

KEY ISSUES IN HEALTH INFRASTRUCTURE IN NIGERIA

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ABSTRACT

Vast issues in the health infrastructure sector in Nigeria are adopted as a study tool in the research paper. The study revealed that 92.4 percent of the participants indicated that health facilities is very accessible to their home, while 7.6 percent of the participants indicated that health facilities is not accessible to their home due to the swampy terrain. Also 3.0 percent of the participants seek alternative health practitioners because of natural herbs, 1.5 percent indicated spiritual basis of health and diseases, 4.5 percent indicated because of use of medicinal herbs. in this modern era, health care system should be well grounded in routine surveillance and maintenance of the health sector, besides adequate management and strong leadership principles.

Keywords: Accessibility, Patronage, ownership, urban, healthcare.

1.1 INTRODUCTION

The health sector in Nigeria in general is a concurrent responsibility of the three tiers of government (Federal, State and Local), but responsibility for the support of the PHCs lies with the local government authorities (Adeyemo, 2005). Like every other sectors in Nigeria, it has been faced with daunting challenges. Hence, healthcare services provision at the primary healthcare centres has been negatively impacted by the challenges with serious implications for quality of services rendered in the PHCs and by extension, the quality of healthcare services available to the down-trodden at the grass root and rural areas. Assessment of the health care system in Nigeria in recent times does not only indicate that it is non-productive; efforts for improvement have not had any obvious impact (Ogunkelu, 2002).

In most developing countries, the number of new cases related to many of these health risks has increased over time, partly due to rising populations. Beyond infectious diseases, the main cause of ill-health is malnutrition. Poverty, hunger and malnutrition are interrelated silent realities for a majority of people in developing countries. Poor health care delivery is a problem in Nigeria. The reports on health indicators such as maternal and child health, infant mortality rates etc are high and life expectancy is still at low level. There is prevalence of communicable/preventable diseases such as malaria, typhoid fever and childhood diseases and non-communicable diseases known as disease of affluence, namely; hypertension, diabetes, heart and renal diseases etc.. The aim of this paper is to examine the socio-cultural factors influencing patronage of health facilities in southern Nigeria using Bayelsa state as a case study. In the face of these appalling statistics, why hasn't there been a major outcry among health authorities and the public in general? Part of the answer probably lies in the fact that primary health care, and in particular public health, is viewed as a complicated and "non-glamorous" area that requires sustaining efforts but does not offer sufficient visibility. Further, most of the common ailments are perceived to be local and not likely to cross borders(Abraham, 2005).

The World Health Organization (WHO) lists the top 10 preventable health risks as childhood and maternal underweight; unsafe sex; high blood pressure; tobacco; alcohol; unsafe water; sanitation and hygiene; high cholesterol; indoor smoke from solid fuels; iron deficiency and obesity. These risks account for about 40 percent of the 56 million preventable deaths that occur worldwide annually, accordingly to WHO. It must be noted that prior to the health sector reform and in spite of the fact that the private hospitals and private health services are more costly than public health services and patronage these of health facilities was very low because capacity for health services. It is evident that the public health sector has failed in health care services since patients go for private hospitals that are very costly which means the services are not available. Another reason is difficulty of accessing the hospitals due to the poor roads. Then there is also the issue of competition from the private practitioners and alternative and traditional medicine practitioners. All these challenges can result in failure for the primary and secondary care centres.

Over the last two decades, Nigeria has devoted significant resources in the health sector such as provision of health facilities, training of doctors and other ancillary staff, etc. Despite these efforts, adequate health care delivery programme has continued to be a problem. For instance, the National Health Policy (1988) identified major defects in Nigeria's health services as: (a) inadequate coverage in which the rural communities and urban poor are not well served; (b) emphasis on curative services rather than preventive services; (c) lack of community mobilization and involvement in decision-making process on matters concerning their health, etc. Poor health care delivery is a problem in Nigeria. The reports on health indicators such as maternal and child health, infant mortality rates etc are high and life expectancy is still at low level. There is prevalence of communicable /preventable diseases such as malaria, typhoid fever and childhood diseases and non-communicable diseases known as disease of affluence, namely; hypertension, diabetes, heart and renal diseases etc. World Health Organization (WHO, 2007:15) stated that, inspite of the success of the National Programme on Immunization (NPI) and increased Oral Rehydration Therapy (ORT), the under five(5) mortality is still high (116/1000 live births). Pneumonia and diarrhoeal diseases are the most common causes of death with malnutrition increasing the death of children under five (5) years of age.

