

AN ASSESSMENT OF THE FACTORS AFFECTING UTILIZATION OF PRIMARY HEALTH CARE SERVICES IN IGABI LOCAL GOVERNMENT AREA OF KADUNA STATE

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ABSTRACT

This paper examines the factors affecting utilization of primary health care services in Igabi local government area of Kaduna State. Data were obtained from hospital and financial records, Focus Group Discussions, in-depth interviews and the purposive administration of 435 copies questionnaires. The results show that 47.8% of respondents claimed to have never utilized PHCS. Out of 265 female respondents 48.3% utilized maternal services during pregnancy and child birth only with the permission of their husbands/mother-in-laws. Also, long waiting time on consultation with doctors affects their decisions to seek for PHCS. Although 83% held that there are drugs at the PHC centres, these drugs are expensive and not easily affordable. The paper also reveals that the quality of treatment at PHC centres is good, however 52.9% held that distance to PHC centres from homes affect their decisions to seek PHCS. Financial allocation by the government to the health sector is inadequate, while community participation in PHC development is low. The rank correlation test shows that there are significant relationship between the background variables and PHCS utilization. Based on the findings it is recommended that health policies at the grassroots should respect people's cultures and traditions so as to promote acceptance; Preventive and curative medicine, and poverty alleviation should top government priority. Public enlightenment and mobilization campaign should be expanded through the mass media.

Key words: Primary health care services, health care centres, alternative care, mortality, Igabi.

INTRODUCTION

Good health is a prerequisite for human development, because productive energy of a healthy population is the driving force for all forms of development. The importance of good health cannot be over-emphasised. The World Health Assembly (WHA) in 1977 set goal of health for all by the year 2000 and beyond, and to achieve this, the assembly decided that goal of all government and international community shall be the attainment by all the people of the world as status of health that will permit them lead socially and economically productive lives (Alakija, 2004)

In recent years the quality of healthcare services has become an issue of concern throughout the world. In the West African Sub-region in particular, (Olumide and Ajayi, 1999) revealed that the quality of healthcare services has dropped noticeably in many countries (including Nigeria) as a result of economic decline, political instability and emigration of healthcare professionals. As a consequence, infections and parasitic diseases, defective malnutrition, maternal morbidity and closely spaced and too frequent pregnancies are glaringly apparent. Attempts to eradicate these diseases have become an uphill task because a number of

socio-cultural bottlenecks. These include gender disparity in to education, health and economic opportunities, gender-based violence, child labour and abuse and poor method of food preparation. An attempt to address these multifaceted health care issues is the introduction of primary health care services (PHCS)

Implementation of PHC in Nigeria actually commenced in 1970s in the form of the Basic Health Services Scheme (BHSS). It was however in 1987 that the PHC program was officially launched in the country with optimism that the system will increase substantially the utilization of PHCS thereby reducing the generally high level of morbidity and mortality. Several strategies were put in place to achieve these laudable dreams. They include; health education, provision of infrastructures to health care centres, provision of adequate and quality staff; implementation of roll back malaria through the promotion and use of Insecticides Treated Net (ITNs); improved nutritional status of children and increase the rate of immunization coverage; raise awareness on Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) pandemic and tuberculosis control programs, through the management of childhood illness and reproductive health programme (Federal Ministry of Health, 2004). More than two decades have lapse yet PHCS have not been well evaluated through research particularly because the raising trends of preventable diseases may be a consequence of factors that hinders utilization of PHC services.

Research on PHC system have shown that the major health related problems in most rural communities in Nigeria (including Igabi LGA) is the existing health care system, which does not reflect the health needs of the majority of the population. Poor healthcare services have been blamed on inadequate facilities, insufficient referral system, lack of community participation and lack of transparency and accountability in governance (Massoud, 2007).

