STAKEHOLDERS' PERCEIVED INFLUENCE OF PRIMARY HEALTH CARE SERVICES ON REALIZATION OF HEALTH FOR ALL IN KWARA STATE, NIGERIA

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(03/25OP021)

B.Sc. (Ed); M.Ed. (Ilorin); MPA(UNAD)

A THESIS SUBMITTED TO THE DEPARTMENT OF HEALTH PROMOTION AND ENVIRONMENTAL HEALTH EDUCATION, FACULTY OF EDUCATION, UNIVERSITY OF ILORIN, ILORIN, NIGERIA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF DEGREE OF DOCTOR OF PHILOSOPHY (Ph.D.) IN HEALTH EDUCATION.

DR. R. A. SHEHU

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DECLARATION

I, Baba, Dare Abubakar (13/250P021) hereby declare that this thesis entitled: "Stakeholders Perceived Influence of Primary Health Care Services on Realization of Health for All in Kwara State, Nigeria", is a report of my investigation carried out in the sixteen (16) Local Government Areas of Kwara State, Nigeria. This thesis has not been presented or accepted in any previous application or consideration, for award of a higher degree. Also, all the sources of information and cited materials were adequately acknowledged.

In addition, the research work has been ethically approved by the University Ethical Review Committee and passed the anti-plagiarism screening of the University of Ilorin Postgraduate School.

_____ _____

Baba D.A. ***Date***

DEDICATION

This thesis is dedicated to Almighty God, who in His infinite mercy, has given me the grace to start and witness the completion of this course and making my dream a reality.

CERTIFICATION

This is to certify that this thesis has been read and approved as meeting the requirements of the Department of Health Promotion and Environment Health Education, University of Ilorin, Ilorin, Nigeria for the award of Degree of Doctor of Philosophy (Ph.D.) in Health Education.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ANC – Antenatal Clinic

BHSS – Basic Health Service Scheme

CHEWs – Community Health Extension Workers

CHOs – Community Health Officers

CMH – Community Mental Health

CMWs – Community Midwives

DHS – Dental Health Service

DRF – Drug Revolving Fund

DRS – Drug Revolving Scheme

EPI – Expanded Programme on Immunization

FGD – Focus Group Discussion

FGN – Federal Government of Nigeria

FMOH – Federal Ministry of Health

IEC – Information, Education and Communication

IMCD – Integrated Management of Childhood Diseases

IPD – Immunization Plus Days

KAP – Knowledge, Attitude and Practice

LGAs – Local Government Areas

LIDs – Local Immunization Days

MCH – Maternal and Child Health

MDGs – Millennium Development Goals

HFA – Health For All

NGOs – Non-governmental Organizations

NHP – National Health Policy

NPC – National Population Commission

NPHCDA – National Primary Health Care Development Agency

NPI – National Programme on Immunization

PHC – Primary Health Care

RBM – Roll Back Malaria

REW – Reach Every Ward

SMOH – State Ministry of Health

TBAs – Traditional Birth Attendants

UNESCO – United Nations Educational Scientific and Cultural Organization

UNICEF – United Nations Children Fund

VHWs – Village Health Workers

VIP – Vertical Intervention Programmes

WBN – World Bank of Nigeria

WHA – World Health Assembly

WHO – World Health Organization

ABSTRACT

Primary Health Care (PHC) services were adopted as a means of achieving "health for all". Nigeria adopted the policy to ensure sustainable health development at the grassroots, but its effectiveness has been underscored due to some lapses noted in the implementation of the component services. This study investigated stakeholders' perceived influence of PHC services on realization of "health for all" in Kwara State, Nigeria. The objectives of this study were to examine stakeholders' perceived influence of: (i) PHC service of health education on prevailing health problems; (ii) adequate supply of water and basic sanitation; (iii) maternal and child health including family planning; and (iv) immunization against infectious diseases.

A descriptive research design of survey type was adopted for the study. The population of the study comprised of 7079 stakeholders which include village heads, health care providers, and members of PHC committees in the sixteen (16) Local Government Areas of Kwara State, Nigeria. Multi-stage sampling technique was used to select 9880 respondents for the study. Researcher's designed questionnaire and focus group discussion guide validated by three experts from related fields were used for data collection. The reliability of the research instruments was determined using test re-test method in which correlation coefficient of 0.76 was obtained. Descriptive statistics was used to analyse demographic data, while Spearman Brown Rank Order Correlation and chi-square statistics were used to test the hypotheses in the study. Thematic analysis was done for the qualitative data generated from focus group discussion.

The findings of the study were that:

i. PHC services were key to the realization of health for all, [cal. r-value (0.99) > critical value (0.06)];
ii. PHC services of health education on prevailing health problems and method of preventing them influence realization of health for all, [cal. x^2 value (743.06) > critical value (21.03)];
iii. PHC services of adequate supply of water and basic sanitation influence realization of health for all, [cal. x^2 (586.82) > critical value (21.03)];
iv. PHC services of maternal and child health, including family planning influence realization of health for all, [cal. x^2 value (708.32) > critical value (21.03)]; and
v. The results of the thematic analysis revealed that most health facility committees in the State were not employing appropriate strategies for the realization of Health for All.

The study concluded that PHC services delivery had influence on the realization of Health for All. This implies that PHC services are functioning well in Kwara State. The study therefore recommended that the Local Government Area Primary Health Care committees within the state should be encouraged to continue the delivery of all the component services by employing different strategies such as cohesive team approach, situation analysis, community mobilization, advocacy, community diagnosis and intersectoral collaboration.

CERTIFICATION

We, the undersigned Internal Examiners, hereby certify that Baba, Dare Abubakar (13/250P021) has satisfactorily effected all the necessary corrections pointed out to him during the Oral Examination of his thesis entitled: "Stakeholders Perceived Influence of Primary Health Care Services on Realization of Health for All in Kwara State, Nigeria", held on 14/09/2017 and recommend that he be awarded the degree of Doctor of Philosophy in Health Education.

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CHAPTER ONE

INTRODUCTION

Background to the Study

Primary Health Care (PHC) services were adopted as a means of achieving "Health for All" worldwide. Nigeria adopted it to ensure sustainable health development at the grassroots. The provision of health services in Nigerian were borne out of policies and programmes designed for implementation at different levels of the health care system. Some of the health services rendered to people are not adequate to cater or address sufficiently, the problems hindering people's health and well being. Kuti, Sorungbe, Oyegbite and Bamisaiye (2002) noted that the health services of Nigeria have evolved through a series of development including a succession of historical plans of action which had been introduced by previous administrations. Examples are the second and third National Development Plans of 1970-74 and 1975-80 respectively. The experts stressed that health services provided in the past are not adequate in meeting the needs and demands of the public as reflected by poor state of health of the population.

At initial stages of implementing health programs and the services in Nigeria, much emphasis were placed on curative services to the detriment of preventive services. The services coverage was low coupled with delivery of dominant curative services. The services were fraught with many inadequacies. Example are; poor facility, non availability of drugs, inadequate personnel, long distance, low coverage and other factors numerous to mention. The need to reduce or even eradicate the spread of diseases within the communities necessitated the adoption and initiation of some preventive strategies especially in the rural areas. Baba (2007b); Federal Ministry of Health (FMOM) (2016); Richard, Kelley and Nick (2002) corroborated that the

curative services rendered within the community before late 70s were not sufficient; to arrest all the infectious diseases. This situation led government at the three tiers to collaborate with Non-Governmental Organizations (NGOs) and adopt new health care approaches based on preventive rather than curative services. Peter (2007) noted that primary health care was adopted 1978 to bridge the gap created by the dominant curative services rendered to the people at the rural areas.

In furtherance of government efforts towards enthronement of viable preventive care and attainment of optimal health for people in the society, greater consideration were given to the health needs and aspiration of people. Johnson (2005) posited that thirty years ago, the objective of health care appeared to be that society had a duty to provide all the health care from which each of its members could practically benefit. This goal was too far from being realistic as a result of lack of means and insufficient benefit that will accrue from such efforts. This made it expedient to revitalize the implementation strategies of health for all to establish its impacts on overall health development.

In an attempt to make health a worth-while asset and accessible to people, the World Health Assembly in 1977 adopted the goal of "health for all by the year 2000" and beyond. The resolution to ensure optimal health for people is a part of commitment and pledge by Joint Committee for attainment of possible level of health for people worldwide. World Health Organization (WHO) and United Nation International Children Emergency Fund (UNICEF) in an international conference held in 1978 in Alma Ata in Soviet Union adopted primary health care as a comprehensive strategy of achieving the goal of health for all by the year 2000. Peter (2007) observed that several studies and experiences of many countries culminated into 1978 conference in Alma Ata that eventually gave rise to primary health care adopted for actualizing the goal of health for all by the year 2000 and beyond.

Primary health care has been constitutionally devoluted to local government administration which is sometimes referred to as grassroot government. It is a health care delivery approach aimed at provision of comprehensive health services based heavily on preventive care. Primary health care is dimensional in its approaches to service delivery. It consists of preventive, promotive, curative and rehabilitative care. It is a health care delivery approach adaptive and suitable for meeting health needs of the people in rural areas. This objective of meeting the needs of majority clearly features in what health planners and experts referred to as most acceptable definition of PHC by WHO and UNICEF in 1978. According to WHO and UNICEF (1978) primary health care is an "essential health service based on practical, scientifically sound and socially acceptable method, made universally accessible to individual and family within the community, at the cost that community and country can afford to maintain at every stage of our development, in the spirit of self reliance and self determination". It is an integral aspect of a country's health care delivery system. It is health care delivery system based heavily on preventive and promotive services. Hence, it is tagged health at the door steps of rural dwellers.

Primary health care is a service delivery approach that has the main objective of bringing health services to the door step of all within the community. Shehu (2000) asserted that the idea of primary health care scheme is to ensure that both rural and urban dwellers not only have access to meaningful health care but that they participate actively in the implementation of every facet of the programme.

Primary health care services revolve round preventive, curative, promotive and rehabilitative services adopted for attainment of optimal health for people within the community.

Shehu (2000) stressed that the idea of primary health care is to have a comprehensive health care system that will tackle promotive, preventive, curative and rehabilitative health challenges.

The primary health care model of health service delivery was adopted as strategy for realization of health for all by the year 2000 and beyond. WHO (2011) noted that the ideal primary health care was adopted in the declaration of the international conference and constitution of member nations held jointly by WHO and UNICEF in Alma Ata, at Kazakhstan in 1978 which later became the concept of health for all.

Primary health care services are based on general principles of self reliance, equity and social justice. The specific principles, according to National Primary Health Care Development Agency (2008) are as follows:

- It is an essential health care services needed by the people at the grassroots;
- It must be universally accessible to people at the grassroot;
- It is health care delivery services that utilize appropriate technology;
- It is health care service offered/provided at an affordable cost;
- It consists of an integrated health care services;
- It ensure full participation of the people at the grassroot;
- It is based on collaborative efforts and joint responsibility of different interests groups existing at the grassroot.

Apart from the principles listed above, PHC has provision for component services. At its inception in 1978, eight component services were adopted. The services later increase to fourteen (14) as a result of the need to address some of the health problems that were not included on the first eight component services. National Primary Health Care Development Agency (2012) stated

that primary health care component services have increased from initial eight to fourteen which are as follows:

- Health education on prevention and control of prevailing health problems;
- Maternal and child health including family planning;
- Adequate water supply and basic sanitation;
- Appropriate treatment of common diseases and injuries;
- Prevention of locally endemic and epidemic diseases;
- Promotion of food supply and adequate nutrition;
- Supply of essential drugs through application of drug revolving scheme;
- Immunization against preventable killer diseases;
- Mental health services;
- Dental health services;
- Care of the aged;
- Care of the handicapped;
- Primary eye care;
- Adolescent health care

A critical look at the delivery of primary health care services shows various programmes and policies which have evolved. Some of these programmes and policies have succeeded in improving health and well being of the people without adequate coverage and community involvement. It has been observed by Kuti et al (2002) that there are diverse view on viability of primary health care services rendered at the grassroots. Kuti et al (2002) maintained that the primary health care end users agreed that the services rendered to them have assisted in improving their health standard, while the health care providers empathically stated that there is

poor participation and involvement of members of community in its provision. Koleoso (2006) observed that there have been several attempts in the past to provide effective and efficient health services with wide coverage in Nigeria. The director maintained that in line with the background of continuing effort to reform health sector and improved primary health care in Nigeria, the pre-occupation of Primary Health Care Development Agency would be revitalization of the health system.

The implementation of primary health care follows different patterns and approaches as entrenched in its guidelines. At certain time, curative care dominate the centre stage of health care while in another stage curative and preventive care were combined together. Health action plans were formulated in line with prevailing economic situation in the country that affect health services (Richard, Kelley & Nick, 2002). This led to succession of health programmes and policies like basic health service scheme, 52 Pilot Local Government Studies and primary health care implementation, Bamako initiative programme on strengthening of primary health care, ward health system, and millennium development goal, population policy, to mention but a few (Baba, 2007).

The implementation of primary health care services according to health experts suppose to improve accessibility, affordability, cost effectiveness of services rendered because of integration of local technology. Despite the laudable objectives of PHC, its implementation continue to witness low patronage by people at the grassroots. Roger (2003) stressed that the major issues in the provision of health care services in rural and urban centres in both developed and developing countries is accessibility of the available services. The researcher further emphasized that almost all rural areas in both developed and developing countries faced

difficulty in obtaining effective health care as a result of poor transportation, communication gap, low productivity, insufficient manpower and poor incomes.

It has also been revealed that the perception held by people at the grassroot is that government pays lip service to implementation of primary health care component services (Federal Ministry of Health & National Primary Health Care Development Agency, 2012). This is evident for instance in the way National Programme on Immunization are being implemented. Most of the grasssroot governments use it as spoils of office to settle the electorates that voted them into power. Many of these electorates were engaged as adhoc staff to carry out vital component of primary health care such as immunization against six childhood killer diseases (Baba 2007a, Kuti et al., 2002).

Some of the stated programmes such as integrated management of childhood infection, roll back malaria, millennium development goals are either poorly implemented or have outlived their time and need total over-hauling. This study is therefore directed towards determining stakeholders' perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria.

Statement of the Problem

In the past, health care delivery services have been incorporated into series of sustainable health development plans and programmes. During this period, much emphasis were placed on curative services at the detriment of preventive care services. This was the period when dominant hospital care occupies centre stage of health care delivery services without considering measure for averting reoccurrence or spread of diseases within the community. The nation's health care before the advent of PHC was essentially sick care system, less attention was paid to preventive health which is the pivotal of the primary health care services.

The dominant curative services were not adequate to cater for numerous health problems such as nutritional deficiencies, water borne disease and other preventable diseases like tuberculosis, hepatitis, poliomyelitis and a host of others, affecting people within the community. The situation was further worsened by low coverage of services provided, non involvement of community at critical points in decision making, insufficient manpower and training, high cost of receiving treatment and lack of basic health statistics. These problems led to enthronement of dominant curative and the need for the evolvement of viable preventive health care service.

The adoption of primary health care system in 1978 by the Nigerian government ushered in provision of essential services as integrated health care delivery approach. The services in most cases have not been effective as to eradicate diseases and health problems affecting people at the local government levels in Nigeria. In Kwara State some of the services provided such as roll back malaria, house to house immunization, Millennium Development Goal (MDG), guinea worm eradication programme are either not adequately delivered or have out-lived their times.

It has been observed by the researcher in most of the Local Government Areas in\Kwara State that the problem stated above is further compounded by poor performance of primary health care providers in the provision of comprehensive integrated health care services consisting of all component services under the same roof. There is also inadequate evaluation of vertical and intervention programme such as drug revolving scheme (DRS), roll back malaria (RBM), Integrated Management of Childhood Diseases (IMCD), kick polio and others.

Apart from the problems noted as confronting primary health care services in most of the local government areas in Kwara State, there is lack of consistencies in the implementation of policies and programmes such as national health policy, millennium development goals, national population policy midwifery scheme, of “reach every ward”, “every child count”, and national

nutrition policy. Most of these policies and programmes were not adequately implemented by their promoters. The programmes and policies were mere documents meant to revitalize primary health care for attainment of health for all (Baba, 2007).

In addition to the problem of inconsistencies in policy formulation and execution, there is resurgence of health problems adjudged to have been totally controlled. Inspite of government efforts and commitment at different levels of health care in Nigeria towards eradication of diseases, most of the Vertical Intervention Programmes (VIP) implemented are not adequate to sustain control of the problems. Hence, the relapse of some preventable diseases such as poliomyelitis, diarrhoea, malaria, tuberculosis and others.

It has been observed by the researcher in one of the field based experience and surveillance initiative that there were poor integration and application of primary health care facilitators to provision of all encompassing health care to people at the grassroots in Kwara State. The facilitators like cohesive health team approach, community mobilization for active participation, proper community diagnosis, situation analysis, intersectoral and collaboration.

The current approach to primary health care delivery lays much emphasis on selective primary health model based on integrated service delivery approach. A careful look at the level of implementation of PHC component services revealed many inadequacies and shortcoming identified above. These wide spread inadequacies have created research gap which this study intend to fill.

Research Questions

The following research questions were raised to guide the study.

- What are the stakeholders' perception of the influence of primary health care services on realization of health for all in Kwara state, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of health education on prevailing health problems on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of adequate food supply and nutrition on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of adequate supply of water and basic sanitation on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of maternal and child health including family planning on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of immunization against infectious diseases on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of prevention and control of endemic diseases on realization of health for all in Kwara State, Nigeria?

- What are the stakeholders' perception on the influence of primary health care service of appropriate treatment of common diseases and injuries on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of provision of essential drugs no realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of primary health care component service of dental health on realization of health for all in Kwara State, Nigeria?
- What are the stakeholders' perception on the influence of primary health care service of primary health care component service of mental health on realization of health for all in Kwara State, Nigeria?

Research Hypotheses

The following research hypotheses were formulated for the study;

Main Hypothesis

Stakeholders perception of primary health care services will not have significant influence on realization of health for all in Kwara State, Nigeria.

Sub Hypotheses

- Stakeholders' perception of primary health care service of health education on prevailing health problems will not have any significant influence on the realization of health for all in Kwara State, Nigeria.

- Stakeholders' perception of primary health care service of adequate food supply and proper nutrition will not have any significant influence on realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of adequate supply of water and basic sanitation will not have any significant influence on realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of maternal and child health including family planning will not have any significant influence on realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of immunization against infectious diseases will not significantly influence realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of prevention and control of endemic diseases will not significantly influence realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of appropriate treatment of common diseases and injuries will not significantly influence realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of provision of essential drugs will not significantly influence realization of health for all in Kwara State, Nigeria.
- Stakeholders' perception of primary health care service of dental health will not significantly influence realization of health for all in Kwara State, Nigeria.

- Stakeholders' perception of primary health care service of mental health will not significantly influence realization of health for all in Kwara State, Nigeria.

Purpose of the Study

This study focused attention mainly on assessing stakeholders' perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria. The investigation were among others assessed:

- Influence of primary health care service of health education on prevailing health problems and method of controlling them on realization of optimal health for all in Kwara State, Nigeria;
- Influence of primary health care service of adequate food supply and proper nutrition on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of adequate supply of water and basic sanitation on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of maternal and child health including family planning on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of immunization against infectious diseases on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of prevention and control of endemic diseases on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of appropriate treatment of common diseases and injuries on realization of health for all in Kwara State, Nigeria;

- Influence of primary health care service of provision of essential drugs on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of mental health on realization of health for all in Kwara State, Nigeria;
- Influence of primary health care service of dental health on realization of health for all in Kwara State, Nigeria;

Significance of the Study

The outcome of this study would create awareness in the communities on the need to make judicious utilization of health facilities and equipment within their domain. This means that the findings of the study would aid peoples' understanding of primary health care and improve their patronage of health centres in their vicinity.

The findings of the study would also assist the primary health care providers in the provision of all the component services. The study outcome will reveal areas of lapses and measures that can be taken by health workers to improve on them. The coverage areas of the service rendered by health workers will greatly increase, because of wideness of study population.

The findings from this study would assist government at all levels most especially grassroot health system to plan and implement various health and health related programmes such as general immunization programme, nutrition intervention programme, drug revolving scheme and so on.

The outcome of this study would also assist non governmental organizations and donor agencies such as global fund foundation; health alive foundation; sight savers organization;

Damien foundation, Belgium; UNICEF, WHO, USAID, NURINNRIM and so on, to identify viable projects that can be executed to meet health needs of people within the community.

This work would be of immense benefit to the policy makers and health planners in areas of provision of infrastructural facilities, equipment and other health intervention programmes and services. The findings from this investigation could be of great benefits to the people within the various communities at grassroot. It would assist people in identifying and joining hands with health care providers and government to ensure effective implementation of primary health care. This is to say that the report of findings from the study will improve level of community participation in the implementation of primary health care for attainment of health for all.

Scope and Delimitation of the Study

The study was carried out in the sixteen Local Government area of Kwara State, Nigeria. The study assessed stakeholders perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria. The investigation was carried out in some selected health facilities in each of the local government areas in Kwara State, Nigeria.

The study was delimited to members of the local government health development committees, the traditional or village heads, members of community development committees and members of selected health facilities committees in the sixteen local government areas of Kwara State, Nigeria. The sample size used for the study was selected among the categories of stakeholders listed above.

The study was specifically delimited to all the component services that revolve round primary health care such as health education, food supply and basic nutrition, water supply and basic sanitation, maternal and child health, immunization, prevention and control of endemic

diseases, treatment of injuries and ailments, essential drug supply, dental health, mental health, primary eye care, care of aged, care of the handicapped, adolescent health care, health intervention programmes, facilitators for implementation of primary health care. Apart from the focused group discussions that were held in some selected villages within the study areas, researcher structured questionnaire was the main instrument used to elicit information for the study.

The administration of instrument was done by the researcher and research assistants who are mainly polyvalently trained primary health care providers. The data that emanate from questionnaire administration was analyzed with use of simple percentage, thematic statistical method, mean ranking method, spearman brown rank order and inferential statistics of chi-square (x^2) at 0.05 alpha level of significance.

Operational Definition of Terms

This aspect explains some of the terms and concepts used in the study.

Health for All: A statement of intent directed at realization of minimum level of health and wellness for people within a given community.

Primary Health Care: The all encompassing and essential health services rendered to people at the grassroot for ensuring optimum level of wellness.

Services: These are useful activities carried out to improve people living standard or address people needs and demands

Stakeholders: Stakeholders as used for this study refer to all those that have contributed to effective implementation of primary health care. They are health personnel, people at the grassroot, the executive officers at Local Governments Areas, traditional or village heads, members of various health committees.

Stakeholders' Perception: These are the view held by those that contribute and benefit from services or programmes deliver to them within the communities.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter examined in details the relevant concepts that are directly associated with the topic under investigation. The review covers works of renowned experts in primary health care as published in Local, National and international journals including internets and textbooks. Some of the relevant concepts reviewed are as follows:

- Theoretical framework of Primary Health care;
- Conceptual framework of Primary Health care;
- Health for all and Primary Health Care Services;
- Health Education on prevailing Health problems, Method of preventing them and Health for All;
- Adequate food supply, nutrition, and Health for All;
- Adequate Supply of Safe Water, Basic Sanitation and Health for All;
- Maternal and child health including Family planning Health for All;
- Immunization against Infectious Diseases and Health for All;
- Prevention and Control of Endemic Diseases and Health for All;
- Treatment of common Ailments, Injuries and Health for All;
- Essential Drugs supply and Health for All;
- Dental Health and Health for All;
- Mental Health and Health for All;
- Care of Aged and Health for All;
- Care of Handicapped and Health for All;
- Primary Eye care and Health for All;
- Adolescent Health Care services and Health for All;

- Health Intervention programmes and Health for All;
- Facilitators for Effective Implementation of Primary Health Care;
  - (i) Community involvement and participation;
  - (ii) Cohesive primary health care team;
  - (iii) Community mobilization and primary health care;
  - (iv) Integrated Health Care Delivery System and Primary Health Care;
  - (v) Community diagnosis and situation analysis and primary health care;
  - (vi) Intersectoral collaboration and primary health care;
  - (vii) Advocacy and primary health care
- National Health Policy and Primary Health care;
- Appraisal of reviewed Literature;

Theoretical Framework of Primary Health Care

It is necessary to state that the provision of viable health care services to teeming population consisting of rural areas and urban centres is often preceded by prioritization of health care needs and resources at people's disposal. In the rural areas for instance, most infrastructural facilities are lacking and the resources at their disposal are grossly inadequate when compared with what obtains in the urban centres. The prioritization measure is further justified by pattern of illnesses and people responses to their treatments and prevention.