The gap identified and that is worth studying focused on healthcare facilities in general, and on the relationship between distance and patronage pattern of the distribution pattern of healthcare facilities. General consensus among researchers investigating this relationship is that fewer people are willing to patronize a particular facility as the distance from it increases (see, for instance, Shanon and Dever,1974; Ipinnimo, 1978; Iyun, 1978; Knox, 1979; Olayiwola, 1990; Aloba, 1995; Olatubara, 1996; Ibikunle, 1997; Ajala et al. 2004. Furthermore, accessibilities problems also affect the level of patronage and utilization of the health facilities in Bayelsa state. This study is divided into four sections, section one is introduction and research problem, section two is the methodology, section three deals with the discussions of result and section four is the conclusion.

2.1 RESEARCH METHODOLOGY

2.1.1 Study Area

Bayelsa state is geographically located within Latitude $04^{\circ} 15$ North, $05^{\circ} 23$ South and Longitude $05^{\circ} 22$ West and $06^{\circ} 45$ East. It shares boundaries with Delta State on the North, Rivers State on the East and the Atlantic Ocean on the West and South. Bayelsa State is a Major oil and gas producing area and it contributes over 30% of Nigerias oil production. Crude oil was first struck in Nigeria in commercial quantities in Oloibiri, Ogbia Local Government in 1956. Gas production activities are currently being intensified in the State.

2.1.2 Sampling Procedure

The study employed the multi-stage stratified sampling technique involving three steps. At the first stage, the Yenagoa the capital of Bayelsa state was purposively selected for the study. At the second stage, health care facilities in both rural and urban communities each were selected by systematic random sampling using table of random number to ensure a spatial distribution of the communities based on the following criteria: Population size and Availability of healthcare facility. At the third step, two hundred (200) copies of questionnaire were randomly administered to the respondents in the study area. while the proportional sampling technique was then used to determine the sample size and number of questionnaire copies to be distributed to the selected communities in the study area.