Of particular interest to note is that, most communities in Igabi LGA live in scattered farmsteads, hamlets and villages. Most of these communities are cut-off from the basic health centres by lack of good roads, especially in the rainy season when most of the roads become impassable. As a result many people are forced to rely on alternative medicines, self medication, buying of drugs in the local markets and more depend on quacks. This paper examines the factors affecting the utilization of Primary Health Care Services (PHCS) in Igabi Local Government Area (LGA) of Kaduna State. The paper assumes that lack of utilization of PHCS among people is due to low incomes, education, long distance from homes to PHC facilities, long waiting time at facility centres and lack of inadequate finance.

MATERIALS AND METHODS

The data from this paper was obtained through the administration of two sets of questionnaires specifically designed to obtain information among other things, on the factors affecting the utilization of PHCS. The first set deal with the demographic and socio-economic characteristics of the respondents, while the second deal with the utilization of PHCS. The study covered the entire LGA between November and December 2009. Out of the total population of 430,299 (NPC, 2006) in the study area, a 0.12% was sampled using purposive sampling method (0.12% of 430,229=516). Out of this number a total of 435 questionnaires were successfully administered, giving a success rate of 84.3%. Focus Group Discussions (FGDs) and in-depth interviews with community leaders, market women, Non Governmental Organization (NGOs) and health care personnel were conducted. The survey was carried out as part of a wider survey on “the Assessment of the Impact of Primary Health Care (PHC) Delivery Systems in Igabi LGA

of Kaduna State". The questionnaires were coded into a computer and analysed with SPSS/PCT+ Computer Software.

The rank correlation test was used to test the reasons for non-utilization of PHCS across certain selected variables. Simple descriptive and inferential statistics and cross-tabulation of variables has been employed in order to understand basic relationships among variables. The information from the questionnaires was complemented with data from hospital records obtained from ten PHC centres located within the LGA. These are; Kampani Zango, Mararaba Jos, Farakwai, Igabi, Mando, Rigachikun, Jaji, Rigasa, Zangon Aya and Al-Amin Clinic. Also complementary data from the revenue department of the LG secretariat was sought to evaluate financial allocation to the health sector.

RESULTS AND DISCUSSION

Demographic and Socio-Economic Characteristics of Respondents

The distribution by age structure of the respondents shows that 69.9 % fall within the age bracket of 15-39 years. This is a clear indication of the youthful nature of the population. This is not unexpected as the study area has the highest population in any LGA in Kaduna State (NPC, 2009). The distribution by sex shows that 53.1 % of the respondents are males while 46.9 % are females. Again data from (NPC, 2009) indicates that Igabi LGA has more males than females, also at the time of the survey, males were more accessible than females.

The proportion of those in marital union is 66.7% compared to 23.3% for never married; those who are widowed are 8.5 % while those who are divorced and separated represent 0.7 % and 1.8 % respectively. Though the rate of divorce and widowhood is quite high in sub-Saharan Africa (Laah, 2003) yet the rate of remarriage is equally high especially in Muslim dominated areas like Igabi LGA where staying without marriage above 18 years is regarded as an act of irresponsibility. This is partly the reason for the low proportion of respondents who are divorced and widowed. Of the number married, 62.1 % are in polygamous union while 37.9 % are in monogamous union. Marriages are mostly contracted between the age brackets of 14-24 years (62.7 %). The remaining 37.3 % of the respondents contracted their marriages between the age of 25 years and above.

Literacy level is quite high in the area with 61.1 % (excludes 9.9 % with only Quranic education). Among those who have acquired western education, Muslims constitute 64.7 %, Christian make up 32.5 % and traditional religion adherents constitute 2.8 % of the respondents. Nearly all the respondents (99.3%) earn income of between ₦5,000–₦24,000 per month. According to National Housing policy of Nigeria (1991), 70% of Nigerians fall in this category. This situation has implications on the utilization of PHC services. The distribution of respondents by number of children ever born shows that 61.1 % had more than four children which is above the National Population Policy (1988)'s recommendation. Household size in the study area shows that about 77.9% of the proportions have more than 5 persons in their homes. Also, NPC (2009) reveals that household size shall be 5 persons per household. Overcrowding and squatters are common. About 81.7% of the respondents live in one or two room accommodation with only 17.4% living in either a flat or duplex.