In establishing justification for adoption and operation of primary health care, the work of renown experts like George Gober (1982) tagged "striking balance between preventive, curative and social support medicine. Maclean and Passmore, (1974) are highly revered. Maclean and Passmore (1974) tacitly remarked that the most effective and easiest way by which people can

remain healthy is to preserve their health through prevention of diseases affliction and promote actions and measures that make such objectives achievable. Maclean and Passmore further identified and amplified five methods of diseases attack which can be likened to some of the primary health care component services. The five methods identified by the researchers are as follows:

- Control of the environment to habitable and healthy to live;
- Ensuring suitable food supply;
- Mass Medication;
- Eradication programmes;
- Modification of behaviour largely through health education;

DIAGRAMMATIC REPRESENTATION OF HEALTH PRESERVATION THEORY BY MACLEAN & PASSMORE (1974)

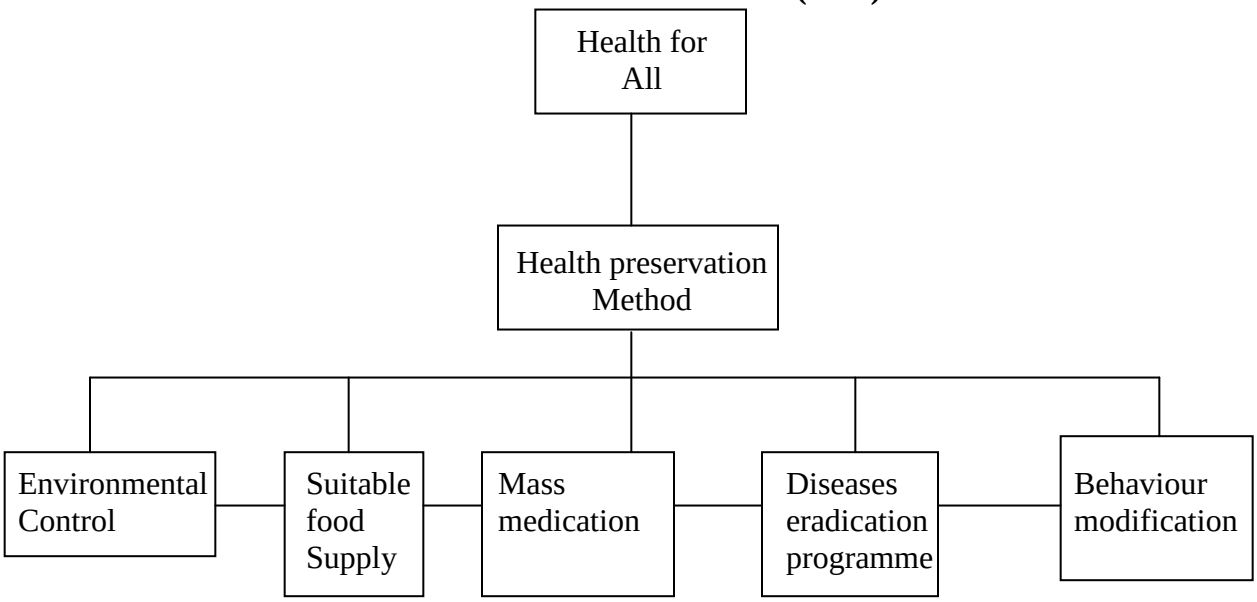


Figure 1: Theoretical Framework of Maclean & Passmore (1974)

Source: Researcher Developed 2017

A critical appraisal of the methods listed above shows that primary health care components services adopted for realization of goal of "health for all" are offshoot of Maclean and Passmore, (1974) theory of preservation of health, prevention of diseases and promotion of action and measures that make such objectives achievable. This theory relates to primary health care objectives because attainment of health for all is hinged on effective provision of primary health care component services. The primary health care component services relate to all the health actions and issues addressed by the health preservation theory. This is evidence from the five (5) health service identified above i.e. environmental control which relates to primary health care component service of basic sanitation suitable food supply primary health service of adequate food supply and proper nutrition among others.

DIAGRAMMATIC REPRESENTATION OF THE THEORY: STRIKING BALANCE ON PREVENTIVE, CURATIVE AND SOCIAL SUPPORT SERVICES

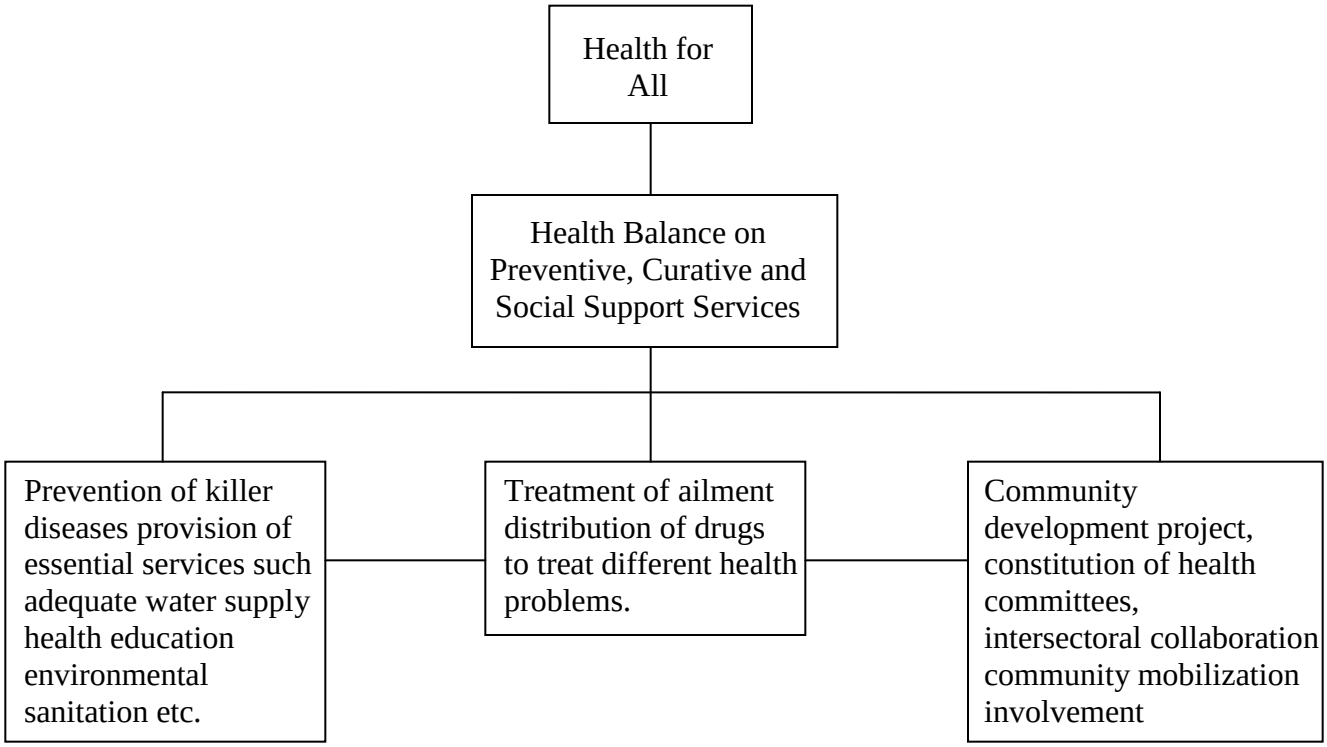


Figure 2: Theoretical Framework Organogram of George Gober of 1982

Source: Researcher Developed 2017

Apart from the diseases elimination theory described above, George Godber theory of striking balance between preventive, curative and social support medicines, constitute determinant and basis for adoption of primary health care. Godber (1982) noted that in the olden days the objective of health care was that government should provide all needed health care for people within the larger society. Today, this goal seem unrealistic and unachievable going by problems of inadequate fund, pattern of illnesses, level of community participation in matter affecting their health and well being. Godber further stressed that a form of rationing exists either by ability to pay or by queuing for limited services available. The theorist summarily stated that the objective of providing all possible care strictly in accordance with need must remain. This is to ensure the provision of needed services for all people and not everything for few people.

DIAGRAMMATIC REPRESENTATION OF DEFECTIVE THEORY OF HEALTH CARE

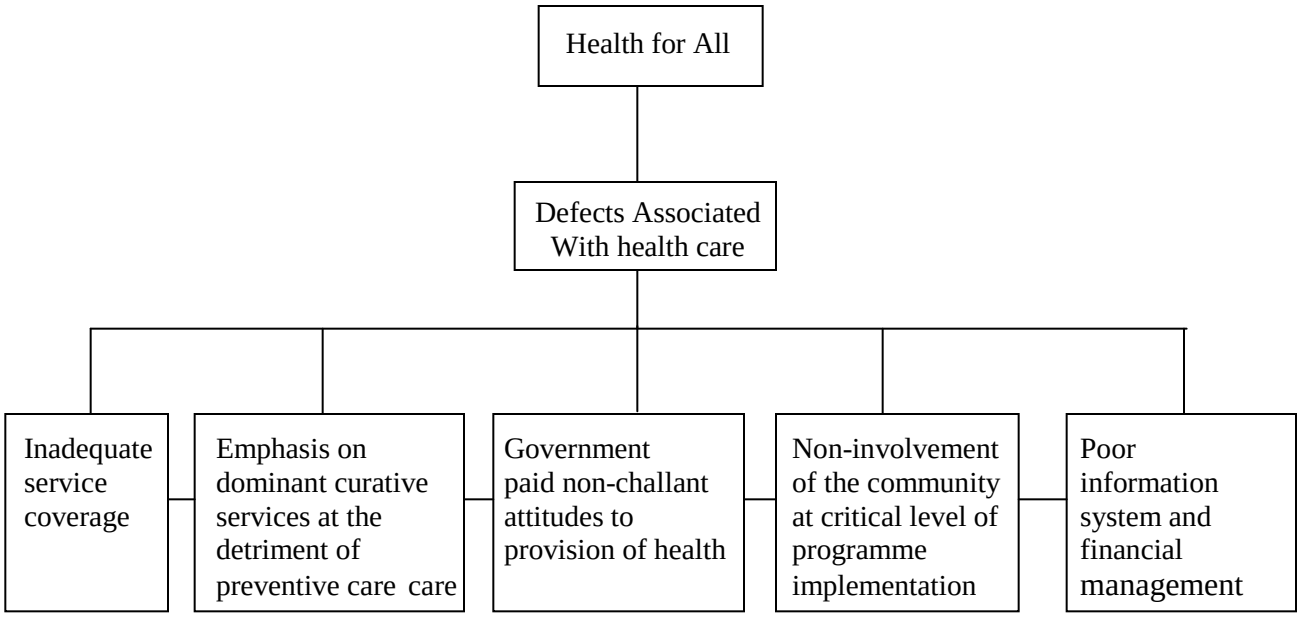


Figure 3: Theoretical Framework Organogram of Kuti et al 2002

Source: Researcher Developed 2017

In addition to the theories of health care examined above, Kuti, Sorungbe, Oyegbite and Bamisaiye (2002) asserted that the health services as organized before the adoption of national health policy show major defects which are as follows:

- Inadequate service coverage of target population;
- There is high investment on curative service at the detriment of preventive care;
- The governments and management at all levels showed non-challants attitudes towards vital issues concerning health and well being of people;
- Community involvement is minimal or not well pronounced at a critical period in decision making;
- Other factors such as lack of basic statistics, poor financial allocation to health services and so on impede viable health care delivery services.

By and large, the above highlighted points showed serious discrepancies and defects impeding smooth implementation of health care services. Kuti et al (2002) remarked that despite the identified inadequacies, there are encouraging cases in which dynamic health administrators, professional persons and lay members of the community have successfully corrected these faults within their local areas. The researchers concluded that a successful adoption of such model of health programme form basis for addressing various constraints impeding effective realization of health policy.

The trends of events enunciated by the theorists in the three theories previously examined justified adoption of primary health care as a means of achieving health for all by the year 2000 and beyond. David (2002) noted that primary health care which is at the centre of health promotion emphasizes prevention rather than cure. According to the researcher, the success of primary health care programmes depends on the extent to which the community knows about and adheres to measures that prevent diseases such as HIV/AIDS and tuberculosis from spreading. This can simply be interpreted to mean that any action taken to maintain health and prevent illness is germane to the objective of primary health care.

In David theory, emphasis is placed on need to maintain health through initiation of different promotive services and activities. This according to the researcher will assist in ensuring effective prevention of illnesses, health promotion involves situation analysis or need assessment, development and implementation of appropriate intervention programmes, and effective programme evaluation. Primary health care consists of health promotion and diseases prevention. Hence, David concludes that primary health care revolves around health maintenance and disease prevention.

Conceptual Framework of Primary Health Care

In the past, the responsibility of providing health care services to teeming Nigerian population resides solely with the federal and state governments that focuses on dominant curative services accessible to people in urban centres. The kind of health service rendered at that period were not adequate to cater for the health needs of people in rural areas in Nigeria. This scenario had made experts and governments to look inward for possible solutions to dispropionate health care services provision at the grassroots. National Primary Health Care Agency (2006) asserted that there have been several attempts in the past to provide effective and efficient health services with wide coverage in Nigeria. The agency further stated that the first attempt was in 1976 when the Federal Government introduced the Basic Health Service Scheme (BHSS) as part of 1975-1980 development plan.

The strive to attain optimal level of health standard for people all over the world received impetus among numerous international health and health related organizations. United Nation High Commission for Human Right & World Health Organization remarked that the declaration "health for all" emanated after a thorough deliberation by the representatives of all members countries on ways by which many and varied health and health related problems can be overcome.

Health for all is an encompassing concept denoting mission and vision for attainment of optimal level of health for people all over the world. Mahler (2000) opined that "health for all" means that health is to be brought within the reach of everyone in a given country. Pan American Health Organization and World Health Organization (2013); and Baba (2007b) corroborated Mahler position that health for all by the year 2000 is a conception and Slogan that has to do

with the process by which people are made to comprehend and recognize all factors and habits that affect health and those that promote it.

The Slogan "health for all" does not mean that everybody will be healthy and that there would not be traces of diseases by the year 2000 or beyond. This means that there will be adequate awareness and knowledge about the prevailing health problems within the community before and beyond year 2000. Peter (2007) noted that "health for all" is more of access to and opportunities for healthy living. The researcher emphasized that access to health is much more than the provision of health facilities within a reasonable distance from individuals.

The persistent Clamouring and Strive for sustainable health development by governments and private organizations receive boost when United Nation International Children Emergency Fund (UNICEF) and World Health Organization (WHO) at Alma Ata adopted primary health care (PHC) as means of realizing goal of "health of all" the year 2000 and beyond. Federal Ministry of Health (FMOH) (2015) and National Primary Health Care Development Agency (2012) asserted that in international conference on primary health care sponsored by WHO and UNICEF at Alma Ata, representatives of 134 governments including Nigeria, adopted primary health care as a tool to achieving "health for all" by the year 2000.

The goal of health for all by the year 2000 and beyond is synonymous with the concept of primary health care. This is because of its focus on reduction or total eradication of prevailing health problems in the society and the need to involve people in addressing issues concerning their health. World Health Organization (2016) empathically stressed that primary health care is the first level of contact of individual, family and community within the national health system.

The adoption of primary health care by the joint assembly of UNICEF and WHO member countries serves as turning point in an attempt at ensuring sustainable health development world

wide. National Primary Health Care Development Agency (2012) stated that the joint constitution of UNICEF-WHO member defined primary health care as follows:

Primary health care is an essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain, at every stage of their development in the spirit of self-reliance and self determination.

Primary health care is considered as key to the development of the national health policy. It forms an integral part of the country health service schemes. Mahler and Baba (2000) asserted that primary health care is the first level of contact of individual, the family and the community within the national health system. It is a scheme designed to bring health services to the door step of the people.

In an attempt at ensuring effective implementation and delivery of health services to the teaming Nigeria population, provision of health care were constitutionally devoluted to the three tiers of government in Nigeria. National Primary Health Care Development Agency (2012) stated that health care delivery has been constitutionally devoluted as primary, secondary and tertiary to local, state and federal government respectively.

The responsibility of implementing primary health care was assigned to the local government as a means of reaching the rural areas where there are many prevailing health problems. The local government is the closest unit to the people living in the remote areas, hence the adoption of primary health care (PHC) to ease the burdens and improve their health and well being.

The primary health care committee at local government department is responsible for the implementation of health policies and programmes aimed at achieving the highest level of health standard for the entire population. The primary health care department at local government is structured along grassroot development committee as shown in the organogram below:

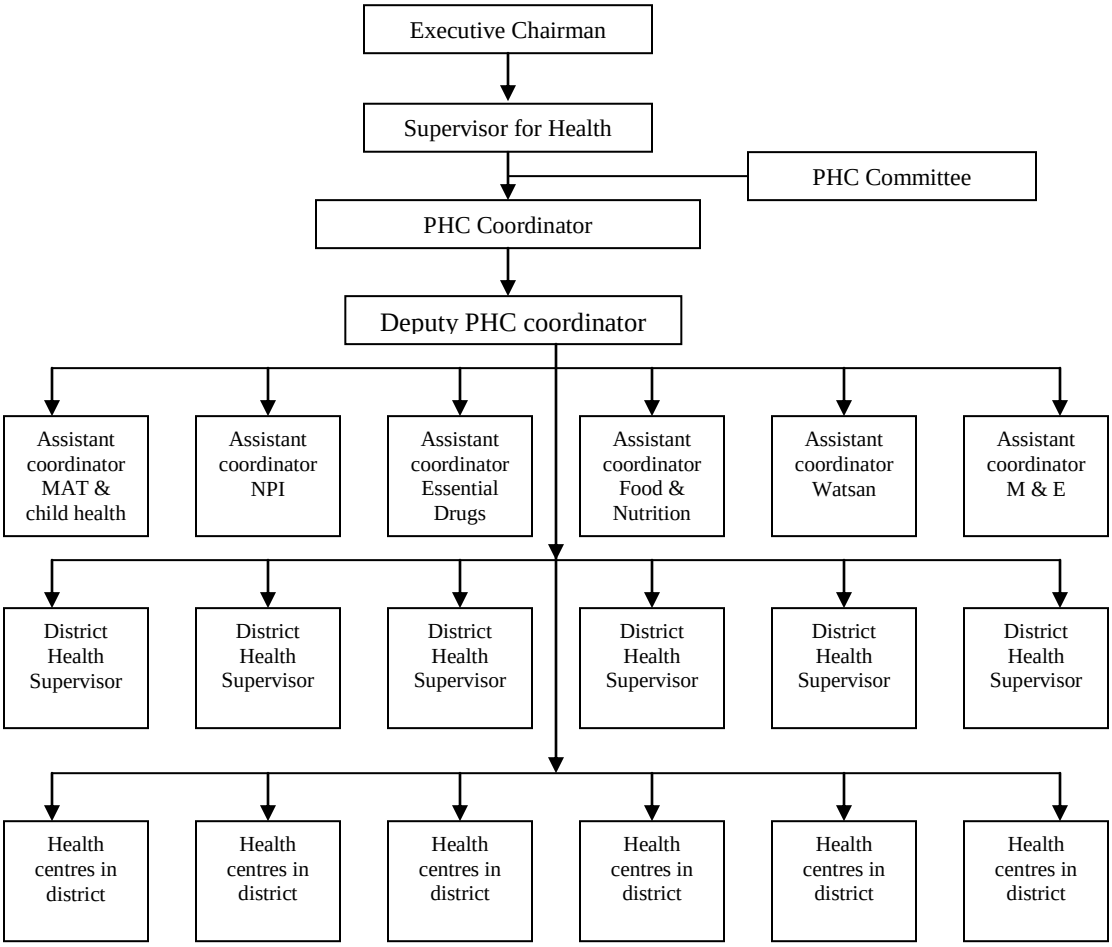


Fig 4: Local Government Primary Health Care Organogram

Source: Federal Ministry of Health (FMOH) and Primary Health Care Development Agency (2012)

The provision of primary health care services is the constitutional right of the local government headed by the executive chairman duly elected by the people. The primary health

care department is structured and saddled with responsibility of bringing health services and programmes to the door-step of rural dwellers. The department is headed by the honourable supervisory councillor for health who is the administrative head of the department and responsible to the chairman of the council. In ensuring smooth sailing of primary health care activities, local government primary health care development committee is usually constituted to take decision on matters affecting health of the people at grassroot.

The honourable supervisory councillor for health is ably assisted in the management and administration of primary health care department at local government level by primary health care coordinator. The PHC coordinator is assisted by Deputy PHC coordinator. The Deputy PHC coordinator is being supported in the implementation of all the component services by various assistant primary health care coordinators as deemed fit by each local government area in the state.

Apart from the district supervisors mentioned above, there are considerable number of health centres, clinics and maternities, health posts and so on that serve people within each district supervised by the district health supervisors. The health facilities within the districts are expected to carry out all component services of primary health care under the same roof. The referral services are expected to follow the same terrain.

In some local government areas, the implementation of PHC component services are shared among the mandatory six assistant coordinators, while some local government areas appoint more assistant coordinators to take charge of lumped component services and intervention programmes. Apart from the coordinating positions mentioned above, there are some considerable number of district supervisors depending on the number of district health units as identified by the local government areas. The district health supervisors are usually field

supervision officers who are responsible to all officers on coordinating positions as situation may demand.

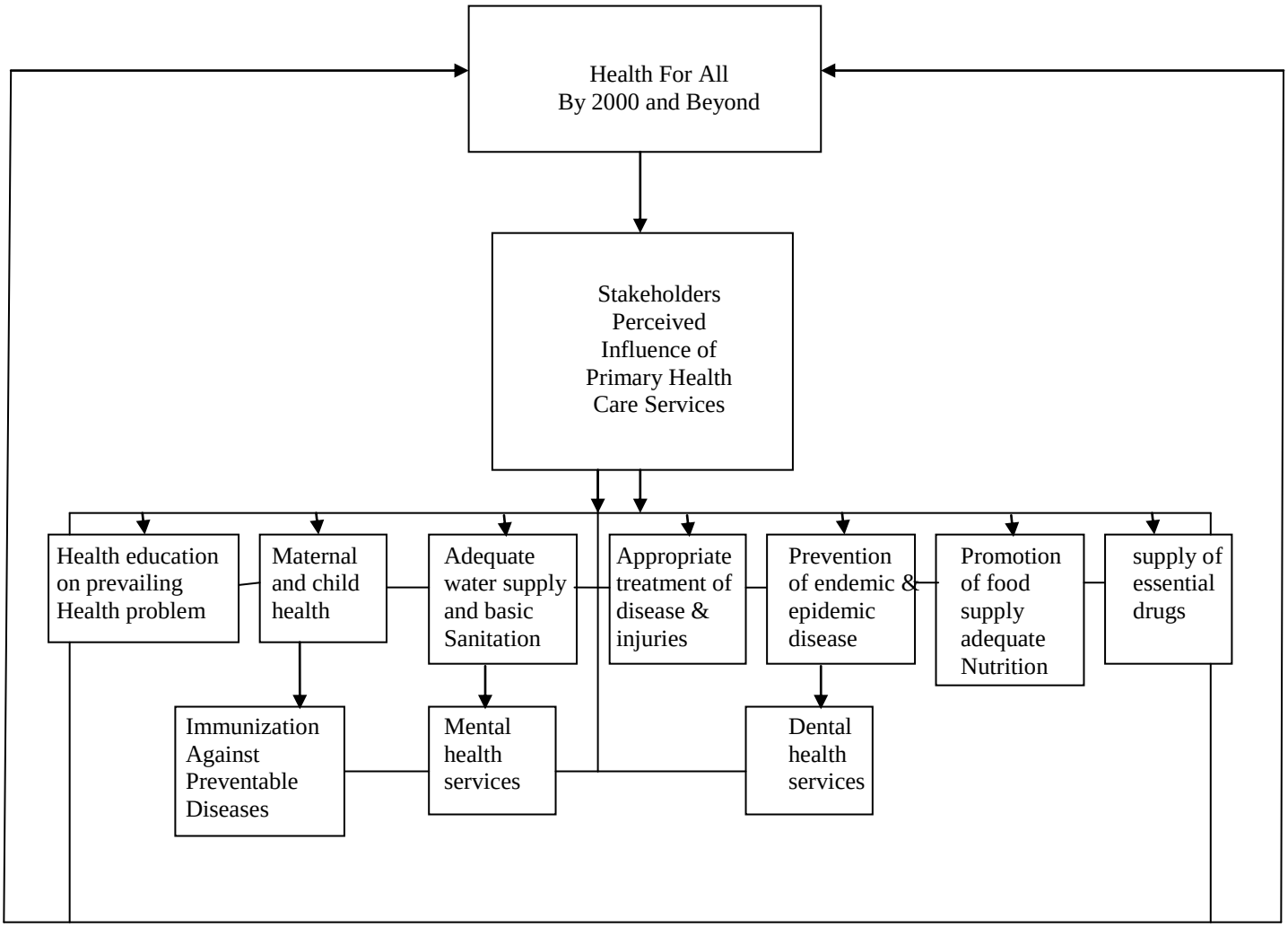


Fig 5: Conceptual Framework of Primary Health Care Service

Source: Researcher Design 2016

The implementation of primary health care has been planned and hinged presently on provision of fourteen (14) component services at the same health facility within the community.

Apart from the component services illustrated above there are considerable number of facilitators and intervention programmes for effective realization of primary health care objectives. The component services, the facilitators for effective PHC implementation and intervention programme were adequately discussed in the subsequent sub-headings below:

Health for All and Primary Health Care Services

The need to address some inadequacies and lapses in the provision of health care services, and to maintain global minimum health standard led to adoption of the good of health for all in 1977 at the joint assembly of world health organization Peter (2007) noted that in 1977 the world health assembly unanimously agreed that by the year 2000 all people of the world should have a level of health which will enable them lead socially and economically productive lives.

The concept “health for all” is a global statement of intent and strategy adopted as a means of ensuring sustainable health development all over the world. It is a goal and objective meant to sensitize and create awareness on measures that promote health and prevent diseases afflictions among people. The goal involves provision of health services that enhance health and well being of general populace. Mahler (2000) conceived “health for all” as a means of bringing health within the reach of everyone in a given country. Health for all implies removal of obstacles to health and wellness.

The goal of “health for all” is a motivational and sustainable objective that makes people to recognize and take appropriate measures against health and health related problems affecting them. Shehu (2000) asserted that health for all demands literacy for all. It demands at least the beginning of an understanding of what health means for every individual.

The declaration of health for all necessitates the adoption of all encompassing care services known as primary health care services at Alma Ata soviet union summit jointly organized by WHO and UNICEF in 1978 a year after declaration of health for all. Mahler (2000) stated that the basis of realization of health for all goal is full implementation of all component services of primary health care.

The rationale behind adoption of primary health care is that noticeable improvement in health of people can be achieved through initiation of viable health measures, which primary health entails FMOH (2004) and Shehu (2000) posited that attainment of health for all depends on continued progress in medical care and public health. The need to make health care services accessible and affordable to people and to ensure meaningful improvement in the wellness state led to the adoption and implementation of primary health care services.

Primary health care was adopted by the world assembly in 1978 after due consideration for defects and problems affecting health of the people in the rural areas and urban centres. The world assembly resolved that minimum health standard can only be achieved if consideration is given to factors such as pattern of illnesses, available human and material resources including factors affecting health. The points highlighted above led to adoption of primary health care for realization of health for all sustainable development solution Network (2014) reiterated that health for all is the bedrock of both vertical and intervention programmes such as primary health care Millennium Development Goals, sustainable development goals, kick polio among others.

Health for All and Sustainable Health Development

Health for all is a global agenda by all the members nations of UNICEF AND WHO to ensure that people are healthy and have access to facilities and care which will make the

objective achievable. As earlier stated, primary health care was adopted in 1978 for realization of health for all.