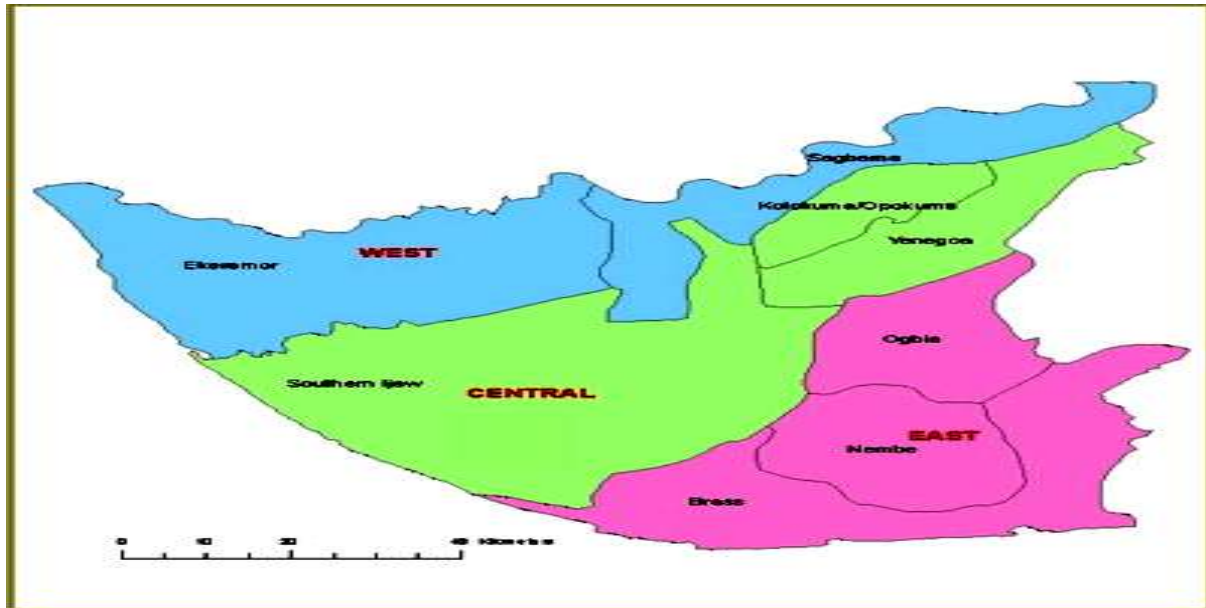


Figure 1: Map of Bayelsa State

3.1 DISCUSSIONS AND FINDINGS

3.1.1 Socio-demographic Profile of the Participants

The demographic characteristics of the respondents considered include; age, sex, income, level of education, religion, marital status and quality of healthcare services.

Table 1 Distribution of Respondents by Sex

Sex	Frequency	Percentage
Male	96	48.5
Female	102	51.5
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 2 Distribution of Respondents by Age

Age group	Frequency	Percentage
Less than 20 yrs	9	4.5
20 – 30 yrs	96	43.4
31 – 40 yrs	82	41.4
41 – 50 yrs	15	7.6

51 – 60 yrs	6	3.0
Total	191	100.0

Source: Authors Fieldwork, 2012.

Table 3 Distribution of Respondents by Marital status

Marital status	Frequency	Percentage
Single	87	43.9
Married	105	54.0
Divorced	3	1.5
Widow	3	1.5
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 1 shows that 48.5 percent of the participants were males, while the majority 51.5 percent were females. Table 2 shows that 4.5 percent of the participants were less than 20 years of age, 43.4 percent were between 20 - 30 years of age, 41.4 percent were between 31-40 years of age, 7.6 percent were between 41 - 50 years of age, while 3.0 percent were between 51-60 years of age. The implication here is that the selected samples were dominated by young adults.

Table 3 shows that 43.9 percent of the participants were single, 54.0 percent were married, 1.5 percent were divorced, while 1.5 percent were widowed. This shows that married participants pre-dominated the sample.

Table 4 Distribution of Respondents by Educational qualification

Educational qualification	Frequency	Percentage
Primary education	3	1.5
Secondary education	20	10.1
OND/NCE	84	42.4
HND/Degree	68	34.3
M.Sc/Ph.D	18	9.1
Others	5	2.5

Total	198	100.0
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Source: Authors Fieldwork, 2012.

Table 5 Distribution of Respondents by Monthly income

Monthly income	Frequency	Percentage
Less than ₦20,000	71	5.6
₦20,001 – ₦30,000	22	13.1
₦30,001 – ₦40,000	5	4.5
₦40,001 – ₦50,000	4	23.2
Above – ₦50,001	106	53.5
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 6 Distribution of Respondents by occupation

Occupation	Frequency	Percentage
Student	26	13.1
Trader	9	4.5
Civil servants	131	66.2
Others	32	16.2
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 4 shows that 1.5 percent of the participants had primary education, 10.1 percent had secondary education, 42.4 percent of the participants had OND/NCE certificate, 34.3 percent had HND/Degree, 9.51 percent had postgraduate certificate while 2.5 percent had other professional certificates. The predominant respondents had OND/NCE.

Table 5 shows that 5.6 percent of the participants indicated that their monthly income was less than ₦10,000, 13.1 percent of the participants indicated monthly income of between ₦10,000 – ₦20,000, 4.5 percent indicated a monthly income of between ₦20,001 – ₦30,000, 23.2 percent

indicated a monthly income of between ₦31,000 – ₦40,000, while 53.5 percent of the participants indicated a monthly income of about ₦40,000.

Table 6 shows that 13.1 percent of the participants were students, 4.5 percent of the participants were traders, 66.2 percent of the participants were civil servants, while 16.2 percent of the participants belong to other professional occupations such as drivers.

