, it is particularly important to maintain standards of practice when huge demands are placed on staff, often resulting in less-than-ideal behaviour. It is precisely in such situations that staffs need to know there is support from their superiors, and managers need to know that the scarce health budget is being used to best advantage. Primary health care in Nigeria and especially in rural areas have come a long way and certainly still require more effort so as to achieve the goal of health for all now and beyond.

RECOMMENDATIONS FOR FUTURE IMPROVEMENT

Having identified the litany of problems against effective and efficient implementation and achievement of the goals and objectives of primary health care services delivery at the local government, the following recommendations are suggested as a way forward:

1. There is the dearth 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 is to 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 of necessity, be reinforced in other to eliminate such diseases as malaria, typhoid and other infectious diseases.
3. There is the need for maintenance of minimum health standard, improved housing condition, adequate potable water supply, environment sanitation and food supply for the sustenance of good health condition.
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, iceliners 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. More financial and other incentives should be provided to prevent the high staff turn-over of health workers.

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