In an attempt to make the goal of health for all achievable, the primary health component services increased from eight (8) to fourteen (14). The strive to ensure minimum health standard and remarkable health development led to initiation of different health and health related intervention programmes such Millennium Development Goals (MDGs), kick polio, sustainable health development goals. Almost all the intervention programmes and goals are offshoots of health for all and were adopted to ensure effective realization of global health development.

The recent of all initiated intervention programmes is Sustainable Development Goals (SDGs) agenda for total transformation of the world by the year 2030. World Health Organization (2016) noted that the seventeen (17) Sustainable Development Goals (SDGs) reflect a significant change in thinking about how to accelerate sustained improvements in development in general and health in particular.

Sustainable Development Goals specifically incorporate vital health programmes into the 17 points agenda to address some of the identified impediments to healthy living. The intervention recognizes that human health and wellness depends to a large extent on policy formulation and execution through political, economic and social system. World Health Organization (2016) identified and adopted the following health and health related points agenda for sustainable health development;

- Move to end poverty by implementing social protection system for all;
- Ensuring availability and sustainability of water and sanitation;
- Ensuring inclusive and equitable education for;
- Move to end hunger, active food security and improved nutrition;

- Move to achieve gender equality and empower all women and girls;
- Promote peaceful and inclusive societies for sustainable development

Health Education on Prevailing Health Problems, Method of Preventing Them and Health for All

The need to prevent diseases and create awareness on factors responsible for illnesses within the community necessitate education as intervention for realizing such objective. Health education is the first component service adopted as instrument for implementation of primary health care. Health education as a component service in primary health care is directed at improving knowledge, attitude and practice of people in relation to their health and illnesses. John (1998) reiterated that if a disease can be prevented through alteration in behaviour, the achievement of such altered behaviour enables its incidence to be greatly reduced in the community.

Health education activities in health care delivery system revolve round three (3) basic elements of behavioural science tagged Information, Education and Communication (I.E.C.) which are channeled towards certain changing processes such as change in Knowledge, change in Attitude and change in Practice (KAP). Naomi (2004) noted that there should be full commitment of people in the realization of primary health care objective because change in behaviour and attitude is involved. The involvement of people is often guided by the level of information, education and communication exhibited by various interested groups.

Health education as one of the method adopted for actualizing primary health care objectives focuses attention on the knowledge, attitudes and practice exhibited by people in issues concerning their health. Baba (2000) asserted that health education has been adopted as

component of PHC to improve knowledge and attitude of people on many existing health problems so as to prevent their spread.

It has been observed that knowledge, attitude and practice determine to a large extent, the level of health and well being of people within the community. Green (2010) posited that knowledge is a prerequisite to appropriate behaviour. The knowledge of problem usually engender feeling of restriction towards it. The attitude exhibited on a given health issue determines people level of practicing activities.

Health education on prevailing diseases and method of controlling them has been adopted to create awareness on health and health related problems and educational intervention adequate for prevention and reducing them. Bolajoko (2004) noted that the overall emphasis of health education is on imparting knowledge on how effective diseases prevention, and assessment habit and attitude of population in relation to the spread of disease. Baba (2010) and National Primary Health Care Development Agency (2012) asserted that health education activities revolve round all other primary health care component services rendered to people at the grassroots to teeming rural population.

Health education as a component service in primary health care delivery system consists of preventive, promotive, curative and rehabilitative services that are geared toward ensuring optimal wellbeing. Udoh, Fawole, Ajala, Okafor and Nwana (2001) posited that the goals of health education are those of medicine as a whole which consist of curative and preventive care. The services are aimed at reducing morbidity, mortality and disability and more recently to reduce the costs of health care. The focus of primary health care component service of adequate food supply and proper nutrition is to ensure that all people at the grassroots have access to foods which contain essential nutrient in prescribed proportion. This service focuses on nutritional

needs of the children, women of child bearing age, pregnant women, the old people and the entire community members at the grassroots.

The health education component service is directed towards ensuring effective preventive care. The trained health educators and primary health care providers usually initiative awareness programmes on some of preventive and promotive measures such as need to ensure personal hygiene, environmental hygiene, water sanitation and so on. The health campaigns rendered by the health workers at the health centres often assist in delivery of effective curative and rehabilitative care. World Health Organization (2016) posited that health education programmes are frequently adopted as means of ensuring effective preventive, promotive, curative and rehabilitative care.

Adequate Food Supply, Nutrition and Health for All

It was discovered before the Alma-Ata Declaration of 1978 World Health Organization (2011) that lack of qualitative and adequate food supply and intake of good diets cause nutritional deficiency diseases which had claimed many lives. Mathur (2007) stated that life is dependent on adequate supply and consumption of safe food and appropriate nutrition. National Primary Health Care Development Agency (2012) stressed that it is necessary for each household to ensure availability of adequate varieties of safe food to meet the dietary needs of all its members and to enable them live active and healthy lives.

It has been adequately Peter (2007) observed that one of the factors that promote people's health and wellbeing is the intake of food rich in all the essential nutrients. The nutritional intake of an individuals determines and relates to their wellness and illness. Mathur (2007) observed

that life is dependent on adequate supply and consumption of adequate food and appropriate nutrition. Nutrition plays an important role in health and diseases.

In an effort at preventing nutrition and nutritional related diseases that affect people, the primary health care component service of adequate food supply and appropriate nutrition was adopted. The adoption of this component service was informed by the poor nutritional knowledge of people at the grassroot. Moore, Adamson, Gill and Waine (2000) asserted that primary health care has been over the years seen by governments at the grassroot as an ideal setting to provide nutrition education for the public.

The censuring and regulating of nutrients intake of people are expedient going by the pattern of illnesses affecting them. Some of the problems hindering health and wellbeing of people at the grassroot are mostly nutritional in nature. Nakajima (1991) posited that freedom from hunger and malnutrition is essential to enjoyment of highest attainable standard of health. It is one of the fundamental rights of human being.

The prevalence of nutritional problems such as malnutrition, anaemia during pregnancy, various childhood nutritional deficiency diseases, obesity, diabetes and so on, have made the implementation of nutritional component of primary health care inevitable. Ibrahim (2008) noted that the ultimate goal of nutrition health and primary health care nutrition policies are to ensure quality health and adequate nutritional status for all Nigerians irrespective of their economic status.

To this end, the primary health care component of adequate food supply and basic nutrition focuses attention on the encouragement of people on utilization and consumption of locally available foods that supply adequate and essential nutrients such as carbohydrates, proteins, fats and oils, vitamins and minerals in the right proportion. This component service is

aimed at ensuring health for all categories of people in the local government areas in Nigeria. Baba (2007a); and World Health Organization (2016) stated that nutritional component of primary health care are geared towards promotion of food hygiene, prevention of nutritional disorders, maintenance of normal growth and development as well as improvement of community nutritional status.

The poor performance of nutritional intervention programmes were due largely to inadequate implementation of programmes, poor nutritional education policy and non-challant attitudes of people towards adherence to rules of food hygiene. United Nation International Children Emergency Fund (2006) emphatically stressed that education plays an important role in determining how resources are utilized to secure food, health and care for children. Sanghvi, Ross and Heymann (2007) stated that despite the availability of primary health care centres in Nigeria, malnutrition is still a big problem arising from the poor implementation of nutrition programmes within the primary health care system.

Adequate Supply of Water, Basic Sanitation and Health for All

It has been discovered by Federal Ministry of Health (FMOH) and National Primary Health Care Development Agency (NPJCDA) (2012) that one of the basic requirement for healthy development is the improvement of environmental health. The major contributory factors to health problems affecting teeming rural population are lack of safe portable water and poor sanitary disposal of wastes. Peter (2007) asserted that water and sanitation are often taken together because both have many things in common in the prevention and causation of disease. Water is necessary for life. Its non-availability in the right quantity and quality has serious implications for health (Peter, 2007).

The term “sanitation” connotes all efforts geared towards maintenance of clean environment devoid of any impediment to healthy living. Sridhar (2008) empathically stressed that in maintaining health and wellbeing, water sanitation and hygiene play a very important role in the home, school and at work. Federal Government of Nigeria (2004) posited that access to environmental and water sanitation means availability of a hygiene facility for human excreta and refuse disposal including portable water supply for human consumption.

The adoption of this primary health care component service is aimed at preventing spread of diseases that may likely resulted from inadequate supply of water and poor environmental hygiene. It is believed that poor sanitation and non-availability of drinkable water account for some of the factors affecting people health and wellness. This is the reason why the component service has been adopted for ensuring health for all.

The frequent campaign and emphasis on environmental and personal hygiene for sustainable health development have been highly remarkable. Federal Government of Nigeria (2004) observed that in order to achieve the goal of free access to safe water, improved sanitation and hygiene, the delivery of these services will be done at the community level with the support of states and local government areas.

It is indisputable fact that untidy environment and poor quality of water supply are major causes of illnesses in developing countries like Nigeria. Sridhar (2000) noted that poor sanitation has a negative impact on the environment, and contaminates water sources with subsequent effects on plant, animal and human communities. World Health Organization (2004) stressed that in Nigeria, the inadequacy of safe water and improved sanitation services is manifested in the prevalence of water and sanitation related diseases.

The existing records showed dismal performance in the provision of safe and drinkable water, and hygiene practices. Akerele and Okungbowa (2002) corroborated that the existing safe drinkable water and, safe means of excreta and refuse disposal particularly in the rural areas are not sufficient enough to support an acceptable level of health as recommended by World Health Organization (2004) which put it at 20 litres of water per person per day for acceptable health and hygiene.

The consequences of inadequate and poor sanitation and water consumption consist of outbreak of water and air borne diseases among teeming population within the affected community. World Health Organization (2009) stated that in view of the low level provision of water supply and adequate sanitation, water borne diseases such as diarrhea, schistosomiasis, typhoid, draculiasis diseases have continued to affect the health and wellbeing of people in the rural communities thereby leading to high rate of death in such community.

The impact of adequate water supply and environmental hygiene on overall health of people are enormous. There is close link and associations existing among quality of water consumed, environmental hygiene and pattern of illnesses prevailing in the community. National Primary Health Care Development Agency (2012) noted that major health problems in Nigeria are preventable diseases associated with consumption of unclean water and lack of proper environmental sanitation. These, according to the agency contribute significantly to high infant mortality and morbidity rate, and poor quality of live.

As a result of unforeseen danger posed by the inadequate supply of safe water and unhealthy habits prevailing in our environment, safe water supply and basic sanitation, (Water Sanitation WATSAN) as one of the components of primary health care has been incorporated into the service to put a lasting solution to the problem. Akerele and Okungbowa (2002) affirmed

that adoption of primary health care as a means of realizing 'Health for All' see to the implementation of component service of safe water supply, and basic sanitation has assisted in prevention and control of diseases outbreak.

Maternal and Child Health Including Family Planning and Health for All

The existing records before the declaration of Alma-Ata of 1978 showed high figure of maternal morbidity and mortality rates. The causes of death can be traced to haemorrhage, ruptured uterus, eclamsia, anaemia, sepsis, hepatitis, measles, tuberculosis, tetanus, diarrhea to mention but a view (Kuti, Aderele & Okungbowa, 2002). Alabi (2002) noted that after thorough appraisal of existing record on maternal morbidity and mortality rate, it was adopted at the Alma-Ata declaration of 1978 that maternal and child health should be given appropriate preference as a means of reducing both morbidity and mortality rate among mothers of child bearing age and their children.

The need to ensure considerable reduction of diseases and death rate among women of childbearing age and their children led to adoption of family planning programme as appendage to maternal and child health component service. Alabi (2002) stressed that maternal and child health campaign was further strengthened by establishment of family planning programme aimed at creating awareness among the couple to promote their health and prevent death that may result from problem highlighted earlier. The programme will further improve the standard of living of people through population regulation.

The vulnerability of women of childbearing age and children to numerous health and health related problems necessitate provision of special health services for them. Peter (2007) asserted that women, especially those of reproductive age and children are the most vulnerable

members of the community. The researcher empathically stressed that the groups deserve special attention to make them realize their full potentials. World Health Organization (2005) posited that maternal and family planning have traditionally been major components of primary health care service.

The adoption and subsequent attempts at implementing maternal and child health including family planning, primary health care component service witnessed development of series of policies and programmes to reduce high incidence of maternal morbidity and mortality rates in Nigeria. Peter (2008) stated that some of the policies and programmes developed and channelled towards realization of optimal health for women of childbearing age and the children include a shift from the maternal and child health policy to the National Reproductive Health Policy and Strategy, safe motherhood, integrated management of childhood illness, family planning, women in health and so on.

A critical appraisal of policies and programme performance shows serious inadequacies and lapses in their implementation. Federal Ministry of Health (2002) emphatically stressed that maternal mortality has remained unacceptably high. The vertical donor driven policies and programmes designed and adopted for reducing the morbidity and mortality rates are consistently failing to make any impact at the level that will yield the greatest dividends. Ejembi, Allagh, Oyemakinde and Iliyasu (2003) observed that at local government areas and community levels, coverage with essential maternal and child health including family planning services remains low. According to the researchers, the quality of care provided are poor as evidenced in the disconnection between the availability of maternal health services and utilization rates, which are much lower than availability.

The provision of effective maternal and child health component services have been hindered by delay of people in taking decision concerning delivery complications and severe childhood illnesses, inadequate manpower, poor obstetric services, insufficient supply of essential drugs, low coverage of immunization programme and so on. Umaru (2004) stated that frequent delivery complications usually resulted from delay in taking decisions by health workers and community people. The delay is often attributed to ignorance about delivery complications, poverty, cultural practices, male dominance, poor manpower skills. Adenike (2008) tacitly stated that provision of adequate screening services, appropriate training of midwives and attendants, prompt immunization would assist in reducing the current maternal mortality and morbidity rates in Nigeria.

Apart from the short-comings identified above, insufficient and inconsistent maternal and child health services account for deteriorating rate of women and children health in Nigeria. Federal Ministry of Health (2007) noted that serious shortage of essential obstetric care services in the country limits the capacity of the primary health care facilities to respond to delivery emergencies such that they are ineffective in reducing maternal deaths.

Immunization Against Infectious Diseases and Health for All

The quest to unravel the mystery surrounding high rate of morbidity and mortality in children revealed the contributory effects of six killer diseases such as tuberculosis diphtheria, whooping cough, tetanus, measles and poliomyelitis. Odunsi (2002) observed that the presence of the above stated six killer diseases posed serious danger to the lives of young children, hence, the adoption of immunization programme at Alma-Ata declaration as a means of curbing the problems.

The Federal Government of Nigeria has adopted different health and health related programmes directed at ensuring optimal health for women and children. The expanded programme on immunization is one of the programmes which aim at preventing the six childhood killer diseases. Baba (2009) asserted that the need to prevent diseases and reduce maternal and infant mortality and morbidity rate necessitated the initiation of various intervention programmes such as Roll Back Malaria, National Onchocerciasis Control Programme, National Programme on Immunization, National Tuberculosis and Leprosy Control programmes.

The Federal Government in a bid to prevent spread of six killer diseases and reduce incidence of all preventable diseases adopted Expanded Programme on Immunization (EPI) in 1989. Baba (2009) emphatically stressed that the National Programme on Immunization (NPI) has been adopted as a measure of preventing and controlling the spread of deadly communicable diseases. Immunization programmes are generally and globally accepted as effective preventive measures against killer diseases.

The immunization programmes have been structurally designed and implemented on sequential basis consisting of clinic based and outreach services. According to National Programmes on Immunization (2008) immunization exercise has been implemented on both routine and supplemental bases. The routine immunization is a general immunization status, while the supplemental programme is usually conducted on a periodical basis and as a make up for the uncovered areas as well as preventing the spread of diseases during epidemic period.

The National Immunization Programme has been implemented in many ways with different strategies and approaches. The programmes were scheduled into phases, depending on prevailing health problems. National Programme on Immunization (2008) noted that in order to

increase the number of eligible children receiving immunization services through routine and supplemental immunization, the following strategies have been put in place:

- Reaching Every Ward (REW) which is the provision of regular effective, qualitative and sustainable immunization activities in all wards, such as fixed posts, mobile/other outreach services.
- Health weeks immunization programme which is often conducted through setting aside weeks by state and local governments to administer additional child survival components to compliment routine immunization services;
- Local Immunization Days (LIDs) which is a strategy that is aimed at rapidly increasing immunization coverage rates and poor access to regular immunization services.
- Immunization Plus Days (IPDs) which is a strategy that is geared towards a more integrated child survival programme which offers routine immunization services as well as other interventions such as insecticide treated bed nets, anti-helminthes, vitamin A supplements and so on.

It has been reliably revealed that immunization coverage was inadequate especially children vaccination. This is evident from dismal performances of all strategies employed for boosting routine exercise. National Primary Health Care Development Agency (2012) observed that Nigeria's universal child immunization coverage has remained low over the past decades. The reasons for the persistent low coverage can be attributed to inadequate funding by government at all levels and over dependence on donor funds, withdrawal of such donor funds used in the conduct of ad-hoc immunization campaigns, weak health structures and system, lack of ownership at community level among others.

By and large, it is necessary to state here that despite the lapses trailing immunization implementation in Nigeria, the programme has contributed to diseases prevention at the grassroot. World Health Organization (2002), National Programme on Immunization (2008) and Federal Government of Nigeria (2008) corroborated that National Immunization Programme has contributed immensely to prevention and control of communicable diseases as well as reducing incidence of maternal morbidity and mortality rate.

Apart from the challenges noted above, non-challant attitude of people towards their full participation account for dismal programme performance. World Health Organization (2005) reported that in Kano State of Nigeria, local leaders claimed that the polio vaccine was tainted with AIDs virus and sterility drugs and decline to participate in a national immunization day programme. This was a serious set back for disease prevention objective of Nigerian government, going by global investment on eradication of poliomyelitis in Africa. This scenario led European union to stop its funding of National Programme on Immunization in Nigeria.

Prevention and Control of Endemic Diseases and Health for All

A disease is endemic if it is common within a locality or community. An endemic disease is one that has high frequency rate within a given environment when compared with the distribution of other diseases globally. Peter (2007) described an endemic disease as one that is constantly present in the community which has a steady high occurrence in a given population.

The death and serious illnesses occurring among Nigerians are due largely to preventable or easily treated conditions. Peter (2007) noted that many diseases in developing countries are manifested by inadequate personal and environmental hygiene and rudimentary social infrastructure; these diseases are largely communicable diseases that are further complicated by

malnutrition, ignorance and insincerity on the part of those charged with the responsibility of making things better for the people.

The need for effective prevention and control of diseases that are prevalence within the locality was further evident in the existing records of death rate resulting from their incidences. World Health Organization (2004) and National Planning Commission (2005) reported that the high level of mortality in young children are due mainly to illnesses that can be easily prevented or can be treated with known remedies, such as malaria, diarrhoeal diseases, acute respiratory tract infection which are deadly in nature.

The existing records revealed that most deaths and serious illnesses occurring among Nigerians are due largely to conditions that are easily preventable or can be easily treated. Baba (2000) noted that communicable diseases, most importantly those that have to do with poor environmental sanitation and poor personal hygiene are common and often compounded by malnutrition. The most common among these diseases are malaria, dysentery and diarrhoeal diseases, measles, pneumonia, gonorrhea, whooping cough, schistosomiasis, chicken pox, tuberculosis, meaningitis and so on.

In order to reduce the occurrence of these diseases, the Alma-Ata declaration of 1978 adopted the component service of prevention and control of communicable diseases. There are different vertical programmes that have been adopted and implemented for effective control of diseases that are common within the locality. These eradication programmes consist of Roll Back Malaria, Deworming programme, immunization, and so on (David, Rohde & Glen, 2009).

The adoption of primary health care component service of prevention and control of endemic diseases has assisted in reducing deaths and complications that often resulted in their outbreak. World Health Organization (2000) noted that there have been remarkable improvement

in the prevention and control of communicable diseases, most especially locally endemic ones. These improvements were due largely to the implementation of some vertical and intervention programmes such as Roll Back Malaria, guinea worm eradication, immunization programme, diarrheal control programme and so on. Benson (1995) corroborated that there have been reduction in the incidence of communicable diseases as a result of effective environmental health control measures such as clean water supply, adequate sanitation, vector control, immunization and so on.

Treatment of Common Diseases and Injuries and Health for All

Primary Health Care is not only concerned with preventive and promotive health service alone. It also deals with curative services which involve treatment of common minor aliments and injuries. Baba (2007) noted that common diseases and injuries like malaria, typhoid fever, stomache, minor eye problems, vomiting, headache, burns, boils, witlow, Laceration and so on are treated by polyvalently trained community health workers.

Primary health care has been adopted mainly to manage the health of people at the local level at lower cost before referring them to the appropriate specialists in the secondary level of care service. Kwara State Ministry of Health (2009) reiterated that as part of the sate government efforts at reducing the spread of diseases and promoting health, different health care services have been initiated. The services consisted of treatment of ailment such as malaria, free test and treatment, cardio vascular check up and treatment of minor injuries and so on.

At the inception of primary health care , it was resolved that some group of health professionals should be trained to man all the health centers and health posts in the rural areas to ensure proper recognition and treatment of already manifested cases. National Primary Health

Care Development Agency (2012) noted that there have been remarkable improvement in disease prevention and control and the treatments initiated by the trained community health practitioners at the grassroot. Mark (1991) asserted that with yearly report collated in all the local government areas nation-wide, the record shows that the inclusion of this components service into primary health care has helped to reduce complication that may have resulted from these minor aliments and injuries plaguing people at the grassroot.

Essential Drug Supply and Health for All

One of the hinderances to effective treatment, prevention and control of diseases and health problems is the shortage and inadequate supply of drugs. Ayanbeku and Sorungbe (2002) noted that one of the key indicators of the successful implementation of a nation's primary health care strategy is the availability of essential drug to the entire population. According to the researchers, shortage of drugs at primary health care centres was due to the following reasons:

- Political demagogy which is a strategy used often by government to deceive people by promising them free health care services;
- The wrong belief of Nigerians that whatever emanate from government belong to them;
- Reduction of government public expenditure on health which may be as a result of low level revenue generation;
- Inefficiency in drugs procurement, preservation and utilization in our health centres/hospitals;
- Increase in the cost of procurement due to exchange rate (Ayanbeku & Sorungbe, 2002).

The problems highlighted above are being tackled through a national essential drug programme which is supported by the World Bank and World Health Organization (WHO). National Primary Health Care Development Agency (2012) posited that essential drugs are those drugs that satisfy the health care needs of the majority of the population. Essential drugs and drug supply is planned to enhance effective primary health care services by making quality essential drugs, vaccines, family planning commodities, consumables and other materials available at all operational level.

The adoption of essential drug supply component services has contributed immensely to effective treatment of health problems and prevention of diseases outbreak. Ayetoro (2011) empathically remarked that there has been a steady increase in the rate of contribution of drug revolving fund towards effective treatment of illness in Nigeria. National Primary Health Care Development Agency (2001) and Federal Ministry of Health (2009) noted with dismay inadequacies trailing the implementation of essential drug services such as expiring of drugs, non-availability of drug list and high cost of purchasing drugs.

The persistent shortage of drugs used in the treatment and prevention of infections have been major obstacle to the realization of goal of health for all. National Primary Health Care Development Agency (2001), Ayanbeku and Sorungbe (2002) observed that the effectiveness of health services in Nigeria is severely hampered by the shortages of essential drugs, the most serious constraints occurring at the Primary Health Centre (PHC) level. Besides compromising most therapies, the shortage of drugs has caused a major decline in the utilization of health service, a concomitant increase in self medication, and loss of public confidence in health services.

Dental Health and Health for All

Dental caries, predonsis, flurosis, thrush, gingivitis, cancrum oris and so on, are not uncommon in the rural areas where level of literacy and hygiene are too low. Most of the people residing in these areas do not attach much importance to daily oral cleaning because of lack of knowledge on the adverse effect of unclean mouth or teeth. Peterson (2003) observed that majority of oral diseases is related to lifestyles and reducing these mostly chronic diseases relies much on changing behaviour. Peter (2007) empathically stressed that mouth plays important and numerous roles in the maintenance and upliftment of physical, social and psychological state and an individual wellness.

There have been little attention paid to issues concerning mouth and its supporting tissues. This perhaps was due to burdens posed by problems affecting other body systems. Bankole, Aderinokun and Denloye (2005) asserted that in developing countries such as Nigeria, less priority is accorded oral health perhaps due to the relatively high burden of communicable diseases which threaten survival and increase morbidity.

It has been observed that the level of oral hygiene determine to a large extent, an individual state of wellness. World Health Organization (2004); Grossi and Genco (1998); Hujoel, Drangsholt, Spiekerman and Deroven (2000) corroborated that the health of the mouth is known to be a good indicator of general health status which is more so today than ever. For instance, there is mounting evidence that chronic gum disease is related to many systemic conditions such as diabetes. Also, the inflammatory and host responses in periodontal disease are associated with coronary heart disease and premature birth.

The old impression that Africa people have strong teeth free from infection is a wrong notion and immoral to healthy living. Peterson, Bourgeois, Ogawa, Estupinan-Day and Ndiaye

(2005) and World Health Organization (2004) posited that globally, dental caries and chronic periodontal diseases are known to be the commonest diseases of the oral cavity and these two have similarly captured the attention of health care planners and profession in Nigeria.

The current oral health situation in Africa sub-region shows wide disparity and variance pattern of dental health problems. World Health Organization (2004) empathically stressed that African oral health profile differs today from what was previously perceived. Widespread poverty, undernourishment and endemic, yet preventable diseases, compromise immunity and render children vulnerable to devastating diseases such as cancrum oris (Noma).

In consideration of perpetual bad oral health habit borne out of ignorance and non-challant attitude, the World Health Organization and United Nations International Children Emergency Fund met and decided to include dental health as one of the components of primary health care to actualize health for all objective. National Primary Health Care Development Agency (2012); Baba (2000); Alabi (2002) and Marchant (2013) asserted that despite the strategies employed by the Federal Government of Nigeria and non governmental organization the impact of the oral health services have not been felt.

Mental Health and Health for All

Health has been conceived as wealth. A healthy man is a wealthy man. Mind cannot be separated from the body. A sound mind free from emotional disturbance(s) is one of prerequisite for healthy living. National Primary Health Care Development Agency (2012) noted that mental health is an integral part of an individual health. It is concerned with the promotion of mental well being, prevention of mental disorders, early diagnosis and rehabilitation of the mentally ill.