Availability and utilization of PHCs

The aim of PHC is to reach everybody particularly those in greatest need of health services, paying particular attention to the needs of high groups such as mothers, children, workers at special risk as well as the elderly (Obionu, 2007). In this study, respondents were asked to mention whether they have PHCS in their areas. About 52.2 % of them claimed to have as against 47.8% who did not. Of the percentage that have access to PHC facilities, 85.3% have dispensaries, 12.4% clinics, 1.4 % herbal/traditional homes while 0.5% and 0.2% have general hospitals and specialist hospitals respectively. The uncategorized respondents mention that they have pharmacist, patent medicine stores and insurance hospitals, and they represent 0.2% of the respondents. In the analysis of those seeking for PHCS, 57% of the sample had ever visited PHC centres for treatment, while 43 % had never. Further analysis shows that of the proportion who had ever visited PHC centres, 48.4% used dispensaries, 13.3% patronised clinics, 20.5% preferred herbal/traditional homes while 8.1% each visited general and specialist hospitals. The 1.6% of the “others” respondents mentioned that they had ever visited pharmacist, patent medicine stores and insurance hospital. It is important to note that the relatively high proportion of the sample who had never visited PHC centres does not mean that people in the area do not seek for healthcare delivery services as the patronage of herbal and traditional medicine practitioners could be a factor (Laah, 2002).

The distribution of respondents by immunization coverage was rather curious because it is the preventive aspects of the healthcare delivery system. About 70% of the respondents revealed that there is regular immunization in their areas as against 30 % who indicate that immunization is not frequent in their communities. When further asked to mention whether they have maternal clinics in their areas, the responses generated also shows that 65% respondents agreed that they have maternal clinics. Further analysis shows that out of 265 female respondents, 60% maintained that they have been utilizing the maternal clinics in their area; while 40% expressed that they do not. Iliyasu (2002) in a similar study in Shira LGA of Bauchi State found that about 40 % of women do not attend antenatal clinics frequently. In the in-depth interviews with different women, we found that distance, religious and cultural reasons are some of the reasons for the non-utilization of maternal services in the area. A 28 year old woman revealed that:

“I cannot attend these clinics because we have a traditional doctor in our family, apart from that the hospital is too far from my home and the doctors don’t have privacy since there are some private matters I cannot share in the presence of other patients”.

Factors affecting the utilization of PHCS

Decision on choice of treatment during Pregnancy and Childbirth.

This is an important parameter because among the Hausas of Northern Nigeria where seclusion after marriage is customary for a woman, any physical departure from the home requires the permission of the husband (Harrison, 1978). On this study, only opinions of female respondents were sought and presented in Table 1. Table 1 reveals that 26.8% of the respondents maintained that they usually decide on their own to attend antenatal clinics during pregnancy and childbirth, while 35.1% and 12.4% expressed that only their husbands and mother-in-laws respectively usually grant the permission.

Table 1: Permission to attend maternal clinics.

Decision	Frequency	Percentage
Only You	71	26.8
Only Husband	93	35.9
Mother In-Law	33	12.4
You and Husband	53	20.0
Others (Specify)	15	5.7
Total	265	100

Source: Field Survey, 2009.

Table 1 further shows that 20% of the responds revealed that both of them (husband and wife) take decision on their treatment, while 5.7% mentioned that socio-cultural and religious reason affect their decision to seek for antenatal care.

Waiting Time before Consultation

The study considers waiting time by antenatal patients at facility centres as an important parameter, and the time given for diagnosis by the health care personnel is very crucial in the utilization of PHCS. Table 2 reveals that 37.4% of the respondents held that waiting time at facility centres takes, between 30 minutes to 3 hours as against 62.6% who maintained that waiting time last between 4-7 hours or more at facility centres.

Table 2: Waiting Time before consultation

Waiting Time	Frequency	Percentage
30mins – 1 hour	50	18.9
2 – 3 hours	49	18.5
4 – 5 hours	132	49.8
6 – 7 hours	19	7.1
7 – 7 hours	15	5.7
Total	265	100

Source: Field Survey, 2009.