3.1.2 Nature and Structure of Health Service

At a high level, health services fall into different categories of health care:

1. Primary health care
2. Secondary health care
3. Tertiary health care

Primary care is usually the first point of contact for a patient. Primary care is typically provided by general practitioners/family doctors, dentists, pharmacists, midwives, etc. By its nature, primary care involves communicating with patients, developing personal connections with patients, going out into the community, using outreach programs for promoting good health and preventative strategies. Secondary health care: In most countries this is usually when a primary care person such as a doctor refers a patient to a specialist. Secondary care providers typically do not have the type of continuous contact with patients that primary care providers do, but help address more complex conditions. Tertiary health care: This is specialized consultative care, often hospital care.

Table 7 Nature of healthcare facility and level of patronage

Nature of healthcare centres	Frequency	Percentage
Primary health centre/clinic	31	15.7
Secondary health centre/clinic	69	34.8
Tertiary health centre/clinic	98	49.5
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 7 shows that 15.7 percent of the participants patronized primary healthcare centre, 34.8 percent of the participants patronize secondary healthcare centre, while 49.5 percent of the participants patronize tertiary healthcare centre

3.1.3 Type and Ownership of health facilities

The government provides health care, funding it through general taxes, and staff patients get no bills. For people who get insurance through their jobs the premiums are split between workers and employers, and private insurance plans pay private doctors and hospitals according to a set fee schedule.

Figure 2 Type and Ownership of health facilities



Source: Authors Analysis, 2012.

Figure 2 shows that 54.5 percent of the participants indicated that the health facilities is publicly owned, while 45.5 percent of the participants indicated that the health facilities is owned by private practitioner.

3.1.4 Accessibility to healthcare facilities

Access to health enables one to enjoy freedom and high level patronage, as a society it is a shared responsibility (much like sharing the burden of funding a military or providing education for all). In many poorer countries, the number of health workers such as doctors and nurses in proportion to the population can be small and in many rural settings, it can be very difficult for people to access services.

Table 8 Accessibility to healthcare centres

Accessibility to facility	Frequency	Percentage
Very accessible	183	92.4
Not accessible	15	7.6
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 9 Distance to health facilities

Distance to health facilities	Frequency	Percentage
Less than 1 km	53	26.8
2 km	26	13.1
4 km	86	43.4
Over 5 km	33	16.7
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 8 shows that 92.4 percent of the participants indicated that health facilities is very accessible to their home, while 7.6 percent of the participants indicated that health facilities is not accessible to their home due to the terrain. Table 9 shows that 26.8 percent of the participants indicated that distance to health facilities patronized is less than 1 km, 13.1 percent of the participants indicated that distance to the health facilities is 2 km, 43.4 percent of the participants indicated that distance to the health facilities is 4 km, while 16.7 percent of the participants indicated that distance to the health facilities is over 5 km.

Table10: Nexus of health facilities and Distance

Nature of health facilities * Distance to health facilities Crosstabulation

			Distance to health facilities				Total
			less than 1 km	2 km	4 km	over 5 km	
Nature of health facilities	Primary health centre/clinic	Count	8	14	6	3	31
		% of Total	4.0%	7.1%	3.0%	1.5%	15.7%
	Secondary health centre/clinic	Count	6	6	45	12	69
		% of Total	3.0%	3.0%	22.7%	6.1%	34.8%
	Tertiary health centre/clinic	Count	39	6	35	18	98
		% of Total	19.7%	3.0%	17.7%	9.1%	49.5%
Total	Count	53	26	86	33	198	
	% of Total	26.8%	13.1%	43.4%	16.7%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	57.685 ^a	6	.000
Likelihood Ratio	51.781	6	.000
Linear-by-Linear Association	.253	1	.615
N of Valid Cases	198		

a. 1 cells (8.3%) have expected count less than 5. The minimum expected count is 4.07.