It is not uncommon to see people suffering from one form of mental illness or another which usually aggravated as a result of lack of proper care. World Health Organization (2001) in its fact sheet stated that one in every four people or 25% of individuals develops one or more mental or behavioural disorders at some stage in life both in developed and developing countries. The mental health situation in Nigeria was consistent with the projected estimates of most developing countries.

At the inception of primary health care, there was restriction of component services to eight. This restriction affect vital and one of the three dimensions of health known as mental health. Olabisi (2008) observed that despite the World Health Organization definition of health as a state of physical, mental and social well being of an individual and not merely the absence of disease or infirmity, the initial components of PHC in Nigeria did not include the promotion of mental health and provision of essential psychotropic drugs. Ogundeji (2002), Jaiyeola (2010) and Olabisi (2008) Corroborated that in 1991, there was declaration of mental health policy by the minister of health, professor Olukoye Ransome Kuti, thereby making mental health become the ninth component of primary health care in Nigeria. The adoption of mental health as component PHC service is aimed at cushioning dangerous effects of mental illness on well being of all Nigerians.

The implementation of mental health component services since its adoption along side dental health services has been poorly managed and integrated into vertical programmes for effective realization of health for all goal. According to World Health Organization (2001) and Federal Ministry of Health (FMOH) (2012) a programme officer said that though mental health policy was promulgated by the federal government, its implementation has not been effectively

pursued with any concrete support either by the federal ministry of health or by donor agency beyond awareness creation similar to what WHO did in its quarterly bulletin.

In a recent study, it was authoritatively revealed that insufficient mental health specialist and the little knowledge of existing ones have been hindrances to effective implementation of mental health component of primary health care in Nigeria. Odejide, Morakinyo, Oshiname, Omigbodun, Ajuwon and Kola (2002) noted that the health care workers such as Nurses, CHOs and CHEWs had minimal knowledge of signs and symptoms of depression and management of such cases.

Care of the Aged and Health for All

Old age is an inevitable condition for any body that has a long life span. It is a depreciating state of an individual wellness. It is a condition characterized with reduction in normal and efficient functioning of human body. According to National Primary Health Care Development Agency (2012) an aged is somebody that has attained the age of seventy (70) years and above.

The care of an aged or elderly people has been adopted as one of the components of primary health care due largely to the fact that considerable number of the old people are prone to one health problem or the other. Baba (2007) posited that the aged period can be likened to the childhood period, the period when old people will not be physically fit to carry out strenuous activities and they are prone to series of health problems resulting from break in their body immunity and accident. National Primary Health Care Development Agency (2012) stated that growing old or ageing is a normal physiological process, which involves gradual decline in the physical, mental and social condition of the elderly person.

The transition to old age is often influenced by range of factors such as physical, biological, psychological and social factors that often lead to depreciation in the health of elderly people. Arogundade (2007) identified chronological aging and social aging as the major processes involved in aging. National Primary Health Care Development Agency (2012) noted that ageing is influenced by environmental factors, nutrition, heredity, physical and social activities, habit and practices of an individual before attaining old age.

The aged people are faced with different health problems ranging from physical debilitation to disorders of sense organs, accidents to infections, social maladjustment to mental abnormality and so on. Adekunle (2012) and Brangman (2005) affirmed that body's ability to perform many of its functions changes gradually over the years. The researchers identified health problems, hearing problems, dental problems, cardio-vascular diseases, sexual dysfunction, mental problems and so on as responsible for such changes.

The health care given to aged people is medically referred to as geriatric service. Jean (1997) noted that since origination of geriatric medicine in 1940 in United Kingdom, it has been progressively generating programmes for the long term care of the chronically ill aged people. Ogunsakin, Shehu and Baba (2012) stated that the geriatric services provided for elderly people involve long and short term medical and hospital based services, depending on the nature of their illnesses.

The care of aged has been adopted as one of the primary health care component services to improve and promote health of aged people in Nigeria. National Primary Health Care Development Agency (2012) observed that the essence of care of aged is to improve the quality of life of elderly Nigerians through well articulated strategies and programmes. Ogunsakin, Shehu and Baba (2012) affirmed that the geriatric, social support and health promotion services

rendered to elderly people are aimed at maintaining their physical, mental and social well being. Wilman (1999) asserted that adequate communication with the elderly patients has been the most important aspect of nursing care and that poor communication is the largest source of dissatisfaction from the aged people.

Care of Handicap and Health for All

It has been adequately observed that there is proliferation of physically challenged people on our major street in Nigeria. World Health Organization (WHO) (1999) annual review of primary health care activities revealed high rate of disabilities in most of developing countries of the world. This situation had led to emergence of a component service tagged care of the handicapped.

As earlier stated above, many streets in Nigeria are full of handicapped people struggling for survival in the face of hard economy. Some of the physically challenged people resorted into alm seeking. National Primary Health Care Development Agency (2012) asserted that one of the common features of streets in Nigeria is the presence of large groups of beggars who are mostly handicapped people.

In the past, the care and prevention of handicapping conditions have been neglected by both government and private organizations. Smith (2008) stressed that many studies have demonstrated that people with disabilities do not receive health screening that is provided to people without disabilities. The researchers added that many do not participate in other preventive behaviours that would enable them to maintain health and wellness within limitation imposed by their disability. These behaviours include exercise, smoking cessation, healthy eating, weight management, age, appropriate immunization and so on.

In line with devolution of health care responsibilities among the three tiers of government, the detection and care of handicapped people rest on local government at the grassroot. National Primary Health Care Development Agency (2012) noted that in Nigeria, the care and rehabilitation of the handicapped in the communities is vested upon the local government areas. It is important for all health workers to know their functions in the care and rehabilitation of the handicapped at all levels of primary health care.

There are multitudes of impediment to effective delivery and utilization of health care services by the physically challenged in Nigeria. United Nation (2009) stated that a variety of barriers make it difficult or impossible for many people with disabilities to achieve optimal health and wellness and to take advantage of health promotion services that are available to people without disabilities. These barriers may be environmental, structural and attitudinal in nature.

Apart from the barrier identified above, inadequate facilities and equipment, coupled with mobility problems serve as hindrances to effective provision of primary health care services for the handicapped people. Smeltzer (2006) posited that lack of accessible transportation to facilities that are physically accessible also contributes to the inability of many people with disability to participate in health promoting activities. National Primary Health Care Development Agency (2012) noted that primary health care centres are the first point of contact for screening and detection of disable conditions among people within the communities at the grassroot.

Primary Eye Care and Health for All

The roles played by the eyes as organs of sight are inestimable. The eyes are body watch dog and coordinates human activities. Obiyemi and Oyerinde (2009) asserted that the eye is the organ of body through which people and animal see. Vision according to the researchers, is one of the body's most precious functions. It is often referred to as lamp of the body.

The existing record on eye and eye related problems shows high rate of blind and partially sighted people in developing counties like Nigeria, Benin republic, Guinea, Ghana and so on. Peter (2007) noted that more than two-third of those with visual disability was in developing countries. It is estimated that 38 million persons are blind globally. The researcher further stated that total loss of sight reduces the life expectancy of those affected generally.

The pattern, causes and prevalence of eye problems affecting people in Nigeria necessitate need for preventive, promotive, curative and rehabilitative services embedded in primary eye care. Peter (2007) affirmed that total loss of sight reduces the life expectancy of those affected, which was responsible for adoption of primary eye care. According to the researcher, primary eye care involves promotion, prevention curative and rehabilitative eye care services. Clare (1998) stated that primary eye care is a broad concept encompassing the prevention of potentially blinding eye diseases through primary health care. It includes the identification with treatment or referral of individuals with treatable causes of blindness, and the diagnosis and treatment of common eye diseases, particularly those causing an acute red eye. Boating (1998).

It has been observed that there was little attention paid to prevention and control of eye problems and infection at initial stage of primary health care implementation Adenike (2008) observed that eye diseases and blindness have not received priority attention in the national

policy and the ensuing services until recently. Boating (1998) World Health Organization (2000) and Peter (2007) asserted that very few of the diseases causing over 70% of blindness have been significantly addressed. World Health Organization in collaboration with many international and non-governmental organizations have initiated a global campaign for the prevention of avoidable blindness tagged vision 2020-right to sight.

The primary eye care services are classified into clinical and preventive activities. Konyama (1998) posited that primary eye care services in the community should be sufficiently comprehensive to cover aspect of primary, secondary and tertiary prevention targeted for all community members whether they have or do not have eye problems.

It has been discovered that there were many hindrances to effective delivery of primary eye care which include inadequate manpower, poor facilities and equipment, poor funding, insufficient training of staff and so on. Adenike (2008) noted that communities everywhere recognize eye disease as a priority issue and primary eye care is already part of primary health care in certain aspect like maternal and child health, immunization, nutrition especially Vitamin A supplementation. The researcher added that barriers such as poor access to primary health services, inadequately trained manpower, poor advocacy, poor technical know how and so on have been hampering effective realization of goal of right to clear vision.

By and large, primary eye care services have contributed to effective prevention and control of blindness and other eye problems in Nigeria. Baba (2000), Boating (1998) and Peter (2007) stressed that primary eye care have contributed to prevention of common eye problems, ensure regular eye screening and effective referrial eye care from grassroot to the secondary and tertiary levels of health care.

Adolescent Health Care and Health for All

The adolescent period is a period intermediate between childhood and adulthood. It is a transitional period that encompasses different developmental changes and challenges. National Primary Health Care Development Agency (2012) posited that an adolescent is that boy or girl whose age falls between 10-18years.

The adolescent period is an active period in the life span of people. It is a developmental stage in which physical, mental and social wellness of young people expanded. In considering the problems facing the adolescents in Nigeria, there is need to provide effective and viable health care services to young people for their proper developmental transition and healthful living. National Primary Health Care Development Agency (2012) reported that in 1986, a World Health Organization study group on young people and health for all by the year 2000 was convened to examine the health challenges that face youth. In furtherance of goal of sustainable health for adolescents, the World Health Assembly (WHA) selected "The Health of Youth" as the subject for its technical discussion in 1989. The assembly recommended that all member countries should develop policies and programmes to enhance the healthy development and living of young people.

It has been discovered that a meaningful and sustainable development is often precipitated on contribution of young people within the country. Ajibola (2012) asserted that the adolescent and youth population of any nation remains an inestimable asset for national development and sustainability. The health of this population becomes an issue of great concern mainly because of peculiarities and uniqueness of this age stage of development.

The adoption of adolescent health service as one of primary health care component services is evident in the pattern of illnesses and health problem afflicting young people.

National Primary Health Care Development Agency (2012) empathically stressed that the major health and health related problems of adolescents in Nigeria are unemployment or underemployment, malnutrition, rural and urban migration, alcohol, drug abuse and dependence, smoking, accidents and risk taking behaviour, sexual and reproductive health problems, mental retardation and other handicapping conditions.

It has been authoritatively revealed by the existing records that despite all the available health care provided for young people, there were little or no reduction in the morbidity and mortality incidences among this age grade. Ajibola (2012) and National Primary Health Care Development Agency (2012) affirmed that young people have limited access to reproductive and other promotive care services. In a situation where health services are available, the non-friendly nature of these facilities to young people limits their utilization. The response of health care system to the needs of young people has been rapid but ineffective.

Health Intervention Programmes and Health for All

The implementation of primary health care has been incorporated into numerous policies and programmes. At the initial stage provision of primary health care was hinged on component services. The component services were found to be insufficient to cater for the health needs and problems affecting teeming Nigeria population. This incidence led to emergence of some special health care services to cushion the effects of such problems.

The needs to ensure sustainable health development have led to evolvement of numerous intervention programmes. The emergency health care delivery services are designed and undertaken by various government and non-government organization to curb the menace of

different health problems that constitute significant proportion of morbidity and mortality rates in a given geographical location.

The implementation of most of the intervention programmes is channeled toward prevalence rate of health problems at a particular period of time and within a given geographical location. National Primary Health Care Development Agency (2012) noted that intervention programmes have been developed and adopted as means of ensuring effective and sustainable health development. Baba (2007) and Alyward, Olive, Hull, Quadrog and Melguard (1998) posited that control and eradication programmes cannot be viewed in isolation. All programmes have implications for the delivery of comprehensive primary health care services.

The existing record revealed that all the health intervention programmes would have been viable if they were adequately planned and implemented based on prevailing situation. Alyward, Achargy, England, Agocs and Linkins (2003) and Barret (2003) asserted that most eradication programmes to date have been launched as visionary, far-reaching efforts with vastly incomplete information. Basic epidemiological information and knowledge of the effectiveness and operation constraints of interventions and costs in different settings are often inadequate, and the required monitoring, evaluation training and researcher components of programmes may be absent.

It has been discovered that despite the short comings and lapses in the implementation of health policies and programmes, some intervention programmes really contributed to significant improvement of people's well being. Baba (2007) and National Primary Health Care Development Agency (2012) empathically stressed that some of health intervention programmes initiated and implemented by Federal government of Nigeria have assisted in prevention and control of diseases and health problems. Some of the health intervention programmes sponsored

and implemented jointly by the federal government and relevant international donor agencies are as follows:

- The National Malaria control programme tagged “Roll Back Malaria”.
- The national Tuberculosis and Leprosy Control (TBL) programme;
- The National onchocerciasis control programme;
- The National Diarrhoea Disease control programme;
- The National acute Respiratory infection prevention and control programme;
- The National Acquired Immune Deficiency syndrome prevention and control programme.

Facilitators for Effective Implementation of Primary Health Care

It has been realized by health planners and programme implementators that primary health care cannot be implemented in isolation. This has led to adoption of some basic indicators as instrument of executing all the component services and the intervention programmes.

Baba (2007a) and World Health Organization (2009) reiterated that the delivery of health care services to the people within the community entails unique and multifarious processes of mutual efforts of the professional health providers and members of the community. Some of the measures and strategies employed for effective realization of primary health care objectives are exhaustively examined below:

Primary Health Care and Community Involvement and Participation

The adoption of primary health care ushered in shared responsibility approach to provision and utilization of its component services. Prior to the introduction of primary health

care, involvement of people in the decision and implementation of numerous health programmes in the community is minimal. Oyegbite (2002) noted that communities very rarely participated in health care decision-making as witnessed today by the various facilities that are located inconveniently to the population they are suppose to serve, facilities that are completed but cannot be put into use, the facilities that are in use but are abused and the low level of coverage.

The cardinal objective of health for all campaign is to make health a worth while asset and achievable goal. The laudable goal cannot be realized in isolation without incorporation inputs of people within the communities at the grassroots. David (2002) asserted that community participation at the initial stage of policy-making is needed since the outcome of every policy-making process affects the quality of services rendered to all the citizens.

It has been observed that no meaningful progress can be recorded in the implementation of primary health care adopted for realization of goal of health for all, without the involvement of people at every stage of its implementation. Baba (2000); Richard, Kelly and Nick (2002) stated that community participation in decision making and provision of health services is a prerequisite to attainment of health for all in Nigeria. According to Hildebrandt (1996) partnerships occur when professionals share information and decision making with the community in a way that result in neighbourhoods and communities where people are effective participants in the administration of their own primary health care services.

It is a long time axiom that people often exhibit spirit of oneness and partnership in progress when they are fully involved in group activities. The involvement of people in implementation of health programmes by giving them position of responsibility often lead to better programme performance. Bawa (2013) asserted that community participation is a hall mark of primary health care without which it will not succeed. It is a process by which

individuals and family assume responsibility for their own health and those of the community and develop capacity to contribute to their development.

The involvement of people within the community at every stage of primary health care implementation is crucial to realization of goal of health for all by the year 2000 and beyond. It helps in identifying and engendering actions needed for desirable outcome. Abdulraheem, Olapipo and Amodu (2012) observed that 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 researchers further stated that, at 1978 declaration of Alma-Ata, community participation was identified as the process by which individuals and families assume responsibility for their own health and welfare and for those of the community.

The need for active involvement in implementation of primary health care becomes visible and heightened going by the nature and method of implementing component services. This is evidenced in provision of services like essential drug service, rural water supply and basic sanitation, food supply and adequate nutrition and so on. Mike (2010) affirmed that there is a large and growing body of evidence that certain types of service delivery are enhanced with the active participation of the communities they serve.

Invariably, one of the primary health care strategies adopted and entrenched in Nigeria National Health Policy to ensure effective realization of health for all goal is full community participation in the implementation of component services. World Bank (2003) asserted that the National Health Policy in Nigeria emphasizes active community engagement in the provision of primary health care services in the spirit of Bamako initiative of 1987. In Bamako, health minister from various African nations adopted resolutions for promoting sustainable primary

health care through community participation in financing maintenance and monitoring of programme performance.

By and large, the onus of community participation in provision of primary health care services is for people to identify health needs through their involvement in various health and health related committee activities. Primary health care is a community oriented health services designed to function with the support of people at the grassroot. Henry (2010) affirmed that in a reciprocal way, the community see the primary health care programme as "our programme instead of the government's programme". Shehu (2000) emphatically remarked that community participation implies that the citizens control the process of transformation whereby they mobilize themselves and resources and act to improve their health and quality of lives.

The Health Team and Primary health care

The implementation of primary health care component services rests squarely on polyvalently trained and skilled health care providers in different areas of specialization. Baba (2007) noted that the delivery of health care services in the community rest squarely on formidable health team. World Health Organization (1988) described a health teams as a group of people that share a common health goal and objective, determined by community needs, to the achievement of which each member of the team contribute, in accordance with his/her competence and skill, and in coordination with the function of others.

As the term implies, health team is a formidable body saddled with provision of all encompassing health care under the same roof within a given period of time. Baba (2007b) opined that health team is a constituted body of experts or personnels charged with the responsibility of rendering health services aimed at achieving optimum level of health for the

entire community through diffusion of skills to that effect. Health team consists of all the cadres of health that provide integrated health care services which are as follows:

- Medical Officer for Health;
- Community Health Officer;
- Public Health Nurse;
- Community Health Extension Worker;
- Nurse and Midwives;
- Environmental Health Officer/Assistant;
- Nutritionist/ Dietician;
- Laboratory technician/pharmacist;
- Physiotherapist;
- Health Education Aides/Officer;
- Health Attendants;
- Drivers

The essence of formidable health team is to ensure cohesiveness and sustainable approach to health care delivery system within a given population. Baba (2007) and National Primary Health Care Development Agency (2012) observed that a cohesive health team approach has been effective tools for achieving sustainable health development through integration of services delivery. A coercive teams approach often engender cooperation, team effort and community support for effective health care delivery services.

Community Mobilization and Health for All

In line with the constitutional devolution of primary health care to the grassroot and the strategies adopted for implementing it, there is need to fully integrate people into mainstreaming programmes. Baba (2000) noted that obviously, community mobilization is one of the key factors of securing full community participation for excellent performance of primary health care services.

Community mobilization according to Baba (2007) is a process of organizing and sensitizing people within a given geographical area towards full participation in the programmes that affect their health and well being through encouragement and arousing of interest. It is a means of bringing people together purposely to embrace an ongoing health programme through their full participation.

The idea of bringing people from different households within the community to embrace health and health related programmes had been in practice for a long time before the adoption of primary health care. Tarimo and Webster (1995) remarked that the primary health care conference of 1978 incorporated the ideals of self reliance, stressing that the success of PHC can be measured by the level of community support and participation it enjoyed.

The people at the grassroot often, through advocacy strategy, participate actively in programmes affecting their health. The aim of advocacy is to create awareness in people to embrace primary health care services. Peter (2007) noted that Alma-Ata declaration also emphasises the need to seek cooperation of political, social and community leaders, organizations, industry, the mass media and other non-health sectors in order to achieve the goal of health for all.

Community mobilization is a process of organizing and sensitizing people within a given geographical area towards full participation in the programmes that affect their health and well being through encouragement and arousing of interests. Okoro (1995) stressed that the community must be made to be award that efficient administration of primary health care services is not only about the delivery of goods and services to passive citizen, but it is about active involvement in the primary health care policy-making process and empowerment.

Community mobilization is highly essential in determining viability of health programmes and taking of crucial decision on matter concerning their health and well being. The protection of individual and minority group rights and interests is necessary through delaying of complicated and difficult public decisions to ensure their better understanding.

Integrated Health Care Delivery System and Primary Health Care

The delivery of health care services before adoption of primary health care was based on need and pattern of illnesses prevailing within the community at a particular period of time. The services rendered to people with health problems were prioritized and based on single unit approach. Baba (2007) asserted that before the adoption of primary health care, a patient with more than one health problem will have to move from one health facility to another health facility in order to address his/her numerous health problems. The kinds of services rendered during this period are dominantly curative in nature which makes the acquisition of complete treatment within the same health facility difficult if not impossible.

The adoption of primary health care as a means of achieving health for all by the year 2000 and beyond through the implementation of its numerous component services necessitated the integration of health care services. Shortel, Gilles, Anederson, Erickson and Mitchell (2010)

emphatically stressed that regardless of the unique organizational and operational characteristics of integrated health care system, most of them aspire to meet five objectives. The researchers reiterated their longitudinal evaluation of 11 systems in 1996 that integration of service delivery aimed at achieving among others effective market focus goal, provision of continuum of care, reliance on information, alignment of financial commitment and incentives, organizational structures and development, and maintenance of ongoing efforts to improve quality.

The design and application of primary health care component services reflect high level of integration for sustainable health care delivery. National Primary Care Development Agency (2006) posited that integration of health service delivery is the provision of comprehensive health services to well defined communities on daily basis at the same time, under the same roof, by the same clinic personnel.

The integration of health care delivery services in whatever way we view it gives room for proper coordination and evaluation of care. Kila (2002) reiterated viability and utility value of integrated health care delivery service as remarked by a community health officer at pakoto as follows:

> "I cannot imagine working any other way now. Integrated services make it so much more convenient for the patients. Think of a mother with three children, all of them requiring different services. When services are integrated, they can all receive care on the same day, in the same clinic setting. We health care workers like it also. It enables us to give quality care and we feel job satisfaction".

It can be deduced from the health officer's report above that integrated health services make it possible for anybody that has two or more health problems or who is to receive more than one component services to do so at the same time, in the same health institution. National Primary Health Care Development Agency (2006) stated that effective coordination and implementation of primary heath care component services is facilitated by the following factors.

- a cohesive health team;
- a committed village health facility and district development committee system;
- a sustained drug revolving fund;
- an effective food and nutrition programme;
- safe water and adequate sanitation;
- an efficient information system;
- a good built-in mechanism for supervision, monitoring and evaluation; and
- an operational two-way referral system.

Community Diagnosis and Situation Analysis in Primary Health Care

In order to ensure sustainable health development and effective implementation of primary health care at the grassroots, an objective study of social-demographic characteristics, health needs and political will of both the people and the government need to be sought. Community diagnosis and situation analysis provide ample ground for actualization of such goal. Kuti et al (2002) posited that community diagnosis otherwise known as baseline survey is comprehensive survey carried out to determine the major health problems in the community. It delves into health needs and pattern of illnesses within a geographical location.

Situation analysis on the other hand, focuses on examination of prevailing health practices and performances of health progrmames in the community. Baba (2007) noted that situational analysis is a process of examining and evaluating the performances and extent to which health care services solve the health problems identified in the community. Kuti et al (2002) stressed that the purpose of situation analysis is to examine the present situation and on the basis of current activities in the project area to forecast future trends in the economy, the environment, the growth, distribution, density and composition of the population.

The application of community diagnosis and situation analysis as facilitators for realization of health for all through primary health care have assisted in engendering effective tools for implementation of intervention. Baba (2000, 2007) asserted that baseline survey and situation analysis really serve as viable evaluative tools that have contributed greatly to effective implementation of primary health care in Nigeria. It encourages judicious utilization of health facilities, drugs and equipment.

Intersectoral Collaboration and Primary Health Care

Primary health care cannot be single handled or implemented by health personnels or professionals alone. Health care delivery services have to be jointly carried out by other relevant sectors within the larger society. This can be achieved through setting up of intersectoral technical sub-committee of local government area primary health care committee including representatives from education, agriculture, community development, ministry of environment and so on. Sorungbe, Bamisaiye and Dola (2002) stated that intersectoral collaboration is the process of involving health related sectors in planning, implementing, monitoring and evaluating for ensuring the support and success of primary health care activities.

The essence of involving experts and professional in health related fields is to ensure qualitative and effective health care delivery services. It is a supportive approach that complements efforts of health professionals. Hegazu, Ferwana and Qureshi (1992) observed that collaboration in primary health care 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. Baba (2007); and Sorungbe, Bamisaiye and Dola (2002) identified the following sectors and health related fields as common collaborators and partners in sustainable health development:

- Ministry of water resources which will facilitate effective provision of portable and drinkable water;
- Ministry of work and housing which will facilitate the effective provision of infrastructural facilities;
- Ministry of environment which will ensure maintenance of environmental sanitation;
- Ministry of agriculture which will ensure adequate food production and supplies;
- Ministry of education which will facilitate the literacy levels of people, so as to ensure effective health communication and the increased level of awareness in the community;
- Ministry of information which is going to assist in the dissemination and spread of health information to the target population;
- Ministry of transportation which will facilitate mobility of human and material resources that promote health;
- Ministry of rural development which will promote community development and eradicate poverty.

Advocacy and Primary Health Care Services

The implementation of primary health care cannot be done in isolation. It is rather designed to be jointly implemented by government and people at the grassroots. Kuti et al (2002) stated that advocacy is the process of creating awareness and support for primary health care at federal, state and local governments. Baba (2007) soliciting and convincing the stakeholders/policy makers of the values inherent in an on-going or intervention health programmes and other health services rendered to people within the community.

Advocacy is an eye opener for the stakeholders and beneficiary of health and health related programmes designed for realization of optimal level of health for people. Advocacy give insight to effective way of implementing health related programmes. Baba (2007) reteriated that advocacy is nothing but an activity aimed at justifying the viability of health intervention programme designed to proffer solution to problems identified through community diagnosis and situation analysis.

Advocacy as strategy of sensitizing the leaders at the helms of affair has contributed immensely to effective implementation of primary health care through full support of stakeholders Abdulraheem, Olapipo and Amodu (2012) and Baba (2007) stated that discreet application of advocacy has really assisted in the improvement of people's health, increasing of socio-economic benefit as well as political will of government.

National Health Policy on Primary Health Care

The implementation of primary health care components services are being guided by the primary health care guidelines and national policy statement formulated as vehicle for operations of three tiers health care delivery services in Nigeria. Baba (2007a) noted that the National

Health Policy is a statement of intent designed to guide the day to day actions or activities of government on health and health related issues.