From this analysis, the inference is that antenatal patients often take too long at facility centres. This finding is confirmed by one pregnant woman during our in-depth interview:

“A very busy woman like me is always worried about the time I would be wasting while in waiting queue or at the pharmacy because I have lost many hours on several visits to the hospital while waiting to see the doctor on antenatal days and sometimes go back home without seeing him.”

Long waiting hours therefore, has serious negative implications on the utilization of PHCS.

Availability and Cost of Drugs

Respondents were asked to rate whether there are drugs in their respective PHC centres. This is because the provision of drugs forms an integral part of the overall health care system, and the rating of the entire PHC system is a function of the availability of drugs without drugs the health care system has no substance and credibility. About 83% (301) of the respondents

claimed that drugs are available while 17% (134) maintained that drugs are not available. Thus, from the respondents view concludes that drugs are available in the PHC centres.

Table 3: Availability and Cost of Drugs

Responses	Frequency	Percentage
Expensive	217	50.0
Moderate	143	33.3
Cheap	25	5.7
No Response	48	11.0
Total	435	100

Source: Field Survey, 2009.

The study further considers whether these drugs are affordable to the majority of people as enshrine in the Alma-Ata declaration. Table 3 shows that 50 % of the proportion revealed that drugs are expensive while 33.3 % argued that the prices of drugs are moderate. About 5.7 % stated that drugs are cheap, and 11 % did not respond to the question. Thus, we can strongly say that drugs at PHC centres are not easily affordable because they are expensive. As a result patients may be forced to rely on alternative medicines, self medication, buying of drugs in the local markets and more dependent on quacks.

Perception of respondentss on the Quality of Treatment

Respondents were further required to rate their perception on the quality of treatment they receive at facility centres. The responses generated from this revealed that 16% of the proportion perceived the quality of treatment at the PHC centres is very good, while 25.3 % among them maintained that the treatment is good and 15% held that the quality of service is fair. About 39.1% of the respondents perceived that the quality of treatment is poor and the remaining 4.6% expressed that the quality is very poor. Thus, it is deduced from the respondents' perception that on the average, the quality of treatment at facility centres in the area is good. We confirmed this during the in-depth interview with some of the community leaders and household heads. A community leader at Rigasa explains thus;

“Some of the workers are good while some are harsh. Some come late to work while some don't even come to work on several occasions. However, the relationship between the nurse and our people is good and she is even part of us because she knows what most of our situations are like.”

Distance to PHC Centres from Homes

The distance separating the potential patients from the nearest health care facility has been shown to be an important barrier to seeking health care, particularly in rural areas (Stocks, 1983). It is against this that respondents were asked to state the distance they cover when seeking for health care services. The responses generated (Table 4) shows that 47.1% of the respondents are living within 4 kilometres range, as against 52.9% who are living within the radius of 5-17 kilometres and above. Thus, it is clear that majority of the people in the area are not within easy reach of PHCS. The World Health Organisation (WHO) (1978) has recommended that a health care facility shall be within 0-4 kilometres radius.

Table 4: Distance from Homes to PHC Centres

Distance	Frequency	Percentage
< 2 kms	95	21.8
2 – 4 kms	110	25.3
5 – 7 kms	85	19.5
8 – 10 kms	65	15.0
11 – 13 kms	50	11.5
14 – 16 kms	20	4.6
17 kms +	10	2.3
Total	435	100

Source: Field Survey, 2009.

Distance covered to healthcares centres also affect the utilization of PHCS. In the FGDs, one of the discussants of Gwaraji village complained:

“The government should know that we are human beings like them, who need hospitals, good roads and potable drinking water. They should provide our village with these facilities so that we can have easy reach to the hospitals they have built in other communities.”