The result in table 10 shows the relationship between distance and healthcare facilities, 4% and 7.1% of participants indicated a distance to health facilities is less than 1km and 2km to the nearest primary health, 3% indicated distance of 4 km, 1.5% indicated distance of over 5 km to primary health. The table also shows that 3% of participants indicated a distance of less than 1km to the nearest secondary healthcare, while 22.7% indicated a distance of 4 km, 6.7% indicated distance of over 5 km to the nearest secondary healthcare. However, 19.7% of participants indicated a distance of less than 1km to tertiary health care, 3% indicated 2km, 7%

indicated a distance of 4km to the nearest tertiary healthcare. The chi-square test indicated a significant association between the distance to health facilities and nature of healthcare ($X^2 = 57.69$, $df=6$, $p<.001$).

Table 11 Preference for modern healthcare facilities

Need more healthcare facilities?	Frequency	Percentage
Yes	183	92.4
No	15	7.6
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table11 shows that 92.4 percent of the participants indicated that they need more modern health facilities, while 7.6 percent of the participants indicated that they do not need more health facilities.

3.1.5 Patronage of traditional health practitioner

Alternative health practitioners are patronized due to belief in spiritual illness, the quest for natural herbs. Traditional practitioners represent another potential reservoir of personnel for primary health care, and their integration into the modern system of medicine should be organized .

Table 12 Patronage of unorthodox health practitioner

Seeking other health practitioner	Frequency	Percentage
Yes	18	9.1
No	180	90.9
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 12 shows that 9.1 percent of the participants indicated that they seek other unorthodox health practitioner, while 90.9 percent of the participants indicated that they do not seek other unorthodox health practitioner.

Table 13 Reasons for seeking other unorthodox health practitioner

Reason for seeking other practitioner	Frequency	Percentage
Natural herbs	6	3.0
There are spiritual basis of health and diseases	3	1.5
Use of medicinal herbs	9	4.5
No response	180	90.9
Total	198	100.0

Source: Authors Fieldwork, 2012.

Table 13 shows that 3.0 percent of the participants indicated that they seek other practitioners because of natural herbs, 1.5 percent of the participants indicated that because there are spiritual basis of health and diseases, 4.5 percent of the participants indicated that because of use of medicinal herbs.

Table 14 Relationship between distance and patronage of health facilities

Distance to health facilities	Accessibility			X ²	df	Sig
	Very accessible	Not accessible	Total			
Less than 1 km	50 (25.3%)	3 (1.5%)	53 (26.8%)	11.95	3	<.01
2 km	20 (10.1%)	6 (3.0%)	26 (13.1%)			
4 km	80 (40.4%)	6 (3.0%)	86 (43.4%)			
Over 5 km	33 (16.7%)	0 (0.0%)	33 (16.7%)			
Total	183 (92.4%)	15 (7.6%)	198 (100%)			

The result in table 14 shows that 25.3% of participants who indicated distance to health facilities of less than 1km also indicated that it is accessible, 10.1% who indicated distance of 2 km distance indicated that it is accessible, 40.4% who indicated distance of 4 km, 16.7% of the participants who indicated distance of over 5 km also affirmed that it is accessible. However, 1.5 of participants with less than 1 km distance to health facilities indicated that it is not accessible,

3% of the participants with 2 km distance to health facilities indicated that it is not accessible, 3% of the participants with 4 km distance to health facilities also indicated that it is not accessible. The chi-square test indicated a significant association between the distance, accessibility to health facilities and patronage level ($X^2 = 11.95$, $df=3$, $p<.001$).

4.1 CONCLUSION

Health facilities are accessible and the patronage level is quite high and the structure of health infrastructure ranges from primary health care, secondary health care and tertiary health care, some spending programs may divert from general needs to specific needs, such as building hospitals (as opposed to strengthening primary care), or funding for specific diseases (which is usually treatment based with less visible effort on preventative care), etc. The enormous numbers of people without access to health, there is a terrible paradox: poverty exacerbates poor health while poor health makes it harder to get out of poverty. Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses hence, patronizes unorthodox health practitioners and patent medicine stores. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced often adds to the fragmentation and health related problems.

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