The national health policy as one of the strategies to achieve health for all Nigerians promulgated in 1988 was the first comprehensive national health policy that decentralized health care responsibilities to all levels of governments in Nigeria. Osotimehin (2009) emphatically stressed that the goal of national health care is to ensure effective promotive, preventive, restorative and rehabilitative services to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social well being and enjoyment of living.

The decentralization of health responsibilities as entrenched in National Health Policy revolved round primary, secondary and tertiary health care system. Osotimehin (2009) asserted that national health policy assigned distinct health responsibilities to three tiers of governments as follows:

- Primary health care is largely the responsibility of local government with the support of state ministry of health and within the overall national health policy.
- Secondary health care has been devoluted to state government in Nigeria. This level of health care provides specialized services to patients referred from the primary health care level through out-patient and in-patient services of hospitals for general medical, surgical, paediatric patients and community health services.
- Tertiary health care is the health care responsibility assigned to the Federal Government of Nigeria. The health care services at tertiary level consist of highly sophisticated and specialized services provided by teaching hospitals and other specialist hospitals which

provide care for specific diseases such as orthopedic, eye, psychotic, maternity and paediatric cases.

The national heath policy was formulated and became operational since 1988 during Ibrahim Badamosi Babangida (IBB regime). It is an embodiment and integrated whole representing the national goals and philosophy of all health system. It was adjudged to be suitable guidelines at early stage of primary health care implementation. The policy was later discovered to be inadequate for meeting health and health related problems in the 90s. This scenario led to holding of national health summit by the federal government, Osotimehin (2009), Baba (2007) and National Primary Health care Development Agency (2008) affirmed that a national health summit was organized in 1995. The recommendations that emerged from the summit and other subsequent activities called for the need to take a critical look at the national health policy with a view of effecting those changes that would accelerate health development in Nigeria.

In line with the emerged recommendations from national health summit, a new health policy on sustainable health sector reforms was handed down by the federal ministry of health to the Federal Government of Nigeria. National Primary Health Care Development Agency (2008) noted that in 2003, a new draft was submitted to the Federal Government of Nigeria by the Department for International Development (DFID) as part of their contribution to the development of a comprehensive health sector reform programme in Nigeria. According to the agency, the current version of the National health policy was developed based on comments and suggestions made at national consultative meeting involving state health commissioners and representatives of various other stakeholders organized to review the final version of the policy document.

National health policy is vehicle on which Nigeria health care delivery activities are hinged. It consists of codes of conduct and guidelines for operations of health care delivery system among the three levels of government in Nigeria. Baba (2007) and National Primary Health Care Development Agency (2008) highlighted salient feature of National Health Policy as follows:

- The Federal, State and Local Government and the private health sector of Nigeria commit themselves and all people to intensive action to attain the goal of health for all, that is a level of health that will permit them to lead socially and economically productive lives at the highest possible level;
- All governments of the federation are convinced that the health of people does not only contribute to a better quality of life, but it is also essential for sustained economic and social development of the country as a whole;
- The people of this nation have right to participate individually and collectively in the planning and implementation of their health care. This is however, not only their right, but their solemn duty;
- Primary health care is the key to attaining the goal of health for all people in Nigeria, and as such shall form an integral part of the national health system whose central function and main focus is the overall social and economic development of the country;
- All government accepts to exercise political will by mobilizing people using all available health resources rationally.

The cardinal goal of National Health Policy is to ensure sustainable health development for Nigeria. Osotimehin (2008) reiterated that the major thrusts of national health policy relates to the following issues;

(i) National Health System and Management;

(ii) National Health Care Resources;

(iii) National Health Information Systems;

(iv) Partnership for Health Development;

(v) National Health Research; and

(vi) National Health Care Laws

Appraisal of Reviewed Literature

This chapter examined in detail some of relevant concepts on primary health care delivery system. It was established in the review that health for all by the year 2000 and beyond is a global intent aimed at ensuring sustainable health development all over the world. The goal of health for all can be realized according to World Health Assembly (1978) through the implementation of primary health care at the grassroots.

The adoption of primary health care as a means of achieving health for all is justified in this review by theories of health preservation through prevention and control of disease affliction in the community by Maclean and Passmore in 1974, the theory of striking balance between preventive, curative and social support medicines by Godber (1982) and Kuti et al (2002) theory of viable preventive measure for elimination of major defects associated with dominant curative services.

Apart from the theories of health care identified above, the review also covered conceptual basis or origin of primary health care as exemplified by the local government organogram by the grassroot health committee activities. The conceptual review shows that primary health care is fully devoluted to the local government closer to the rural dwellers.

It was also established in the review that primary health care is expected to be implemented at the grassroot through integrated health care delivery approach. This is achievable through provision of considerable number of component services under the same roof at primary health centre setting. The component health services are rendered by polyvalently trained primary health care providers at local government level.

In addition to the provision of component services, there are some indicators or facilitators designed and adopted for effective implementation of primary health care services at grassroot; some of the facilitators include cohesive health team, community mobilization for their full participation, intersectoral collaboration, community diagnosis, advocacy, situational analysis and so on.

In an attempt at consolidating the success of primary health care in actualizing the goal of "health for all" some health intervention programmes have been designed and implemented at the grassroot. The intervention programmes are expected to beef up provision of some major services and achievement of meaningful prevention of diseases outbreak. Some of the intervention programmes implemented so far are, roll back malaria, guinea worm eradication programme, tuberculosis and leprosy control programme, HIV/AIDS prevention programme, massive polio eradication campaign, acute diarrhoeal control programme and so on.

By and large, the National Health Policy was adopted in 1978 and amended in 1999 by the Federal Government of Nigeria to serve as legal document and guidelines for implementing health care delivery services, especially primary health care services in Nigeria. The need for training and retraining of different levels and categories of health care providers was emphasized in the primary health care guidelines.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter described in details the methods and procedures that are employed in conducting the research work. The methods and procedures used in carrying out this study the include research design, population of the study, sample and sampling techniques, research instrument, validity of the instrument, reliability of the instrument, procedure for data collection and method of data analysis.

Research Design

The research design adopted for this study is descriptive research design of survey method. The survey method has been most suitable method of gathering data from large number of sample units within short period of time. Survey method is considered appropriate in carrying out this study that aimed at investigating views of stakeholders on perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria.

Population of the Study

The target population for this study comprised of all those that participated at different stages of implementation and delivery of primary health care services in the sixteen local government area within Kwara State, Nigeria. The people in this category include local government areas chairmen and their executive members, primary health care team within the local government areas, staff of all existing health centres within the local government areas and all heads of the communities in the local government areas of Kwara State.

The study population therefore cut across the sixteen local governments area of Kwara of Kwara State, Nigeria. It consists of the policy makers, the traditional leaders, health care providers and members of community development associations in the state. The Kwara State Ministry of Health (2014) estimated total population of stakeholders in Kwara State to be two million, three hundred and seventy one thousand, eighty-nine (2,371,089) consisting of one million, two hundred and twenty thousand, five hundred and eighty one (1,220,581) male inhabitants and one million one hundred and fifty thousand five hundred and eight (1,150,508) are female inhabitants within the state.

Sample and Sampling Technique

The respondents for this study were drawn with the use of multi-stage cluster sampling technique. Shehu (2000), stated that multi-stage cluster sampling technique is a complex techniques which involve the initial sampling of groups of elements (multistage) that usually followed by the selection of elements within each of the identified clusters. The technique according to Babbie (1990) involves repetition of two basic steps of listing and sampling.

Stratified random sampling technique was used to identify the sixteen local government areas within the state. This process was followed with the use of cluster sampling technique to group existing health facilities in the sixteen local government into state, local and privately owned health institutions. Thereafter, a proportionate sampling technique was employed to select 10% of all the existing health facilities in the sixteen local government areas of Kwara State. Also, 10% of the respondents were proportionally selected for the study among the stakeholders which include members of health facility committees, local government primary health care (PHC) committees and heads of villages where selected health centres were located. The table 1

and 2 below summarized all the government and privately owned health facilities within the sixteen local government areas of Kwara State from where sample size were drawn.

Table 1: Primary Health Care Facilities in Kwara State (Federal, State, LGA and Private)

SN	L.G.A	Federal	No of State H/F	No of L.G.A. H/F	No of private H/F	Total
1	Asa		4	37	5	46
2	Baruten		5	54	20	79
3	Edu		5	43	9	57
4	Ekiti		4	14	3	21
5	Ifelodun		8	68	12	88
6	Ilorin East	1	1	33	19	54
7	Ilorin South		6	21	29	56
8	Ilorin West		4	22	26	52
9	Irepodun		8	33	17	58
10	Isin		6	18	4	28
11	Kaiama		2	22	16	40
12	Moro		5	36	16	57
13	Offa	1	1	25	15	42
14	Oke-Ero		3	16	2	21
15	Oyun		5	17	2	24
16	Patigi		3	31	3	37
	Total	**2**	**70**	**490**	**198**	**760**

Source: Adapted from State Ministry of Health Annual Health Facility update of 2014

As earlier stated above, ten percent (10%) of health care facilities were selected proportionately from all facilities within each of the local governments areas in Kwara State. A total of seventy six (76) health facilities were selected for this study. The list of health facilities and the respondents that were selected for this study are as follows:

Table 2: Distribution of Stakeholders in the Sixteen Local Government Areas of Kwara State

S/N	L.G.A.	Number of health facilities	No of H/F selected (10%)	Total number of stakeholders	Total No of respondents selected for the study (10%)
1.	Asa	46	5	598	60
2.	Baruten	79	8	1027	103
3.	Edu	54	5	702	70
4.	Ekiti	24	2	312	31
5.	Ifelodun	88	9	1144	114
6.	Ilorin East	54	5	702	70
7.	Ilorin South	56	6	728	73
8.	Ilorin West	52	5	676	68
9.	Irepodun	58	6	754	75
10.	Isin	28	3	364	37
11.	Kaiama	40	4	520	52
12.	Moro	57	6	741	74
13.	Offa	44	4	572	57
14.	Oke-Ero	19	2	247	25
15.	Oyun	24	2	312	31
16.	Patigi	37	4	481	48
	Total	**760**	**76**	**9880**	**988**

The table two (2) above shows the distribution of stakeholders within the sixteen local government areas of Kwara State, Nigeria. In all there are nine thousand eight hundred and eighty (9880) stakeholders in the sixteen (16) local government areas in Kwara State consisting of members of health facilities committees, local government health committee, village heads of communities where all the health facilities are located.

Research Instrument

The research instrument that was used in carrying out this study is a researcher structured questionnaire. According to Nwana (2010) questionnaire serves as a form of standardized quantitative interview. The questionnaire used was patterned and modified to seek the opinion of respondents on perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria.

The structured questionnaire consists of two sections (sections A and B). Section A elicits information on personal data of the respondents selected for the study. Some of the personal characteristics of the respondents contained in the questionnaire are age, sex, occupation, religion, level of education, location, tribe and local government area.

The section B gathered information on perception of the respondents on influence of primary health care services on realization of health for all in Kwara State, Nigeria. In all, this section contained sixty (60) items on stakeholders perceived influence of Primary Health Care services on realization of health for all in Kwara State, Nigeria.

The sixty (60) items were fashioned into a likert scale format of Strongly Agreed (SA), Agreed (A), Disagreed (D) and Strongly Disagreed (SD) from which the respondents to chosed

alternative options deemed appropriate. The options of the responses of the respondents were rated as follows:

Strongly Agreed	(SA)	-	4 points
Agreed	(A)	-	3 points
Disagreed	(D)	-	2 points
Strongly Disagreed	(SD)	-	1 point

Validity of the Instrument

In determining the utility value of the research instrument that was used for this study, the draft questionnaire was subjected to the supervisor's assessment and thorough scrutiny. The draft questionnaire was also given to three jurors in the field of test and measurement, Community Health and Epidemiology; and Health Promotion and Environmental Health Education in the University of Ilorin. All their suggestions and observations were incorporated into the final draft of the questionnaire.

Reliability of the Instrument

In testing the reliability of the instrument that was used for this study, a test re-test method was used to ascertain its consistency. The research instrument was pilot tested with the use of test re-test method on twenty (20) respondents selected among the study population that did not participate in the final exercise in Ilorin South Local Government Area of Kwara State. The administration of research instrument was carried out twice within a given interval of two weeks. The two results obtained was compared using Pearson Product Moment Correlation

Coefficient (PPMC). The instrument was found reliable at 0.76 correlation coefficient of reliability which connotes a strong consistency needed for effective research oriented outcome.

Procedure for Data Collection

The researcher with the help of four (4) trained research assistants who are mainly primary health care providers administered the questionnaire to selected respondents in the sixteen Local Government Areas of Kwara State. The research assistants were selected from the sixteen Local Government Areas of Kwara State.

The six (6) selected research assistants were trained on contents, how to guide and administer questionnaire to the respondents. The research assistants who are mainly polyvalently trained primary health care providers were given a day training on how to interprete and guide respondents on method of filling the questionnaire. The researcher and the trained research assistants helped in the conduct of Focused Group Discussion (FGD) with the stakeholders before the general administration of questionnaire. The researcher sought and secured an introductory letter from the Head of Department, Health Promotion and Environmental Health Education, University of Ilorin. The letter were presented to each of the selected study areas for their consent to participate in the study.

The focus group discussions was held with some inhabitants of selected study areas. The focus discussion was carried out in each of the selected health facilities in three (3) local government areas from three senatorial districts in Kwara State. The groups were formed by the hospital attendees prior to the administration of questionnaire. The researcher and research assistants discussed structured questions on level of PHC implementation with the community people seeking PHC services in the health centres.

The essence of adopting focus group discussion for this study is to determine the level of people's awareness and involvement in the implementation of primary health care services aimed at actualizing health for all objective. This discussion serve as guide and aid to the general administration of the questionnaire to sampled respondents.

The focus group discussions for this study was held in three strategic local government areas of Kwara State. The three local government areas are Ilorin West Local Government, Offa Local Government Area, and Moro Local Government Area of Kwara State.

In all, nine participants constitute member for each of the three (3) groups. The discussion period and time was fixed at around 10.00am and did not exceed one (1) hour. The medium of communication are Yoruba and English languages. The discussions were hinged on different open-ended questions (as presented in appendix II) centred on the relevant study variables and guided by the researcher. The researcher organized a light refreshment for participants in the focus group discussion.

The researcher incorporated some of the useful information elicited from outcome of focus group discussion to the final draft of questionnaire. The researcher with the trained research assistants immediately commence administration of questionnaire after the focus group discussion. The respondents were guided on interpretation and filling of questionnaire contents through the use of local languages or English language.

Method of Data Analysis

There are four (4) procedures that were used to analyse the data collected for the study. Descriptive statistics of frequency count and percentage were used to analyse demographic data of respondents and answering of research questions while mean rank method, Spearman Brown

rank order correlation method and chi-square method were employed to test hypotheses formulated for the study using SPSS version 20.0 at 0.05 alpha level of significance.

CHAPTER FOUR

RESULTS AND DISCUSSION OF FINDINGS

This chapter presents the results of the analysis of data generated from the study carried out on stakeholders' perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria. In all, a total of nine hundred and eighty-eight (988) questionnaire was administered to the selected respondents from the sixteen local government areas of Kwara State. The analysis of data collected was done with the use of descriptive statistics of frequency count and percentages for personal data of respondents, thematic analysis was done for the qualitative data generated through focus group discussion, while Spearman Brown rank order correlation and chi-square (x^2) were used to test the hypotheses of the study at 0.05 alpha level of significance using SPSS version 20.0.

Section A: Analysis of Personal Data of Respondents

Table 3: Frequency Distribution of Respondents used for the study

SN	ITEMS	FREQUENCY	PERCENTAGE
1.	**Gender**		
	Male	635	64.30%
	Female	353	35.70%
		988	**100.00**
2.	**Age**		
	20-29years	50	5.10
	30-39years	110	11.10
	40-49years	350	35.40
	50-59years	340	34.40
	60years & above	138	14.00
		988	**100.00**
3.	**Educational Background**		
	Primary education	84	8.50
	Secondary education	280	28.30
	Higher education (Bachelor degree)	441	44.70
	Informal education	183	18.50
		988	**100.00**
4.	**Occupation**		
	Civil servant	490	49.60
	Self employed	205	20.70
	Unemployed	45	4.60
	Farmers	64	6.50
	Trader	152	15.40
	Artisan	32	3.20
	Others (Specify)	0	0
		988	**100.00**
5.	**Religion**		
	Islam	468	47.40
	Christianity	400	40.50
	Traditional religion	120	12.10
	Others	0	0
		988	**100.00**
6.	**Ethnicity**		
	Yoruba	310	31.40
	Hausa	284	28.70
	Nupe	64	6.50
	Baruba	80	8.10
	Igbo	55	5.60
	Fulani	195	19.70
		988	**100.00**
7.	**Social Status**		
	Community leaders	74	7.50
	Religious workers	54	5.50
	Members of health committee	380	38.40
	Health workers	160	16.20
	L.G.A. council members	320	32.40
	Others	0	00.00
		988	**100.00**
8.	Residence/Type of dwelling		
	Rural area	670	67.80
	Urban centre	318	32.20
		988	**100.00**

The analysis on table 3 above shows distribution of respondents based on characteristics such as gender, age, educational background, occupation, religion, ethnicity, social status, domicile. Table 4 revealed that 635(64.30%) of the respondents were male while 353(35.70%) were female. The table above revealed that majority of respondents 350(35.40%) fall within age range of 40-49years. It could be deduced from the table that majority of respondents 441(44.70%) possess higher education qualification of B.Sc., B.A., HND., B.Sc. Ed., M.A., M.Ed., M.Sc., Ph.D. The table shows that majority of the respondents 490(49.60%) were civil servants. The table also revealed that majority of respondents 468(47.40%) were Muslims. The table also shows that majority of respondents 316(31.40%) belong to the Yoruba ethnic group. The table also revealed that 380(38.40%) of respondents in the social status category were members of health facilities committees within the community. The distribution of respondents according to the geographical locations revealed that over whelming majority of them 670(67.80%) were rural dwellers, while 318(32.20%) were within the urban centres.

Section B: Thematic Analysis of Data on Focus Group Discussion

This section presents graphical representations of thematic analysis of qualitative data generated through focus group discussion carried out. In all, bar charts were used to represent level of respondents awareness on implementation of PHC services at the grassroots. The pictures of focus groups for the discussion carried out in four local government selected from the three senatorial districts which include Ilorin East, Ilorin West, Moro and Offa Local government areas of Kwara State were attached to appendix V.

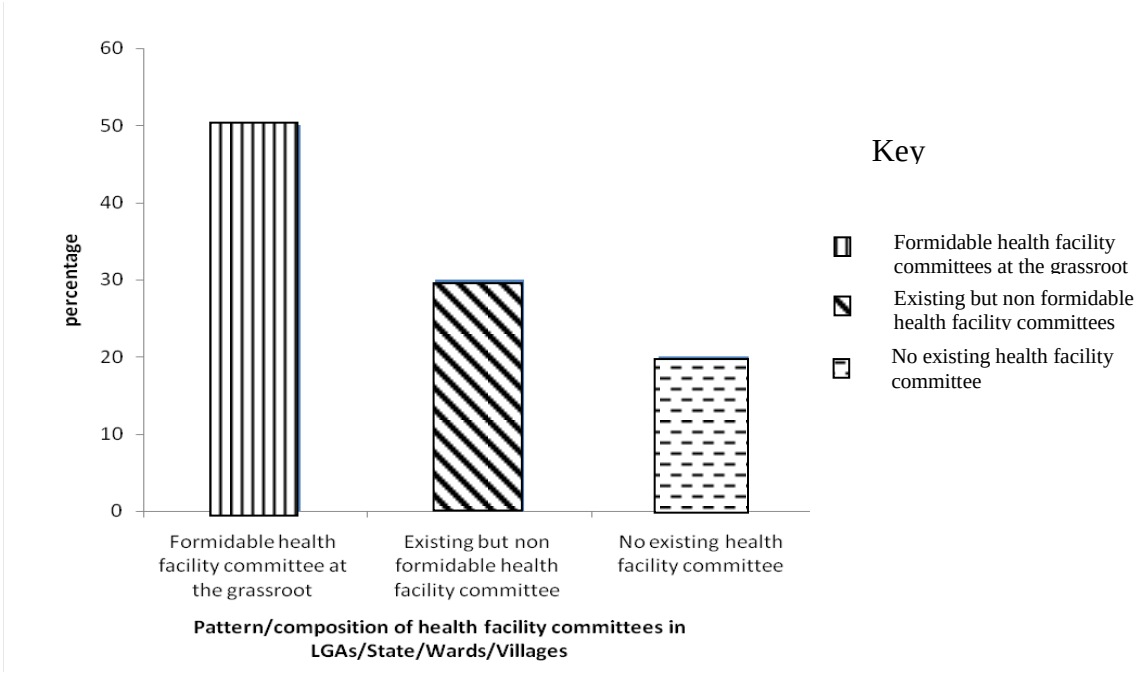


Figure 6: Bar chart of responses on records of existing health facility committees in LGAs

The figure 6 above shows that most of the health centres have constituted health facility committees which are either formidable or non formidable. It is only in few health centres that are yet to constitute their health facility committees.

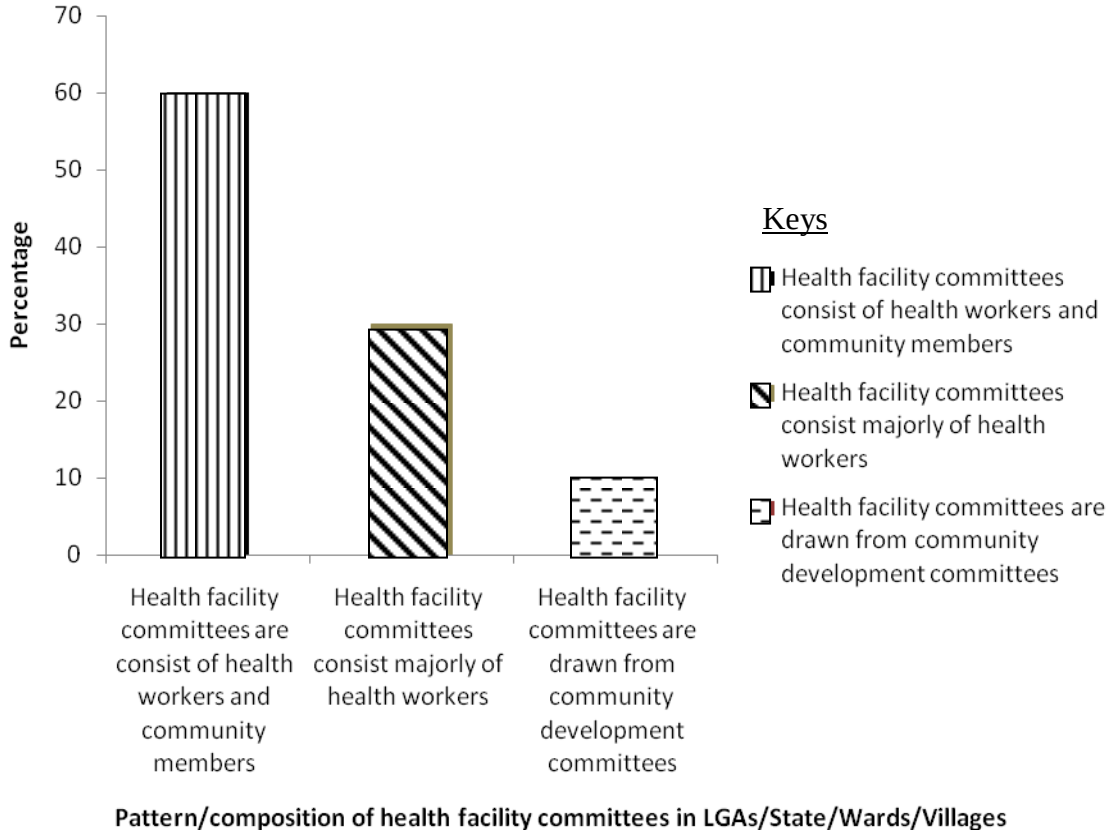


Figure 7: Bar chart of responses on composition of health facility committee

The figure 7 above shows pattern and composition of health facility committees that oversee smooth operation of primary health care centres and programmes. It is shown in the graph that majority of respondents confirmed that health facility committees are jointly constituted by community members and health workers. It has also been conceived by some respondents that health facility committees are formed either by health workers only or community development committees in Kwara State.