Financial Commitment by Government

Igabi LG council, like any other LGA obtain her operational fund through statutory financial allocations and services (including health) through internally generated revenues. The health department runs its services under the provision of National Health Policy (NHP) which is base in PHC. Over a period of six years for which data are available (that is from 2004–2009), the health department has witness a declining share of total budgetary allocation from the LGA as Table 5 reveals. The Table (5) revealed that the year 2004, the health sector received ₦91,404,951 out of ₦1,033,386,373 which translates to 8.8 %. In 2005, the approved budget for the health sector was ₦ 84,481,884 for the LGA, and in 2006 it received ₦89,278,335 out of a total budget of ₦1,821,385,822 and this represents 5.0 % of the total spending for the year. In 2007 and 2008, the health sector received ₦104,051,230 and ₦224,351,679 out of a total budget of ₦1,967,809,513 and ₦3,295,122,700 which represents 5.5% and 6.8% respectively for the LGA, while in 2009 the approved budget for the health sector was ₦64,600,000 representing 2.1% of the total budget of ₦3,145,893,645.

Table 5: Budgetary Allocation to Igabi LGA 2004 – 2009

Year	Actual Budget Allocation (₦)	Allocation for Health (₦)	Percentage
2004	1,033,386,373	91,407,951	8.8
2005	1,202,238,827	84,481,884	5.4
2006	1,812,385,822	89,278,335	5.0
2007	1,967,809,513	104,051,230	5.3
2008	3,295,123,700	224,351,679	6.8
2009	3,145,893,645	64,600,000	2.1
Total	12,456,836,888	638,171,070	

Source: Revenue Department Igabi LGA, 2009.

In absolute terms, these figures represent a marked decrease in budgetary allocation for the health sector over the years. This implies that governments do not provide adequate funds

for healthcare services in the LGA. Lack of adequate funding of PHC services have been used to explain the ineffectiveness of the health sector to provide adequate healthcare services in Nigeria (Massoud, 2007).

Community Participation in PHC Development

In this study, community participation range from taking part in decision making in priority health programs to providing manpower or resources to execute specific projects. Respondents were asked to state whether they have, in any way contributed to the development of the PHC system. Out of 435, 41%(178) agreed that they have contributed to the development of PHC development as against 59%(257) who mentioned that they have not.

Table 6: Form of Community Participation in PHC Development

Participation	Frequency	Percentage
Financial assistance	40	22.5
Labour	66	37.0
Free drugs	45	25.3
Furniture	11	6.2
Vehicles	5	2.8
Others	11	6.2
Total	178	100

Source: Field Survey, 2009.

Table 6 reveals that, of the 178 respondents who have ever contributed to PHC development, 22.5% of the proportion made their contributions financially while 37% made their own contributions through free labour. About 25.3%, 6.2% and 2.8% donated drugs, furniture and vehicles in that order. Other contributions are through prayers, providing security, provision of free accommodation to PHC staff and taking part in environmental sanitation.

It is obvious from this analysis that community participation in PHC development is low. The Alma-Ata Declaration of 1978 maintained that health teams should promote community participation in health programs, so as to promote acceptance and utilization (Okpala, 1999; Obionu, 2007). From the FGDs with health workers and supervisory councilors, it was revealed that various health committees have been formed in many communities in order to give a sense of belonging and ownership. However, a community leader at Farakwai disagreed with this:

“I don’t know anything about health committee in this area. I have never seen or heard about it, therefore many people hardly contribute in other to assist the government. This even discourages many people to go for treatment.”

Because the local communities are not allowed to take full charge of their own health in policy and implementation, they did not see formal management structures in the area as particularly relevant to their existence.

Logistics and supportive facilities

To further assess the utilization of PHCS, hospitals records were obtained from ten PHC centres across the LGA to know the level of logistic services. The PHC centres are those in-Kampani Zango, Mararaba Jos, Farakwai, Igabi, Mando, Rigachikn, Jaji, Zangon Aya, Rigasa and Al-Amin Clinic. The record reveals that there are one ward each for Mando, Rigachikun, Zangon Aya and Rigasa PHC centres; two wards for Jaji and three for Al-Amin PHC Centres, while the rest of the centres have none. Again only Rigachikun, Jaji, Zangon Aya, Rigasa and Al-Amin PHC centres have one motor cycle each.