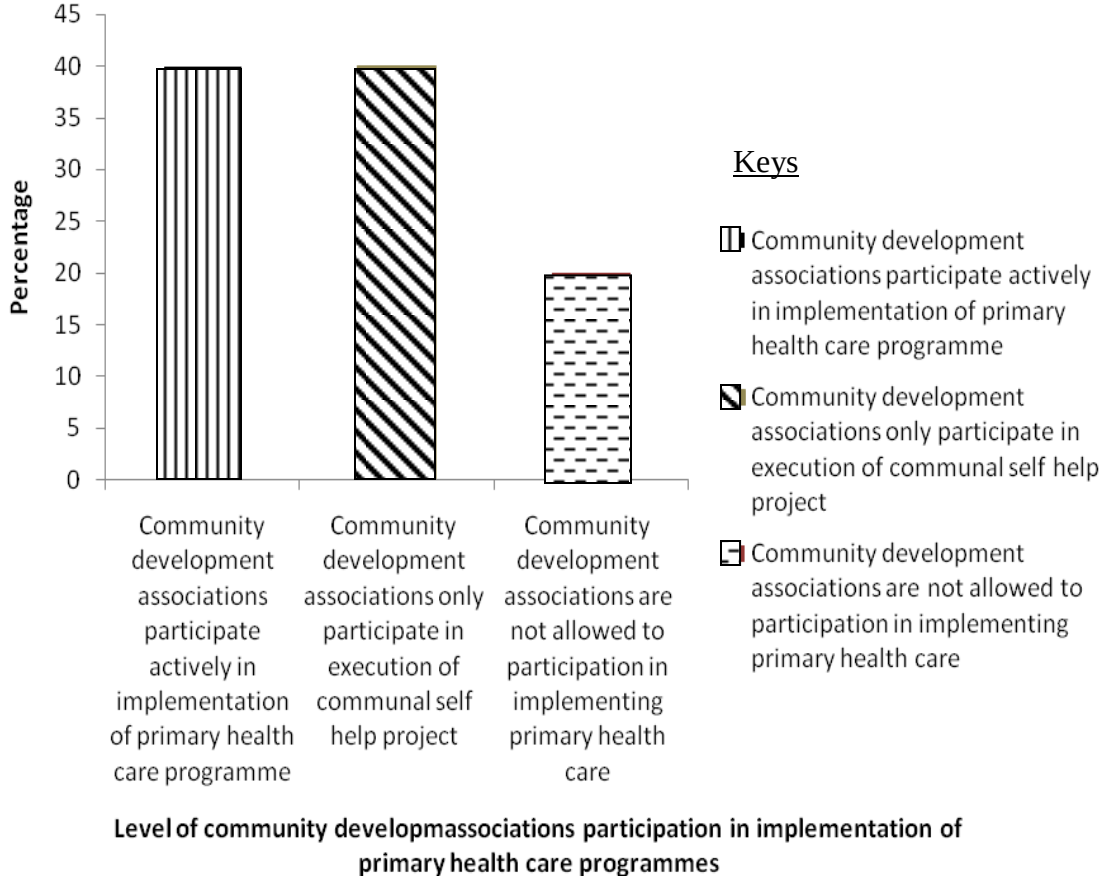
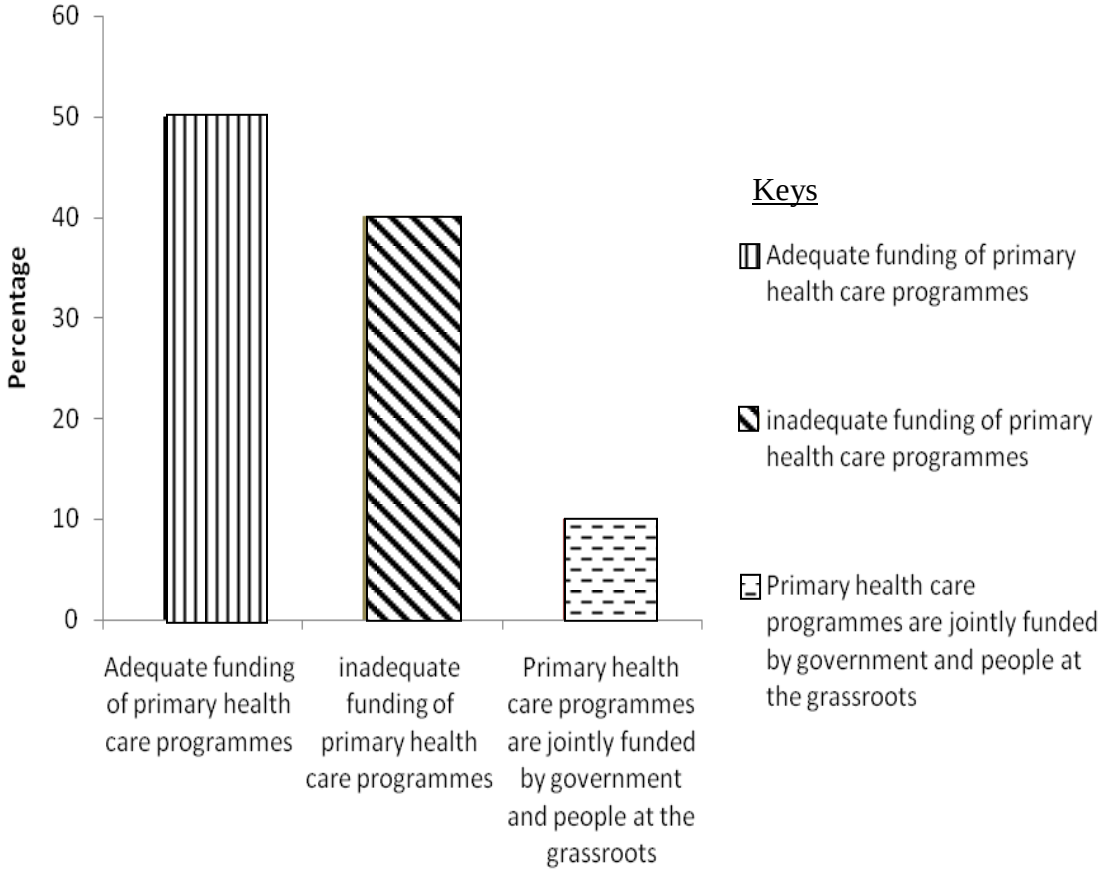


Figure 8: Bar chart of responses on level of participation on implementation of primary health care programmes

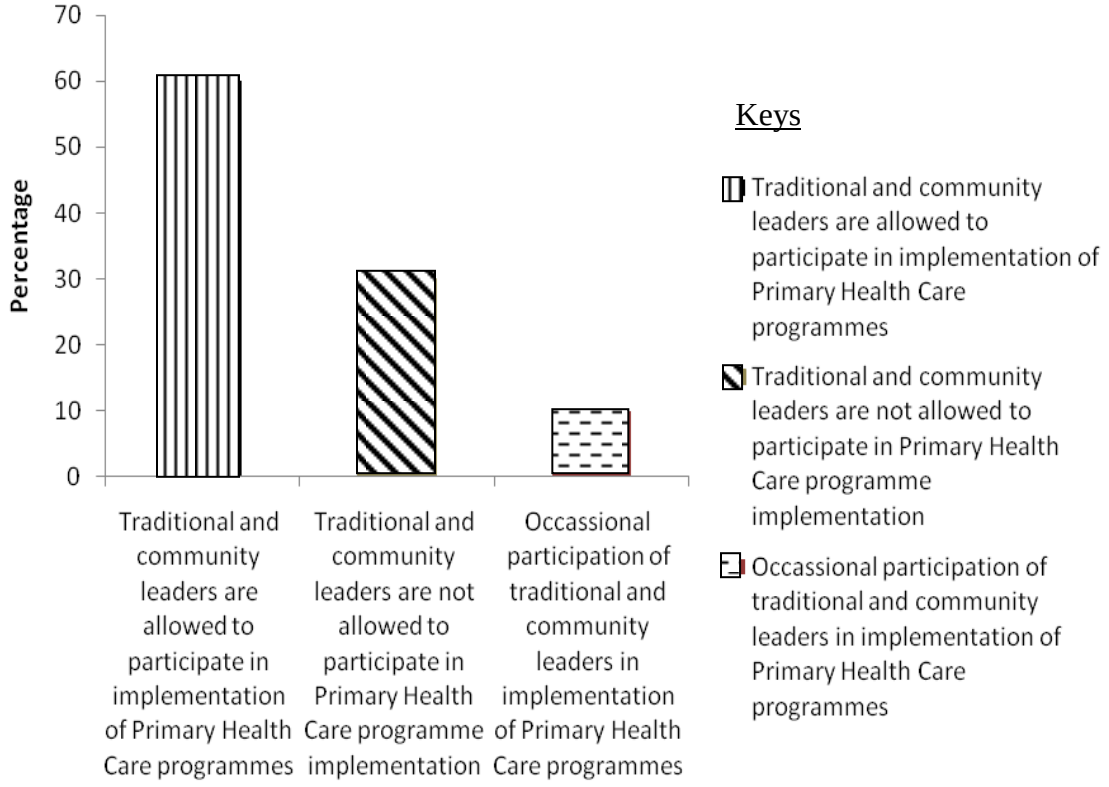
The figure 8 above shows that community development associations contribute to effective implementation of primary health care programmes either in overall implementation of PHC services or execution of community self help projects that have greater influence on realization of health for all in Kwara State. Some of the projects and programmes carried out by the community development associations are digging of borehole, sanitation exercise, construction of toilet among others.



Level of funding of Primary Health Care programme in Kwara State

Figure 9: Bar chart on level of funding of primary health care programmes in Kwara State

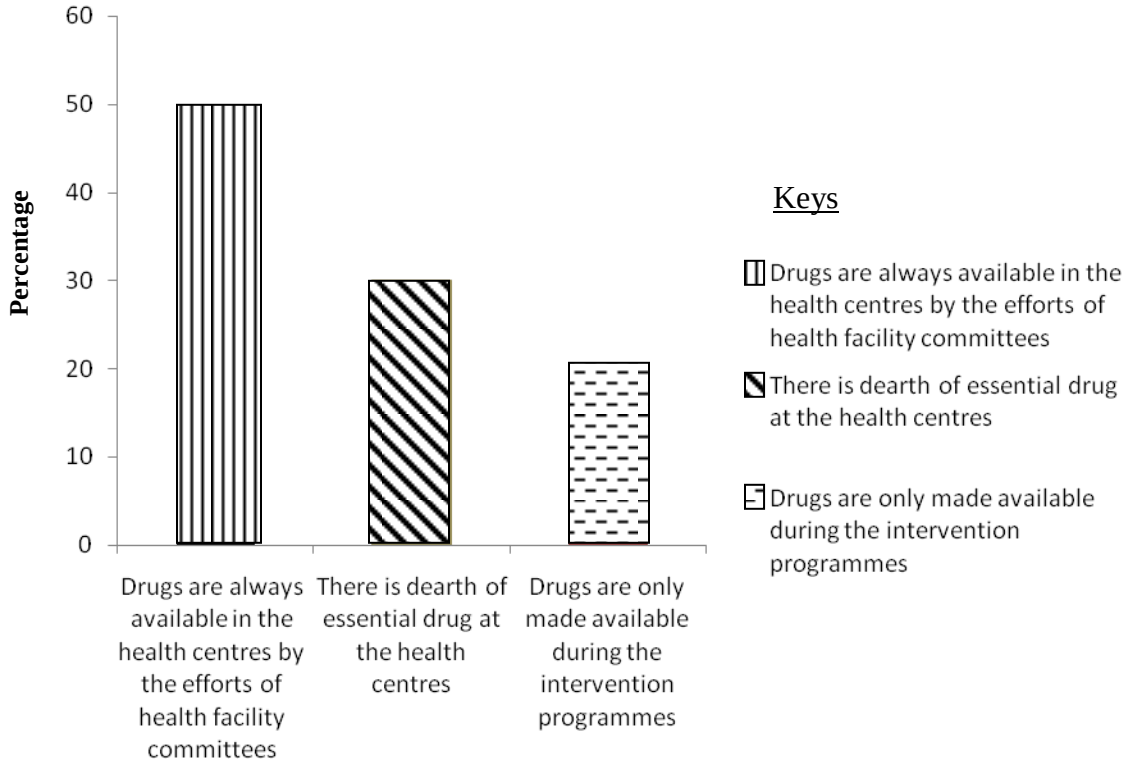
The chart in figure 9 shows that there is adequate funding of PHC programmes at the grassroots. The figure also revealed that few respondents agreed that PHC programmes are not adequately funded. This further established the need for strengthening community involvement in the implementation of PHC programmes/services in Kwara State. Adequate funding is required for drugs, materials and other logistic support.



Level of involvement of traditional and village heads in the implementation of Primary Health Care programmes

Figure 10: Bar chart on level of involvement of traditional and community leaders in the implementation of primary health care programmes

The figure 10 above shows that majority of respondents confirmed that most of the traditional and community leaders participated fully in implementation of PHC programmes and services. The chart also reveals that some community leaders are not fully involved in PHC implementation because of non-existence of formidable health facility committees. Some of the community leaders participate in implementation of intervention programmes on invitation at the community level in Kwara State.



Level of operation of drug revolving scheme at the primary health care centres

Figure 11: Bar chart on level of operation of drug revolving scheme in primary health care centres

The figure 11 above shows that there is availability of most of essential drugs used for the treatment of health and health related problems affecting people at the community level. This is due largely to effective operation of drug revolving scheme at the health centre(s). it is confirmed by few respondents that there is dearth of essential drugs due largely to non existence of formidable health facility committees at the grassroot in Kwara State. Some of the respondents (20%) also reported that drugs are available in their health facilities only during intervention programmes.

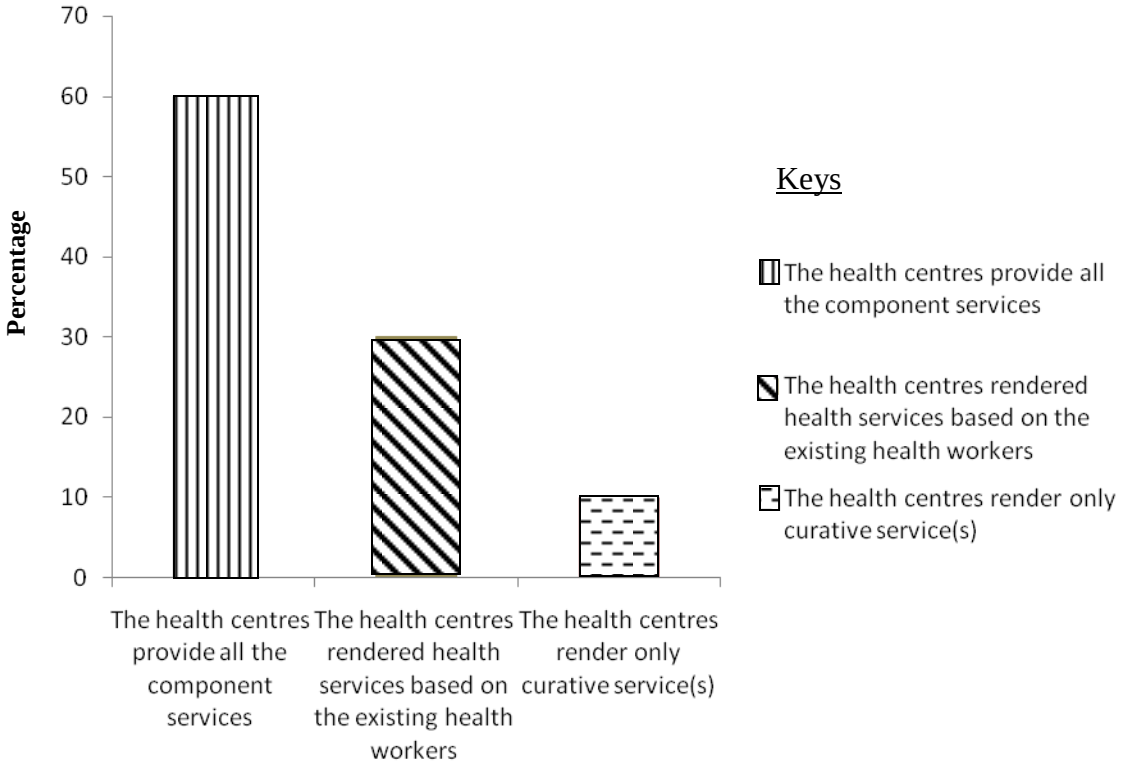


Figure 12: Bar chart on types of primary health care services rendered at the health centres in the community

The chart in figure 12 shows that majority of respondents confirmed that most of the health centres within the community rendered comprehensive health services covering all the PHC component services at the same time and in the same health centre(s). It is also shown on the chart that few health centres rendered health services based heavily on curative services. This has been adduced to be due to inadequate supply of polyvalently trained PHC providers in Kwara State.

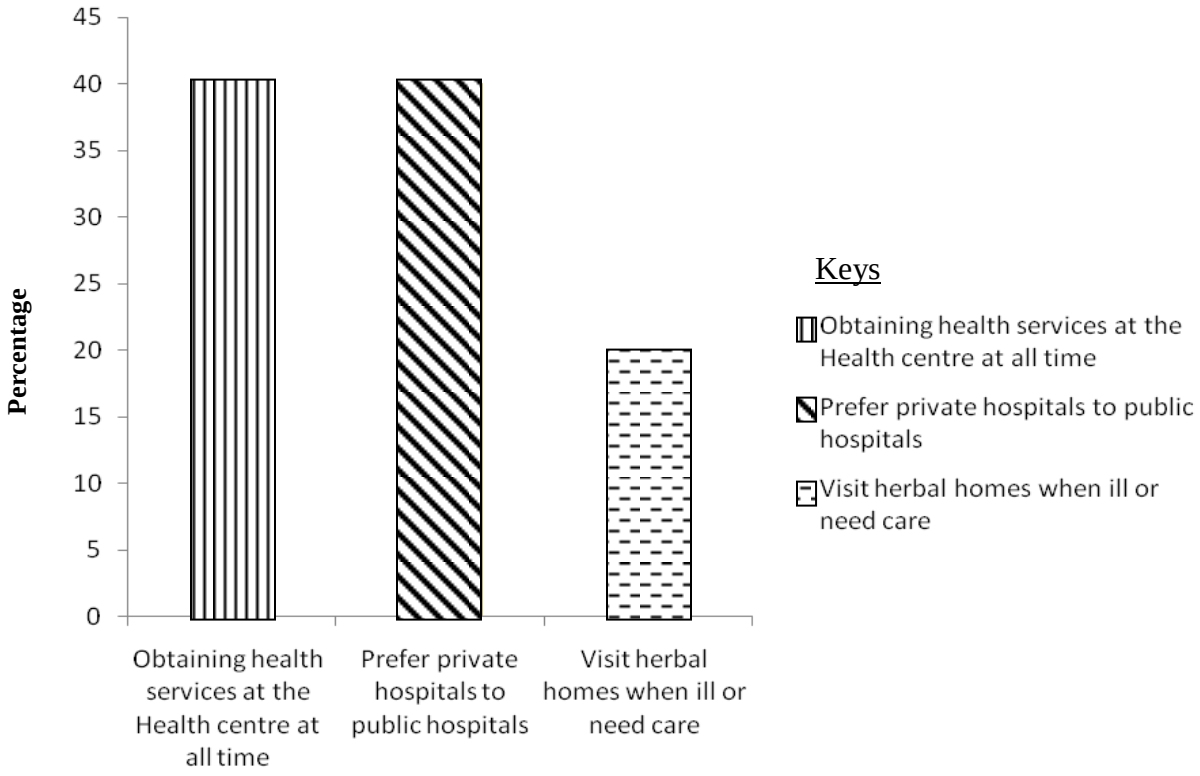


Figure 13: Bar chart on mode of obtaining health services in Kwara State

The chart in figure 13 shows that there is divergent views of respondents on mode of obtaining health services among people within the community. A considerable number of respondents confirmed that they obtain services in the health centres while some of them prefer private hospitals to public hospitals. The chart also shows that few rural dwellers frequently visit herbal homes to obtain treatments. This result shows that there is poor awareness and lack of adequate community mobilization at community level in Kwara State.

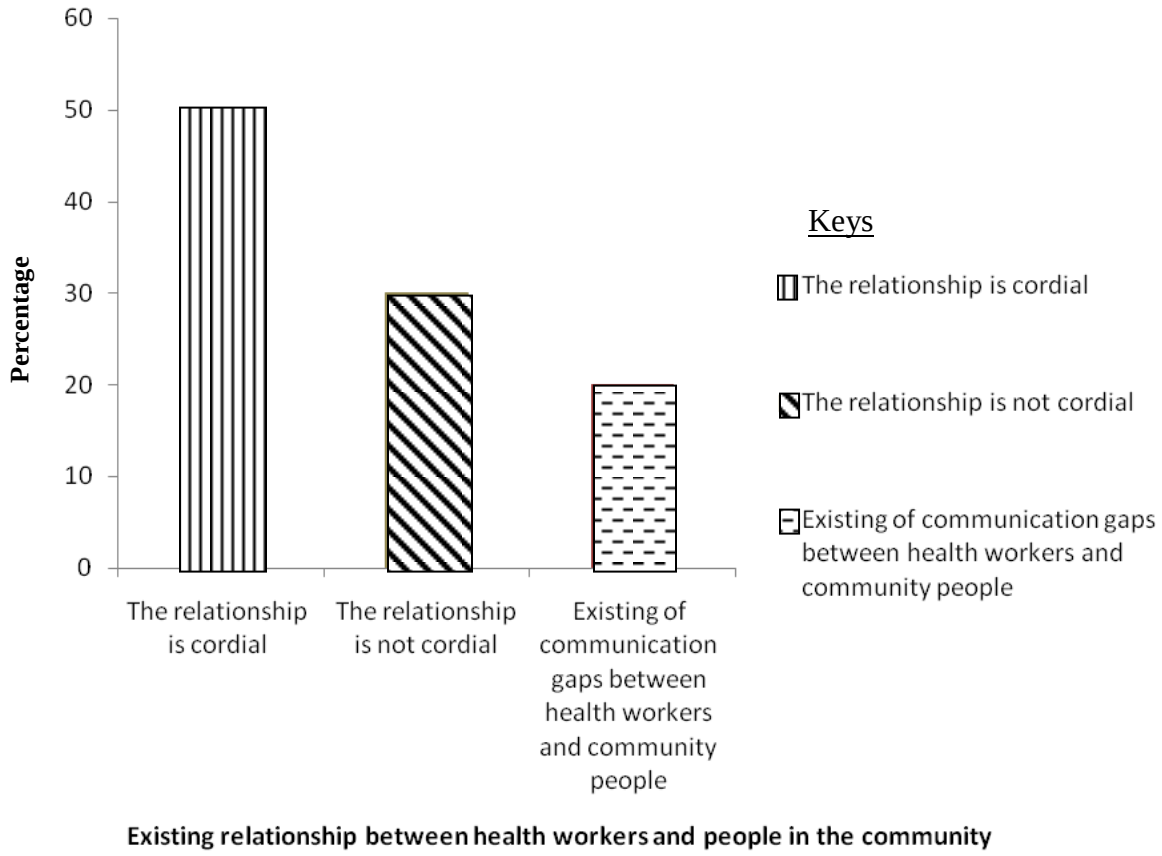


Figure 14: Bar chart on relationship between health workers and people in the community

The figure 14 above shows that majority of the respondents agreed that the relationship that exist between health care providers and community people are cordial. The chart also revealed that some of the respondents maintained that the relationship is not cordial because of existing communication gap in Kwara State.

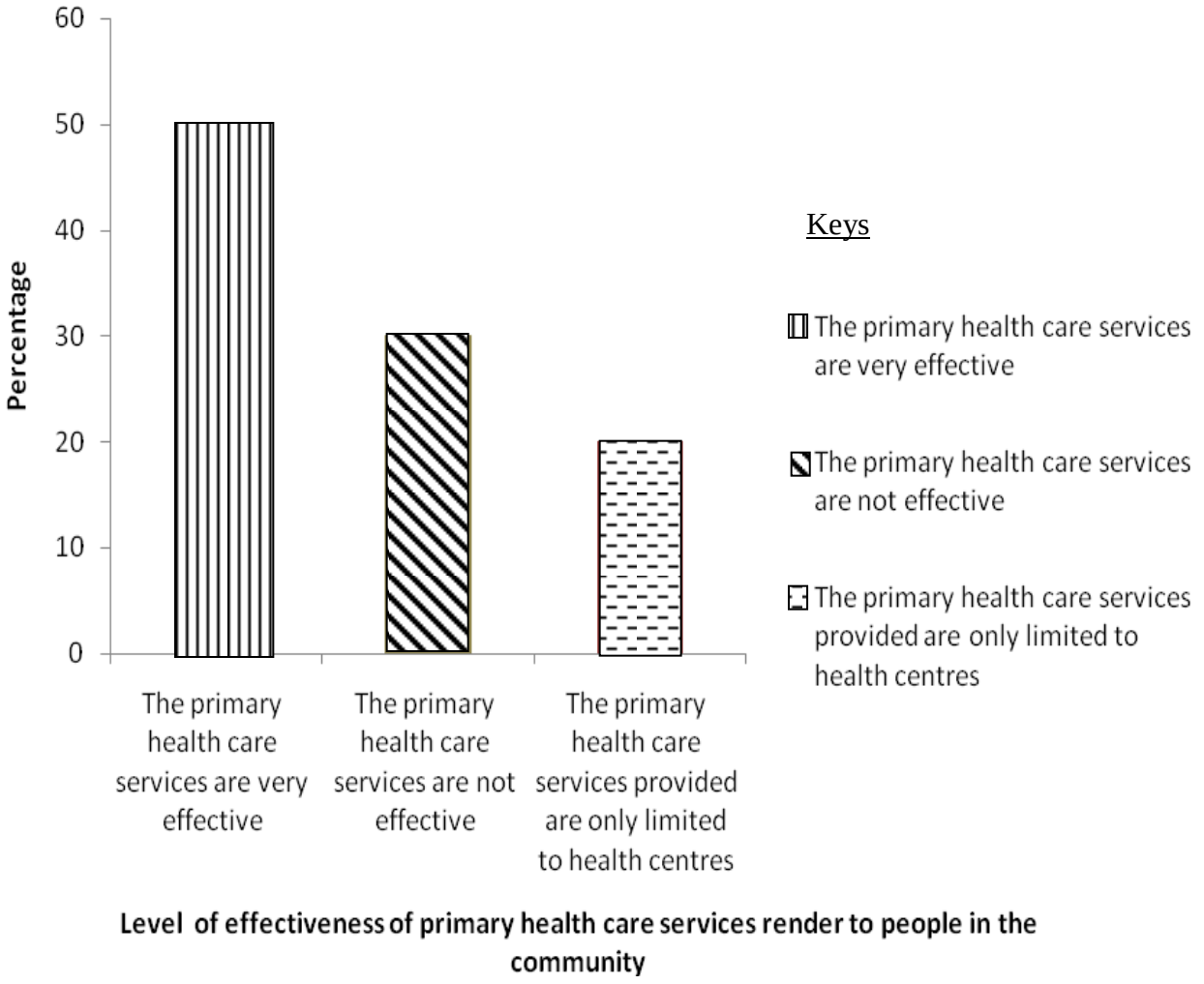


Figure 15: Bar chart showing level of effectiveness of PHC services rendered to people in the community

The chart in figure 15 above shows that majority of respondents confirmed that health services rendered at the health centres are highly effective. It is also deduced from the figure that few respondent agreed that the services provided are not effective, because the services are hospital based approach is in use in Kwara State. This means that the primary health care

services provided are not adequately utilized due to ineffective application of facilitators strategies like cohesive team approach, situation analysis, community mobilization, advocacy, community diagnosis and intersectoral collaboration.

The results of the thematic analysis revealed that most health facility committees in the state were not employing appropriate strategies for the realization of health for all in Kwara State, Nigeria.

Section C: Answers to Research Questions Raised for the study

This section vividly present analysis of data generated on the research questions raised and used to guide the study. In all, answers were given to the eleven (11) research questions used for the study as seen below:

Research Question One: What are the stakeholders' perception of influence of primary health care services on realization of health for all in Kwara state, Nigeria.

Table 4: Analysis of Responses to research question on influence of primary health care services on realization of Health for All

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	Health services rendered to the people at primary health care centre are affordable target at improving the health status of the people	82 (8.3%)	791 (88.36%)	873 (88.36%)	89 (9.0%)	26 (2.6%)	115 (11.64%)	988
2.	Primary health care allows for full participation of people within the community in its implementation	102 (10.32%)	800 (91.30%)	902 (91.30%)	68 (6.9%)	18 (1.8%)	86 (8.70%)	988
3.	Primary health care services ease the peoples' burdens of having to go to different hospital to obtain the required services or care hospitals	231 (23.38%)	838 (84.82%)	838 (84.82%)	94 (9.5%)	56 (5.7%)	150 (15.18%)	988
4.	Primary health care bring health services to the door step of people through citing of clinics, health centres, health posts and placement of clinic master cards to all households in the community.	198 (20.0%)	903 (91.36%)	903 (91.36%)	65 (6.6%)	20 (2.0%)	85 (8.64%)	988
5.	The health services rendered by primary health care providers utilize local technology and materials abound in the community for card and management of sicked people.	95 (9.6%)	750 (75.90%)	750 (75.90%)	198 (20.0%)	40 (4.1%)	238 (24.10%)	988
6.	Primary health services are accessible to all categories of people and age groups, and at distance not far from house.	60 (6.0%)	820 (85.96%)	820 (82.92%)	133 (13.5%)	35 (3.5%)	**168 (17.08%)**	**988**
7.	The types and hours of operation in primary health care centres has been adjusted to meet the needs of community members.	40 (4.0%)	830 (85.96%)	830 (85.96%)	98 (9.9%)	60 (6.1%)	**158 (14.04%)**	**988**
8.	The services provided in most of the primary health care centres within the communities in the Local Government are adequate and meet people health needs.	78 (7.90%	858 (87.85%)	858 (87.85%)	80 (8.1%)	50 (5.0%)	**130 (12.15%)**	**988**
9.	Almost all the services at primary health centres are rendered by qualified health workers and trained volunteers in the community.	100 (10.1%)	800 (81.00%)	800 (81.00%)	140 (14.1%)	48 (4.90%)	**188 (19.00)**	**988**
10.	Most of related sectors and units such as agricultural, water resources, information, environment etc assist the Local Governments in the implementation of both primary health care vertical and intervention programmes.	305 (30.9%)	800 (81.00%)	800 (81.00%)	78 (7.9%)	110 (11.1%)	**188 (19.00%)**	**988**
	Column Total	**1291**	**7083**	8374 (84.76%)	**1043**	**463**	**1506 (15.24%)**	**9880 (100%)**

The analysis of item 1 in table 4 shows that 873(88.36%) of respondents agreed that health service rendered to people in the health centres at the grassroot are affordable with the aim of improving the health status of the people. A total of 902 (91.30%) of the respondents agreed that primary health care gives people opportunities to participate in the matter affecting their health. Also, 838(84.82%) of the respondents agreed that primary health care reduce burdens of people on having to visit different health centres or hospital to obtain needed treatments. Furthermore, 903(91.36%) of the respondents agreed that primary health care bring health services to the door step of people through siting of health centres, clinics and placement of master card to all the households at the grassroots. The table also revealed that 750(75.90%) of the respondents agreed that almost all services rendered by primary health care providers make use of locally available materials and technical know- how. A total of 820(82.92%) of the respondents agreed that primary health care are available to all categories of people within the community. It is also revealed in item 7 of the table that 830(85.96%) of the respondents agreed that time and types of health services rendered in primary health centres vary at the rural and urban areas. The table shows that 858(87.85%) of the respondents agreed that the services provided in the primary health centres to people are adequate and meet their health needs. Also, 800(81.00%) of the respondents agreed that almost all the primary health care services and programmes implemented within the communities at the grassroots are jointly carryout out by health workers and people. It is revealed from the table that 800(81.00%) of the respondents agreed that primary health care services implementation are supported by various sectors such as agriculture, information, education, environment and so on.

The overall results of the items analysis of the research question one (1) above shows that 8374(84.76%) of the respondent agreed on the ten (10) items as presented on the table above,

while 1506(15.24%) of them disagreed with the statement. This implies that primary health care is affordable, ensure full participation of the people in its delivery, accessible and adequate for meeting health needs of people.

Research Question Two: What are the stakeholders' perception on influence of primary health care service of health education on prevailing health problems and method of preventing them on realization of health for all in Kwara State, Nigeria?

Table 5: Analysis of responses to research question on influence of health education on prevailing health problems and method of preventing them on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	Health education components of primary health care provides avenue for determining health seeking behaviour of people within the community with a view of promoting their health and well being.	288 (29.15%)	630 (63.77%)	918 (87.92%)	50 (5.1%)	20 (2.0%)	70 (12.08%)	988
2.	Massive campaigns usually organized by primary health care providers help in sustaining health and wellbeing of people in the community.	44 (4.5%)	710 (71.9%)	754 (76.40%)	194 (19.6%)	40 (4.0%)	234 (23.60%)	988
3.	Health talks given to people at clinic levels help in improving and promoting their health.	350 (35.4%)	501 (50.1%)	851 (85.50%)	87 (8.8%)	50 (5.1%)	137 (14.50%)	988
4.	The focus group discussion that are organized in the community often help to sensitize people on need to adopt healthful lifestyles that improve their health and wellbeing.	480 (48.6%)	430 (43.5%)	910 (92.10%)	60 (6.1%)	18 (1.8%)	78 (7.90%)	988
5.	The health education given to people both in the health centres and community level usually change their attitudes to desirable health behaviours.	370 (37.4%)	410 (41.5%)	780 (78.90%)	160 (16.2%)	48 (4.9%)	208 (11.10%)	988
	Column Total	**1532**	**2681**	4213 (85.28%)	**551**	**176**	727 (14.72%)	**4940 (100%)**

The analysis of item 1 in table 5 above shows that 918(87.92%) of the respondents agreed that health education component service of primary health care is a means of determining health

seeking behaviour of people is aimed at promoting their health and wellness. A total of 754(76.40%) of the respondents agreed that massive campaign organized by health care services providers help in sustaining health and wellbeing of people in the community. Also, 851(85.50%) of the respondents agreed that health talk given to clients during visit to clinic and health centres help in improving and maintaining their health and wellness. The analysis of item 4 in the table above shows that 910(92.10%) of the respondents agreed that the small group discussion usually conducted by health care services providers help to sensitize people on helpful health behaviour and promote their wellbeing. Furthermore, 780(78.90%) of the respondents agreed that health education given to the people in both the community and clinic level often lead to long lasting desirable health behaviour.

The overall results of the analysis of items above shows that 4213(85.28%) of the respondents agreed that the provision of primary health care service of health education on prevailing health problems and method of preventing them have influence on realization of health for all, while 727(14.72%) of them disagreed with the statement. This means that health education assists in determination of health seeking behaviour and creation of awareness for effective implementation of PHC.

Research Question Three: What are the stakeholders' perception on influence of primary health care service of adequate food supply and proper nutrition on realization of health for all in Kwara State, Nigeria?

Table 6: Analysis of responses to research question on influence of adequate food supply and proper nutrition on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	Current education and information on methods of food preservation, preparation, handling and consumption are sufficient in ensuring adequate and proper nutrition of people in the community.	99 (10.0%)	680 (68.8%)	779 (78.80%)	198 (20.0%)	11 (1.1%)	209 (21.20%)	988
2.	Food Supply and Basic Nutrition afford the people opportunity to get access to food that provides basic needs for the people.	28 (2.8%)	700 (70.9%)	728 (73.70%)	210 (21.2%)	50 (5.1%)	260 (26.30%)	988
3.	Food Supply and Basic Nutrition ensures good consumerism among the regular.	88 8.9%)	650 (65.8%)	738 (74.70%)	190 (19.2%)	60 (6.1%)	250 (25.30%)	988
4.	The services rendered by health workers in ensuring adequate food preservation and processing have improved the knowledge of people on food spoilages and loss of nutritional values derivable from foods we eat.	345 (35.0%)	600 (60.7%)	945 (95.70%)	33 (3.3%)	10 (1.0%)	43 (4.30%)	988
5.	Food Supply and Basic Nutrition provide adequate knowledge of nutritional education to the people.	105 (10.6%)	743 (75.2%)	848 (85.80%)	80 (8.1%)	60 (6.1%)	140 (24.20%)	988
	Column Total	**665**	**3373**	4038 (81.74%)	**711**	**191**	902 (18.26%)	**4940 (100%)**

The analysis of item 1 in table 6 above revealed that 779(78.80%) of the respondents agreed that current education and information on method of food preservation, preparation, handling and consumption are sufficient in ensuring adequate and proper nutrition helped for people at the grassroots. Also, 728(73.70%) of the respondents agreed that services provided to ensure enough food supply and good nutrition and access to food and improved nutritional practice of people in the community. Furthermore, 738(74.70%) of the respondents agreed that the services provided on food supply and food utilization assisted people in taken wise decision on improvement of their nutritional intake for proper growth and development. A total of 945(95.70%) of the respondents agreed that the services rendered by health workers to ensure adequate food preservation and processing improved knowledge of people on food spoilage and

loss of derivable food nutrients. The analysis of item 5 in the table 6 above shows that 848(85.80%) of the respondents agreed that provision of services on need for availability and proper consumption of foods ensure adequate knowledge of people on good nutritional practice and education.

The overall results of all items analysis in the above table shows that 4038(81.74%) of the respondents agreed that the provision of adequate food supply and proper nutrition have influence on realization of health for all, while 902(18.26%) disagreed with the statement. This implies that the provision of nutrition education, food supplement programmes, food display have much influence on realization of health for all.

Research Question Four: What are the stakeholders' perception on influence of primary health care service of adequate supply of water and basic sanitation on realization of health for all in Kwara State, Nigeria?

Table 7: Analysis of responses to research question on influence of adequate water supply and basic sanitation on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	Government efforts at various levels, especially at LGAs have helped in ensuring adequate and supply of drinkable water through digging of boreholes and hand-pumps water supply.	185 (18.7%)	700 (70.9%)	885 (89.60%)	93 (9.4%)	10 (1.0%)	103 (10.40%)	988
2.	Regular monitoring and supervision of water supply by the environmental health officers and community health care providers have helped in maintenance of and ensuring consumption of good clean water.	108 (10.9%)	705 (71.4%)	813 (82.30%)	120 (12.1%)	55 (5.6%)	175 (17.70%)	988
3.	The establishment and mounting of heavy campaign on environmental sanitation both in rural and urban centres have helped in ensuring clean environment devoid of infection or diseases agents.	330 (33.4%)	508 (51.4%)	838 (84.80%)	90 (9.1%)	60 (6.1%)	150 (15.20%)	988
4.	Some government and non-government organizations have helped in the digging of boreholes and provision of Ventilated Improved Pit (VIP) Latrine promote the health of people.	166 (16.8%)	402 (40.7%)	568 (57.50%)	380 (38.5%)	40 (4.0%)	420 (42.50%)	988
5.	Provision of effective means of refuse disposal on basis of size of communities through methods such as control tipping, incineration, composting have assisted in reduction of spread of infections.	188 (11.9%)	690 (69.8%)	808 (81.70%)	140 (14.2%)	40 (4.1%)	180 (18.30%)	988
	Column Total	**907**	**3005**	**3912 (79.19%)**	**823**	**205**	**1028 (20.81%)**	**4940 (100%)**

The analysis of item 1 in table 7 shows that 885(89.60%) of the respondents agreed that government efforts at ensuring adequate water supply and rural sanitation have helped in provision of drinkable water and maintenance of clean environment through digging of boreholes and prompt availability of hand pumps water. Also, 813(82.30%) of the respondents agreed that environmental health officers and community health care providers have assisted in maintenance and effective consumption of good clean water. A total of 838(84.80%) of the respondents

agreed that the initiation and mounting of heavy campaign on environmental sanitation both in the rural areas and urban centres have assisted in ensuring environment free of infection and dirts. The item 4 in table 6 above shows that 568(57.50%) of the respondents agreed that Kwara State government and non-governmental organizations have helped in digging boreholes and provision of sanitaries which promote peoples wellness. The analysis of item 5 in the table 6 above revealed that 808(81.70%) of the respondents agreed that provision and maintenance of effective means of refuse disposal will help in reduction of spread of diseases.

The overall results of analysis of the items in the table above revealed that 3912(79.19%) of respondents agreed that provision of adequate water and basic sanitation influence realization of health for all, while 1028(20.81%) of them disagreed with the statement. This means that the digging of boreholes, construction of toilet facilities, general environmental sanitation programmes have assisted in ensuring healthy living within the state.

Research Question Five: What are the stakeholders' perception on influence of primary health care service of maternal and child health including family planning on realization of health for all in Kwara State, Nigeria?

Table 8: Analysis of responses to research question on influence of maternal and child health including family planning service on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	The health services rendered to pregnant women have assisted in ensuring smooth delivery in the health centres.	85 (8.6%)	640 (64.8%)	725 (73.40%)	203 (20.5%)	60 (6.1%)	263 (26.60%)	988
2.	The immunization and vaccinations given to pregnant women often help in ensuring safe delivery and promotion of health of both the mothers and the babies.	380 (38.5%)	585 (59.2%)	965 (97.70%)	18 (1.8%)	5 (0.5%)	23 (2.30%)	988
3.	The health services rendered to nursing mothers and the babies usually assisted in promotion of their health and wellness.	288 (29.2%)	530 (53.6%)	818 (82.80%)	90 (9.1%)	80 (8.1%)	170 (17.20%)	988
4.	The attitudes of health workers towards the pregnant women and nursing mothers during ante-natal and post-natal section in the health centres reduce patronage.	375 (38.0%)	480 (48.6%)	855 (86.60%)	103 (10.4%)	30 (3.0%)	133 (13.40%)	988
5.	The heavy campaigns mounted on safe delivery and need for pregnant women to attend antenatal clinics have helped in reducing illness rates and death of potential mothers and their babes and ensure adequate maternal nutrition.	210 (21.3%)	605 (61.2%)	815 (82.50%)	120 (12.1%)	53 (5.4%)	173 (17.50%)	988
	Column Total	**1338**	**2840**	**4178 (84.58%)**	**534**	**228**	**762 (15.42%)**	**4940 (100%)**

The analysis of item 1 in table 8 shows that 725(73.40%) of the respondents agreed that the health services rendered to pregnant women helped in ensuring smooth delivery at the health centres. Also, an overwhelming majority of the respondents 965(97.7%) agreed that immunization and vaccination given to pregnant women often assist in ensuring safe delivery and safety of mothers and newborn. A total of 818(82.80%) of the respondents agreed that health care given to nursing mothers and the babies usually assisted in promotion of their health and wellness. The responses on item 4 in the table 7 above revealed that 855(86.60%) of the respondents agreed that the attitudes of most of the health workers towards pregnant women

during their visits often reduce patronage. Furthermore, 815(82.50%) of the respondents agreed that heavy campaign mounted on safe delivery and need to attend antenatal clinics often promote health and well being of pregnant women and their unborn babies.

The overall findings from the analysis above shows that 4178(84.58%) of the respondents agreed that the delivery of maternal and child health including family planning has much influence on realization of health for all, while 762(15.42%) disagree with the statements. This implies that the prenatal, antenatal, postnatal, child-spacing, campaign against home delivery really have greater influence on realization of health for all.

Research Question Six: What are the stakeholders' perception on influence of primary health care service of immunization against infectious diseases on realization of health for all in Kwara State, Nigeria?

Table 9: Analysis of responses to research question on influence of immunization against infectious diseases on realization of Health for All

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	The general vaccinations given in the health centres and hospitals have helped in reducing infections that are preventable.	440 (44.5%)	471 (47.7%)	911 (92.20%)	55 (5.6%)	22 (2.2%)	77 (7.80%)	988
2.	The immunization of women has helped in reduction of mortality that may likely result from pregnancy and delivery.	105 (10.6%)	680 (68.8%)	785 /(79.40%)	193 (19.5%)	10 (1.1%)	203 (20.60%)	988
3.	Mass immunization carried out on children by the government at the grassroot has contributed to prevention and control of some deadly diseases such as tuberculosis, diphtheria, pertussis, tetanus, hepatitis and so on.	399 (40.4%)	492 (49.8%)	891 (90.20%)	72 (7.3%)	25 (2.5%)	97 (9.80%)	988
4.	The general immunization given also assisted in reducing suffering and complications that may likely result from ailment such as tetanus, paralysis, coughing and chest pain.	48 (4.8%)	790 (80.1%)	838 (84.90%)	105 (10.5%)	45 (4.6%)	150 (5.10%)	988
5.	Immunization exercise afford people of the opportunity for supplement deficient nutrients and other materials needed for body utilization such as vitamin C, iron supplement and growth monitoring for children and so on.	410 (41.5%	530 (53.6%)	940 (95.10%)	38 (3.9%)	10 (1.0%)	48 (4.90%)	988
	Column Total	**1402**	**2963**	**4365 (88.36%**	**463**	**112**	**575 (11.64%)**	**4940 (100%)**

The analysis of item 1 in table 11 shows that 911(92.20%) of the respondents agreed that the general immunization given in the health centres and hospitals often helped in reduction of preventable infections. The table analysis also revealed that majority of the respondents 785(79.40%) agreed that the immunization given to women helped in reduction of mortality that may likely result from pregnancy and delivery. A total of 891(90.20%) of the respondents agreed that regular mass immunization carried on children usually helped in prevention and central of some deadly diseases like tuberculosis, diphtheria, pertussis, tetanus, hepatitis and so on. Furthermore, majority of the respondents 838(84.90%) agreed that the general immunization given often helped in reducing suffering and complications that may result from ailment such as tetanus, paralysis, coughing and chest pain. Also, an overwhelming 940(95.10%) of the respondents agreed that general immunization exercise afford people the opportunity to supplement deficient nutrients and other material needed for normal growth and development.

The overall results of analysis in the above table shows that 4365(88.36%) of respondents agreed that provision of immunization services against infectious diseases have much influence on realization of health for all, while 575(11.64%) of them disagreed with the statement. This means that the mass immunization and nutrients supplements given to people influence realization of health for all.

Research Question Seven: What are the stakeholders' perception on influence of primary health care service of prevention and control of endemic diseases on realization of health for all in Kwara State, Nigeria?

Table 10: Analysis of responses to research question on influence of prevention and control of endemic diseases on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	The distribution of ivermectin drug to prevent and control on-cocerciasis has helped in reducing its incidence in the community.	180 (18.2%)	700 (70.9%)	880 (89.10%)	85 (8.6%)	23 (2.3%)	108 (11.90%)	988
2.	Mass administration of supplement drugs such as folic acid ferrous sulphate, yeast tablets and so on contribute to prevention and control of health problems such as anaemia, dizziness and shock to mention but few efforts.	72 (7.3%)	486 (49.2%)	558 (56.50%)	320 (32.4%)	110 (11.1%)	430 (23.50%)	988
3.	The effort of government and non-governmental organizations in digging of boreholes and water purification enlightenment programmes have assisted in reducing infection resulting from intake of impure water.	380 (38.5%)	495 (50.1%)	875 (88.60%)	105 (10.6%)	8 (0.8%)	113 (11.40%)	988
4.	The efforts put up by government and people of this community in ensuring adequate toilet facilities and determine have contributed to reduction of diseases that often resulted to food poisoning and worm infestations.	108 (10.9%)	790 (80.0%)	898 (90.90%)	70 (7.1%)	20 (2.0%)	90 (9.10%)	988
5.	The general housing scheme and environmental protection programmes initiated by government within the community have helped in prevention of diseases such as cerebro-spinal meningitis, malaria, food poisoning and so on.	99 (10.0%)	480 (48.6%)	579 (58.60%)	391 (39.6%)	18 (1.8%)	409 (21.40%)	988
	Column Total	**839**	**2951**	**3790 (76.72%)**	**971**	**179**	**1150 (23.28%)**	**4940 (100%)**

The analysis of item 1 in table 10 shows that 880(89.1%) of the respondents agreed that the free distribution of ivermectin drugs help in prevention and control of oncerciasis within the community. Also, majority of the respondents 558(56.50%) agreed that mass administration of supplement drugs like ferrous sulphate, folic acid, yeast tablets and so on contribute to effective prevention and control of food deficiency diseases such as anaemia, dizziness, shock and so on have assisted ineffective prevention and control of food deficiency diseases such as anaemia, dizziness and shock. A total of 875(88.60%) of the respondents agreed that the efforts put up by government and non-governmental organizations towards digging of boreholes and purification of water sources have helped in reduction of water borne diseases. The analysis of item four in

the table 10 above revealed that 898(90.90%) of the respondents agreed that the joint efforts put up by government and people within the community have actually contributed to reduction of food poisoning and worm infestations. Furthermore, 579(58.60%) of the respondents agreed that the general housing scheme and environmental protection programmes initiated by government within the community have assisted in prevention of diseases such as cerebro-spinal meningitis, malaria, food poisoning and so on.

The overall results of analysis of items in the table above revealed that 3790(76.72%) of the respondents agreed that provision of PHC service of prevention and control of endemic diseases influence realization of health for all, while 1150(23.28%) disagreed with the statements. This implies that the distribution of ivermectin and other anti-malaria drugs, promotion of good housing and provision of drinkable water have much influence on realization of health for all.

Research Question Eight: What are the stakeholders' perception on influence of primary health care service of appropriate treatment of common diseases and injuries on realization of health for all in Kwara State, Nigeria?

Table 11: Analysis of responses to research question on influence of appropriate treatment of common diseases and injuries on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	The citing and establishment of health posts, clinic and health centres through governments and communal efforts in various villages have made treatment of minor infection and health problems easy.	106 (10.7%)	694 (70.2%)	800 (80.90%)	146 (14.8%)	42 (4.3%)	188 (19.10%)	988
2.	The training of traditional birth attendants and village health workers nominated by the community has assisted in the identification and treatment of minor health problems.	74 (7.5%)	604 (61.1%)	678 (68.60%)	296 (30.0%)	14 (1.4%)	310 (31.40%)	988
3.	The home visiting carried out by community health providers has contributed to the discovery of some simple and preventable ailments and their subsequent treatment.	351 (35.6%)	520 (52.6%)	871 (88.20%)	90 (9.1%)	27 (2/7%)	117 (11.80%)	988
4.	The inadequate supply of diagnostic materials has impeded effective diagnostic and confirmation of some common ailments.	188 (19.0%)	670 (67.8%)	858 (86.80%)	110 (11.1%)	20 (2.1%)	130 (13.20%)	988
5.	Insufficient number of qualified and trained personnel hinders effective management of minor infections and injuries.	60 (6.1%)	770 (77.9%)	830 (84.0%)	120 (12.1%)	38 (3.9%)	158 (16.0%)	988
	Column Total	**779**	**3258**	**4037 (81.72%**	**762**	**141**	**903 (18.28%)**	**4940 (100%)**

The analysis of item 1 in table 11 above shows 800(80.90%) of the respondents agreed that the treatment of minor ailment and health problems are made easy by various health centres, health post, clinics cited within different communities. A total of 678(68.60%) of the respondents agreed that the training of traditional birth attendants and village health workers nominated by the community has assisted in identification and treatment of minor ailments. Also, 871(88.20%) of the respondents agreed that the home visiting carried out by community health care providers contributed to the prevention and treatment of ailments discovered during the exercise. Furthermore, 858(86.80%) of the respondents agreed that inadequate supply of diagnostic materials and equipment often impede effective diagnosis of some common ailment or diseases. The analysis of the item 5 in the table 11 above shows that 830(84%) of the respondents agreed

that inadequate supply of qualified and trained personnel marred effective management of minor infections and injuries.

The overall results of items analysis in the above table shows that 4037(81.72) agreed that the delivery of PHC service of appropriate treatment of common diseases and injuries influence realization of health for all, while 903(18.28%) of them disagreed. This implies that the training of traditional birth attendants, establishment of health centres, home visiting carried out by primary health care providers have much influence on realization of health for all in Kwara State.

Research Question Nine: What are the stakeholders' perception on influence of primary health care service of provision of essential drugs service on realization of health for all in Kwara State, Nigeria?

Table 12: Analysis of responses to research question on influence of essential drug supply on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	The existence of village health workers has made the sales of essential drugs to teeming rural dwellers easy and accessible.	89 (9.0%)	808 (81.8%)	897 (90.80%)	81 (8.2%)	10 (1.0%)	91 (9.20%)	988
2.	The joint communal efforts on drug revolving scheme contribute immensely to prompt supply and availability of common drugs used for treatment in the health centre.	282 (28.5%)	660 (66.8%)	942 (95.30%)	30 (3.1%)	16 (1.6%)	46 (4.70%)	988
3.	The non-challant attitudes of governments at grassroot on supply and availability of drugs in the clinics and health centre often hindered effective health care services.	35 (3.6%)	680 (68.8%)	715 (72.40%)	245 (24.8%)	28 (2.8%)	273 (27.60%)	988
4.	The current free drugs distribution to patients after treatment in the health centres within the community account for increased patient attendance or patronage.	90 (9.1%)	803 (81.3%)	893 (90.40%)	75 (7.6%)	20 (2.0%)	95 (9.60%)	988
5.	The management approach used in strengthening drug revolving scheme has assisted in controlling circulation of fakes and substandard drugs.	265 (26.8%)	439 (44.5%)	704 (71.30%)	180 (18.2%)	104 (10.5)	284 (28.70%)	988
	Column Total	**761**	**3390**	**4151 (84.03%)**	**611**	**178**	**789 (15.97%)**	**4940 (100%)**

The analysis of item 1 in table 12 above revealed that 897(90.80%) of the respondents agreed that the training and operation of village health workers on sales of essential drugs made accessibility and purchase of the drugs easy. A total of 942(95.30%) of the respondents agreed that the joint communal efforts on drug revolving scheme contribute immensely to prompt supply and availability of common drugs used for treatment in the health centres. Also, 715(72.40%) of the respondents agreed that non-challant attitude paid by government to supply and ensure availability of essential drugs often stall effective treatment of ailments in our health centres. Furthermore, 893(90.40%) of the respondents agreed that free distribution of essential drugs for treatment and prevention of ailments in some of the health centres has assisted in increasing patience patronage. A total of 704(71.30%) of the respondents agreed that approach used in management of drug revolving scheme has assisted in controlling circulation of fake and adulterated drugs at the grassroots.