The records further reveals that the PHC centres with at least one Ambulance include Al-Amin clinic, Jaji and Rigasa. Furthermore, only Al-Amin clinic has an X-ray machine while Igabi, Mando, Rigachukun, Jaji, Zangon Aya, Rigasa and Al-Amin health care centres have one generators each. All the PHC centres have at least one deep freezer/fridge except Kampani Zangon PHC centre. The records also show that all the PHC centres selected have more than one cold box except Kampani, Zango, Mararaba Jos, Farakwai and Igabi who have one each. In addition all the ten PHC centres have one bore hole each. Another finding is that they do not have screening machines except Rigachikun, Jaji and Al-Amin with one each. These findings are similar to that reported by other researches (Obionu, 2007; Massoud, 2007). There is no doubt that the non-utilization of health care services by many people especially Igabi LGA is due among other factors to the inability of government at all levels to provide adequate logistics in the health care system.

Table 7: Spearman Rank Correlation test for Level of Significance

Variable	N	Mean	SD	r	DF	P	Critical	Remark
Education	435	2.6621	1.5608	0.861	433	0.000	0.195	Significant
Health seekers	435	1.4092	0.4923	-	-	-	-	
Income	435	1.8713	0.8783	0.673	433	0.000	0.195	Significant
Utilization	435	1.2276	0.6043	-	-	-	-	
Distance	435	2.8966	1.5333	0.841	433	0.000	0.195	Significant
Utilization	435	1.4299	0.4956	-	-	-	-	
Waiting Time	435	1.2890	0.4540	0.840	433	0.000	0.195	Significant
Utilization	435	1.7862	0.9733	-	-	-	-	

Source: Computed from Field Survey, 2009.

Table 7 reveals the rank correlation test for the analysis of the PHCS utilization for education, income, distance and waiting time. The analysis for education shows that the low level of education is a significant factor for utilization of PHCS. The observed correlation coefficient (0.861) is much higher than the critical value of 0.195, and the observed level of significance (0.000) is lower than 0.05. This implies that the two variables are significantly related. This relate to our earlier assertion that utilization of PHCS tend to increase with increasing level of education. This finding agrees with Cadwell and Cadwell (1985), on their study on education and literacy as factors in health. The calculated values for income and utilization indicate that the observed r(0.673) is greater than the critical value of (0.195) at 433 degrees of freedom and at 0.05 level of significance. Again, there is significant difference between the two variables. Again, utilization of PHCS increases with higher incomes.

The result for the test on distance and health seekers shows that at 0.05 levels of significance and at 433 degrees of freedom, the assertion is therefore rejected since the observed

correlation coefficient (0.841) is much greater than the critical values (0.195). This means that the two variables are significantly related, implying that distance to PHC centres from homes affect the decision to seek for health care services, same for waiting time.

SUMMARY AND CONCLUSION

The study reveals the underlying factors affecting utilization of PHC programme in Igabi LGA which may be applicable to Kaduna State in general. A major summary is that socio-cultural and religious beliefs, long waiting hours at facility centres, lack of location of PHC facilities within reasonable distance and lack of serious interaction between formal management structures the local resident resulting to lack of mechanisms for ensuring adequate financial allocation to the PHC facilities and lack of adequate logistics are some of the reasons for non-utilization of PHC in Igabi LGA. As a result, health care seekers prefer to seek medical care outside the facility centres through alternative non-PHC agencies or visit quacks.

Government health policies at the grass roots should include respect for the people's cultures and traditions. This implies that any propose solution must be understood and accepted by the people whom it is meant for. Focus on preventive and curative medicine, and poverty alleviation programme as well as the provision of necessary health facilities should top government priority. This will be effective through intensive enlightenment and mobilization campaign, and because the mass media is an effective source of information dissemination, it should be expanded to have a wider coverage. Though our value system and socio-economic conditions differ, the government should carefully examine China, Cuba and Tanzania models towards improving her health problems.

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