The overall results of analysis of items on the table above shows that 4151(84.03%) of the respondents agreed that provision of essential drug service have greater influence on realization of health for all, while 789(15.97%) of them disagreed with the statement. This means that the free distribution of drugs, joint communal efforts on drug revolving scheme, good management approach directed at strengthening drug revolving scheme, the activities of traditional birth attendants in sale of drugs, have much influence on realization of health for all.

Research Question Ten: What are the stakeholders' perception on influence of primary health care service of primary health care component service of dental health on realization of health for all in Kwara State, Nigeria?

Table 13: Analysis of responses to research question on influence of dental health care on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	Oral health care services provided to people at health centres have considerable impact in maintaining clean teeth and mouth.	177 (17.9%)	781 (79.0%)	958 (96.90%)	25 (2.6%)	5 (0.5%)	30 (3.10%)	988
2.	Dental health care helps to minimize the effects of oral health problems on health of people.	96 (9.7%)	682 (69.0%)	778 (78.70%)	180 (18.2%)	30 (3.1%)	210 (21.30%)	988
3.	Regular dental check-up often reduced incidence of dental caries and diseases of gum through intake of low sugar foods.	345 (34.9%)	490 (49.6%)	835 (84.50%)	103 (10.4%)	50 (5.1%)	153 (15.50%)	988
4.	The modern dental care has contributed to reduction in teeth accidents and injuries such as teeth dislocation, removal of teeth, poor teeth alignment, cracked teeth and so on	74 (7.5%)	664 (67.2%)	738 (74.70%)	190 (19.2%)	60 (6.1%)	250 (25.30%)	988
5.	Regular dental check up afford people the opportunity to know strategies and measures necessary in ensuring effective oral hygiene.	245 (24.8%)	560 (56.7%)	805 (81.50%	160 (16.2%)	23 (2.3%)	183 (18.50%)	988
	Column Total	**937**	**3177**	**4114 (83.28%)**	**658**	**168**	**826 (16.72%)**	**4940 (100%)**

The analysis of item 1 in table 13 above shows that 958(96.90%) of the respondents agreed that the dental health care given to people at the health centers influence maintenance of good oral hygiene and healthy teeth. Also, 778(78.70%) of the respondents agreed that the dental services rendered to people helped in minimizing the effects of oral health problems on them. Furthermore, 835(84.50%) of the respondents agreed that regular dental check up often helped in reducing dental caries and diseases of gum through intake of low sugar foods. A total of 738(74.70%) of the respondents agreed that modern dental care has contributed to reduction of teeth accidents and injuries such as teeth dislocation, poor teeth alignment, crack teeth and so on. The analysis of item 5 in the above table shows that 805(81.50%) of the respondents agreed that regular dental check up afford people the opportunity to know effective measures of ensuring good oral hygiene.

The overall results of analysis of items in the table above shows that 4114(83.28%) of respondents agreed that provision of dental health care have greater influence on realization of health for all, while 826(16.72%) of them disagreed with the statement. This means that the periodic and regular dental health care rendered by PHC providers, periodic dental check up and health education on proper maintenance of oral hygiene influence realization of health for all in Kwara State.

Research Question Eleven: What are the stakeholders' perception on influence of primary health care service of primary health care component service of mental health on realization of health for all in Kwara State, Nigeria?

Table 14: Analysis of responses to research question on influence of mental health care on realization of health for all

S/N	Item	SA	A	FR	D	SD	UR	Row Total
1.	The diagnostic services and treatment rendered to pregnant women with known history of delivery fit at the health center help in prevention of mental illness in them.	81 (8.2%)	497 (50.3%)	578 (58.50%)	290 (29.4%)	120 (12.1%)	410 (41.50%)	988
2.	Community mental health education plays a significant role in good mental state.	90 (9.1%)	681 (68.9%)	771 (78.00%)	187 (18.9%)	30 (3.1%)	217 (22.00%)	988
3.	Mental illnesses have been prevented through meaningful control of drug abuse among people.	100 (10.1%)	770 (77.9%)	870 (88.00%)	76 (7.7%)	42 (4.3%)	118 (12.00%)	988
4.	The heavy campaign mounted against substance abuse has helped to minimize incidence of drug addiction in the community.	299 (30.3%)	641 (64.9%)	940 (95.20%)	38 (3.8%)	10 (1.0%)	48 (4.80%)	988
5.	The sanction imposed on drug peddling and indiscriminate selling of drugs has helped to reduce the incidence of drug abuse and misuse.	107 (10.8%)	790 (80.0%	897 (90.80%)	71 (7.2%)	20 (2.0%)	91 (9.20%)	988
	Column Total	**677**	**3379**	**4056 (82.10%)**	**662**	**222**	**884 (17.90%)**	**4940 (100%)**

The analysis of item 1 in table 14 above shows that 578(58.50%) of the respondents agreed that the health services rendered to pregnant women with known case of delivery fit help in prevention of mental illnesses in them. A total of 771(78%) of the respondents agreed that community mental health education plays vital role in ensuring good mental health. Also, 870(88%) of the respondents agreed that mental health services have assisted in prevention of mental illness through control of drug abuse among people. Furthermore, 940(95.20%) of the respondents agreed that the heavy campaign mounted against substance abuse really help to minimize incidence of drug addiction in the community. The analysis of item 5 in the table 14 above shows that 897(90.80%) of the respondents agreed that the sanctions imposed on drug peddling and indiscriminate selling of drugs have helped to reduce the incidence of drugs abuse and misuse.

The results of all the items in the table above revealed that 4056(82.10%) of respondents agreed that provision of mental health care have much influence on realization of health for all, while 884(17.90) of them disagreed with the statement. This implies that the community mental education delivered to people in the communities, heavy campaigns mounted against substance abuse, the sanction impose on drug peddlers have much influence on realization of health for in Kwara State, Nigeria.

Section D: Hypothesis Testing

The research hypotheses formulated and employed for the study were tested with the use of mean ranking method, Spearman Brown rank order correlation method and inferential statistical method of chi-square (x^2) set at 0.05 alpha level of significance. In all eleven hypotheses were formulated and tested for the study as presented in the table analysis below:

Hypothesis One (1): Stakeholders perception of primary health care service will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 15a: Mean ranking of respondents responses of influence of primary health care services on realization of health for all

S/N	Items	Mean	Rank	Decision
1.	Health services rendered to the people at primary health care centre are affordable target at improving the health status of the people	2.94	5th	Not significant
2.	Primary health care allows for full participation of people in its implementation	3.0	4th	Significant
3.	Primary health care services ease the peoples' burdens of having to go to different hospitals to obtain the required services or care hospitals	3.30	2nd	Significant
4.	Primary health care bring health services to the door step of people through citing of clinics, health centres, health posts and placement of clinic master cards to all households in the community.	3.89	1st	Significant
5.	The health services rendered by primary health care providers utilize local technology and materials abound in the community for card and management of sicked people.	2.82	10th	Not significant
6.	Primary health services are accessible to all categories of people and age groups, and at distance not far from house.	2.86	8th	Not significant
7.	The types and hours of operation in primary health care centres has been adjusted to meet the needs of community members.	2.88	7th	Not significant
8.	The services provided in most of the primary health care centres within the communities in the Local Government are adequate and meet people health needs.	2.90	6th	Not significant
9.	Almost all the services at primary health centres are rendered by qualified health workers and trained volunteers in the community.	2.86	8th	Not significant
10.	Most of related sectors and units such as agricultural, water resources, information, environment etc assist the Local Governments in the implementation of both primary health care vertical and intervention programmes.	3.01	3rd	Significant
	Column Total	**30.19**		

Average mean = 3.0

The result of mean ranking above shows that items 4,3,10 and 2 are highly significant. This means that their mean scored are above or within the bench mean score of 3.0. This shows that primary health care brings health services closer to the door steps of people by citing hospitals, clinics health centre within the community; primary health care services reduces peoples' burdens of having to visit different health facilities before addressing their health problems; primary health care services ensure intersectoral collaboration in the implementation of both vertical and intervention programmes. This implies that the four items have greater influence on realization of health for all. The result of the ranking also revealed that items 1, 5, 6,7, 8 and 9 have influence on realization of health for all but not as greater as the first four (4) items above the bench mean score. The overall results of the items analysis show that implementation of primary health care services have influence on realization of health for all in Kwara State.

Table 15b: Showing Spearman rank order correlation analysis on influence of primary health care services on realization of health for all in Kwara State, Nigeria

Variable	N	Mean	Std	df	Cal. R value	Crit. value	Sig.	Remark
PHC services	988	837.40	48.261	986	0.990	0.064	0.000	Ho Rejected
Health for all	988	150.60	48.261					

P< 0.05 alpha level

The analysis on table 15b above shows the calculated r-value of 0.990 against the critical r-value of 0.064 with degree of freedom of 986 at 0.05 alpha level of significance. Since the

calculated r-value is greater than critical r-value, the hypothesis stated above is hereby rejected. Therefore, stakeholders perception significantly influences the realization of health for all in Kwara State, Nigeria using primary health care services. This implies that the stakeholders perceived that the implementation of PHC services bring health to the door steps of rural dwellers, PHC is affordable and accessible, the services ease the people's burden. All these were targeted at the realization of health for all in Kwara State, Nigeria.

Hypothesis Two (2): Stakeholders' perception of primary health care service of health education on prevailing health problems will not have any significant influence on realization of health for all in Kwara State, Nigeria.

Table 16: Chi-square analysis showing stakeholders perceived influence of primary health care services of health education on prevailing health problems and method of preventing them on realization of health to all

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	Health education components of primary health care provides avenue for determining health seeking behaviour of people within the community with a view of promoting their health and well being.	288 (29.1%)	630 (63.8%)	50 (5.1%)	20 (2.0%)	988				
2.	Massive campaigns usually organized by primary health care providers help in sustaining health and wellbeing of people in the community.	44 (4.5%)	710 (71.9%)	194 (19.6%)	40 (4.0%)	988				
3.	Health talks given to people at clinic levels help in improving and promoting their health.	350 (35.4%)	501 (50.1%)	87 (8.8%)	50 (5.1%)	988	743.06	12	21.03	Hypothesis Rejected
4.	The focus group discussion that are organized in the community often help to sensitize people on need to adopt healthful lifestyles that improve their health and wellbeing.	480 (48.6%)	430 (43.5%)	60 (6.1%)	18 (1.8%)	988				
5.	The health education given to people both in the health centres and community level usually change their attitudes to desirable health behaviours.	370 (37.4%)	410 (41.5%)	160 (16.2%)	48 (4.9%)	988				
	Column Total	**1532**	**2681**	**551**	**176**	**4940**				

The finding from analysis of hypothesis two (2) in table 16 above shows the calculated chi-square value of 743.06 against the critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated chi-square value is greater than the critical value, the hypothesis stated above is hereby rejected. Therefore, stakeholders' perception of primary health care service of health education on prevailing health problems significantly influence on realization of health for all in Kwara State, Nigeria. This implies that health education, FGD, health talks, campaigns and awareness frequently organized by PHC providers on prevailing health problems and method of preventing them have much influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Three (3): Stakeholders perception of primary health care service of adequate food supply and proper nutrition will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 17: Chi-square analysis showing stakeholders perceived influence of primary health care service of adequate supply of food and proper nutrition on realization of heath for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	Current education and information on methods of food preservation preparation, handling and consumption are sufficient in ensuring adequate and proper nutrition of people in the community.	99 (10.0%)	680 (68.8%)	198 (20.0%)	11 (1.1%)	988	590.20	12	21.03	Hypothesis Rejected
2.	Food Supply and Basic Nutrition afford the people opportunity to get access to food that provides basic needs for the people.	28 (2.8%)	700 (70.9%)	210 (21.2%)	50 (5.1%)	988				
3.	Food Supply and Basic Nutrition ensures good consumerism among the regular.	88 8.9%)	650 (65.8%)	190 (19.2%)	60 (6.1%)	988				
4.	The services rendered by health workers in ensuring adequate food preservation and processing have improved the knowledge of people on food spoilages and loss of nutritional values derivable from foods we eat.	345 (35.0%)	600 (60.7%)	33 (3.3%)	10 (1.0%)	988				
5.	Food Supply and Basic Nutrition provide adequate knowledge of nutritional education to the people.	105 (10.6%)	743 (75.2%)	80 (8.1%)	60 (6.1%)	988				
	Column Total	**665**	**3373**	**711**	**191**	**4940**				

The analysis of hypothesis three (3) in the table 17 above shows the calculated chi-square of 590.20 against critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated chi-square value is greater than critical value, the stated hypothesis above is hereby rejected. Therefore, stakeholders' perception of primary health care service of adequate food supply and proper nutrition significantly influence the realization of health for all in Kwara State, Nigeria. This means that prompt nutritional education and information on effective method of preserving and preparing food for consumption, accessibility to required foods that supply needed nutrients, adequate nutritional knowledge on food preservation and processing to prevent food spoilage given by health workers have greater influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Four (4): Stakeholders perception of primary health care service of adequate supply of water and basic sanitation will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 18: Chi-square analysis showing stakeholders perceived influence of primary health care service of adequate supply of water and basic sanitation on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	Df	Crit. x^2 value	Remark
1.	Government efforts at various levels, especially at LGAs have helped in ensuring adequate and supply of drinkable water through digging of boreholes and hand-pumps water supply.	185 (18.7%)	700 (70.9%)	93 (9.4%)	10 (1.0%)	988				
2.	Regular monitoring and supervision of water by the environmental health officers and community health care providers have helped in maintenance of and ensuring consumption of good clean water.	108 (10.9%)	705 (71.4%)	120 (12.1%)	55 (5.6%)	988				
3.	The establishment and mounting of heavy campaign on environmental sanitation both in rural and urban centres have helped in ensuring clean environment devoid of infection or diseases agents.	330 (33.4%)	508 (51.4%)	90 (9.1%)	60 (6.1%)	988	586.82	12	21.03	Hypothesis Rejected
4.	Some government and non-government organizations have helped in the digging of boreholes and provision of Ventilated Improved Pit (VIP) Latrine promote the health of people.	166 (16.8%)	402 (40.7%)	380 (38.5%)	40 (4.0%)	988				
5.	Provision of effective means of refuse disposal on basis of size of communities through methods such as control tipping, incineration, composting have assisted in reduction of spread of infections.	188 (11.9%)	690 (69.8%)	140 (14.2%)	40 (4.1%)	988				
	Column Total	**907**	**3005**	**823**	**205**	**4940**				

The analysis of hypothesis four (4) shows the calculated chi-square value of 586.82 against the critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than critical value, the above stated hypothesis is hereby rejected. Therefore, stakeholders' perception of primary health care service of adequate supply of water and basic sanitation significantly have influence on realization of health for all in Kwara State, Nigeria. This means that the joint efforts of government and people within the community really assisted in ensuring adequate water supply effective refuse disposal, heavy campaign mounted by health workers on environmental sanitation both in rural area and urban centres have greater influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Five (5): Stakeholders perception of primary health care of maternal and child health including family planning will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 19: Chi-square analysis showing stakeholders perceived influence of primary health care service of maternal and child health including family planning on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	The health services rendered to pregnant women have assisted in ensuring smooth delivery in the health centres.	85 (8.6%)	640 (64.8%)	203 (20.5%)	60 (6.1%)	988	708.32	12	21.03	Hypothesis Rejected
2.	The immunization and vaccinations given to pregnant women often help in ensuring safe delivery and promotion of health of both the mothers and the babies.	380 (38.5%)	585 (59.2%)	18 (1.8%)	5 (0.5%)	988				
3.	The health services rendered to nursing mothers and the babies usually assisted in promotion of their health and wellness.	288 (29.2%)	530 (53.6%)	90 (9.1%)	80 (8.1%)	988				
4.	The attitudes of health workers towards the pregnant women and nursing mothers during ante-natal and post-natal section in the health centres reduce patronage.	375 (38.0%)	480 (48.6%)	103 (10.4%)	30 (3.0%)	988				
5.	The heavy campaigns mounted on home delivery and need for pregnant women to attend antenatal clinics have helped in reducing illness rates and death of potential mothers and their babes and ensure adequate maternal nutrition.	210 (21.3%)	605 (61.2%)	120 (12.1%)	53 (5.4%)	988				
	Column Total	**1338**	**2840**	**534**	**228**	**4940**				

The analysis of hypothesis five (5) in table 19 above shows the calculated chi-square value of 708.32 against the critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than the critical value, the stated hypothesis above is hereby rejected. Therefore, stakeholders perception of primary health care of maternal and child health including family planning significantly influence the realization of health for all in Kwara State, Nigeria. This means that the regular antenatal services, postnatal

services, immunization of pregnant women and newly born babies, heavy campaign mounted on home delivery and so on have greater influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Six (6): Stakeholders perception of primary health care service of immunization against infectious diseases will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 20: Chi-square analysis showing stakeholders perceived influence of primary health care service of immunization against infectious diseases on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	The general vaccinations given in the health centres and hospitals have helped in reducing infections that are preventable.	440 (44.5%)	471 (47.7%)	55 (5.6%)	22 (2.2%)	988	765.24	12	21.03	Hypothesis Rejected
2.	The immunization of women has helped in reduction of mortality that may likely result from pregnancy and delivery.	105 (10.6%)	680 (68.8%)	193 (19.5%)	10 (1.1%)	988				
3.	Mass immunization carried out on children by the government at the grassroot has contributed to prevention and control of some deadly diseases such as tuberculosis, diphtheria, pertussis, tetanus, hepatitis and so on.	399 (40.4%)	492 (49.8%)	72 (7.3%)	25 (2.5%)	988				
4.	The general immunization given also assisted in reducing suffering and complications that may likely result from ailment such as tetanus, paralysis, coughing and chest pain.	48 (4.8%)	790 (80.1%)	105 (10.5%)	45 (4.6%)	988				
5.	Immunization exercise afford people of the opportunity for supplement deficient nutrients and other materials needed for body utilization such as vitamin C, iron supplement and growth monitoring for children and so on.	410 (41.5%	530 (53.6%)	38 (3.9%)	10 (1.0%)	988				
	Column Total	**1402**	**2963**	**463**	**112**	**4940**				

The analysis of hypothesis six (6) in table 20 above shows the calculated chi-square value of 765.24 against the critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than the critical value, the hypothesis stated

above is hereby rejected. Therefore, stakeholders perception of primary health care service of immunization against infectious diseases significantly influence the realization of health for all in Kwara State, Nigeria. This means that the routine immunization given at the health centres and hospitals, immunization of pregnant women and children, the general immunization given to prevent infections and supplementary drugs given by health workers have greater influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Seven (7): Stakeholders perception of primary health care service of prevention and control of endemic diseases will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 21: Chi-square analysis showing stakeholders perceived influence of primary health care service of prevention and control of endemic diseases on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	The distribution of ivermectin drug to prevent and control on-cocerciasis has helped in reducing its incidence in the community.	180 (18.2%)	700 (70.9%)	85 (8.6%)	23 (2.3%)	988	553.07	12	21.03	Hypothesis Rejected
2.	Mass administration of supplement drugs such as folic acid ferrous sulphate, yeast tablets and so on contribute to prevention and control of health problems such as anaemia, dizziness and shock to mention but few efforts.	72 (7.3%)	486 (49.2%)	320 (32.4%)	110 (11.1%)	988				
3.	The effort of government and non-governmental organizations in digging of boreholes and water purification enlightenment programmes have assisted in reducing infection resulting from intake of impure water.	380 (38.5%)	495 (50.1%)	105 (10.6%)	8 (0.8%)	988				
4.	The efforts put up by government and people of this community in ensuring adequate toilet facilities and determine have contributed to reduction of diseases that often resulted to food poisoning and worm infestations.	108 (10.9%)	790 (80.0%)	70 (7.1%)	20 (2.0%)	988				
5.	The general housing scheme and environmental protection programmes initiated by government within the community have helped in prevention of diseases such as cerebro-spinal meningitis, malaria, food poisoning and so on.	99 (10.0%)	480 (48.6%)	391 (39.6%)	18 (1.8%)	988				
	Column Total	**839**	**2951**	**971**	**179**	**4940**				

The analysis of hypothesis seven (7) above shows the calculated chi-square (x^2) value of 553.07 against the critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated chi-square value is greater than critical value, the above stated hypothesis is hereby rejected. Therefore, stakeholders perception of primary health care service of prevention and control of endemic diseases significantly influence on realization of health for all in Kwara State, Nigeria. This means that the distribution of ivermectin drugs to control oncocerciasis, administration of supplement drugs such as folic acid, ferrous sulphate, yeast tablets by health workers to prevent anaemia, dizziness and shock, governments efforts at dinging boreholes and purification of water sources, building of toilet facilities, general housing and environmental protection scheme and so on have much influence the realization of health for all in Kwara State, Nigeria.

Hypothesis Eight (8): Stakeholders perception of primary health care service of appropriate treatment of common diseases and injuries will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 22: Chi-square analysis showing stakeholders perceived influence of primary health care service of appropriate treatment of common diseases and injuries on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	The citing and establishment of health posts, clinic and health centres through governments and communal efforts in various villages have made treatment of minor infection and health problems easy.	106 (10.7%)	694 (70.2%)	146 (14.8%)	42 (4.3%)	988				
2.	The training of traditional birth attendants and village health workers nominated by the community has assisted in the identification and treatment of minor health problems.	74 (7.5%)	604 (61.1%)	296 (30.0%)	14 (1.4%)	988				
3.	The home visiting carried out by community health providers has contributed to the discovery of some simple and preventable ailments and their subsequent treatment.	351 (35.6%)	520 (52.6%)	90 (9.1%)	27 (2/7%)	988	492.20	12	21.03	Hypothesis Rejected
4.	The inadequate supply of diagnostic materials has impeded effective diagnostic and confirmation of some common ailments.	188 (19.0%)	670 (67.8%)	110 (11.1%)	20 (2.1%)	988				
5.	Insufficient number of qualified and trained personnel hinders effective management of minor infections and injuries.	60 (6.1%)	770 (77.9%)	120 (12.1%)	38 (3.9%)	988				
	Column Total	**779**	**3258**	**762**	**141**	**4940**				

The analysis of hypothesis eight (8) in table 22 above shows the calculated chi-square (x^2) value of 492.20 against the critical value of 21.03 with the degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than the table value, the hypothesis stated above is hereby rejected. Therefore, stakeholders perception of primary health care service of appropriate treatment of common diseases and injuries significantly influence the realization of health for all in Kwara State, Nigeria This means that the joint efforts of the governments and people in the community in citing clinics, health centres, health posts really assisted in treatment of minor injuries and infections, the efforts of trained TBA, VHWs, in identification and treatment of minor ailment or problems, home visiting conducted by health

workers helps in discovery of health problems and appropriate treatment and so on, have much influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Nine (9): Stakeholders perception of primary health care of essential drug supply will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 23: Chi-square analysis showing stakeholders perceived influence of primary health care service of essential drug supply on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	Df	Crit. x^2 value	Remark
1.	The existence of village health workers has made the sales of essential drugs to teeming rural dwellers easy and accessible.	89 (9.0%)	808 (81.8%)	81 (8.2%)	10 (1.0%)	988				
2.	The joint communal efforts on drug revolving scheme contribute immensely to prompt supply and availability of common drugs used for treatment in the health centre.	282 (28.5%)	660 (66.8%)	30 (3.1%)	16 (1.6%)	988				
3.	The non-challant attitudes of governments at grassroot on supply and availability of drugs in the clinics and health centre often hindered effective health care services.	35 (3.6%)	680 (68.8%)	245 (24.8%)	28 (2.8%)	988	700.32	12	21.03	Hypothesis Rejected
4.	The current free drugs distribution to patients after treatment in the health centres within the community account for increased patient attendance or patronage.	90 (9.1%)	803 (81.3%)	75 (7.6%)	20 (2.0%)	988				
5.	The management approach used in strengthening drug revolving scheme has assisted in controlling circulation of fakes and substandard drugs.	265 (26.8%)	439 (44.5%)	180 (18.2%)	104 (10.5)	988				
	Column Total	**761**	**3390**	**611**	**178**	**4940**				

The analysis of tested hypothesis (9) in table 23 above revealed the calculated chi-square (x^2) of 700.32 against critical value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than the critical value, the above stated hypothesis is hereby rejected. Therefore, stakeholders perception of primary health care of essential drug supply significantly influence the realization of health for all in Kwara State, Nigeria. This implies that the sales of essential drugs by village health workers/traditional birth

attendants to rural dwellers, the joint efforts of health workers and people within the community in ensuring effective operation of drug revolving scheme, free distribution of drugs to patients for treatment and prevention of infections and so on have greater influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Ten (10): Stakeholders perception of primary health care service of dental health will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 24: Chi-square analysis showing stakeholders perceived influence of primary health care service of dental health care on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	Oral health care services provided to people at health centres have considerable impact in maintaining clean teeth and mouth.	177 (17.9%)	781 (79.0%)	25 (2.6%)	5 (0.5%)	988	626.35	12	21.03	Hypothesis Rejected
2.	Dental health care helps to minimize the effects of oral health problems on health of people.	96 (9.7%)	682 (69.0%)	180 (18.2%)	30 (3.1%)	988				
3.	Regular dental check-up often reduced incidence of dental caries and diseases of gum through intake of low sugar foods.	345 (34.9%)	490 (49.6%)	103 (10.4%)	50 (5.1%)	988				
4.	The modern dental care has contributed to reduction in teeth accidents and injuries such as teeth dislocation, removal of teeth, poor teeth alignment, cracked teeth and so on	74 (7.5%)	664 (67.2%)	190 (19.2%)	60 (6.1%)	988				
5.	Regular dental check up afford people the opportunity to know strategies and measures necessary in ensuring effective oral hygiene.	245 (24.8%)	560 (56.7%)	160 (16.2%)	23 (2.3%)	988				
	Column Total	**937**	**3177**	**658**	**168**	**4940**				

The analysis of hypothesis ten (10) showed the calculated chi-square (x^2) value of 626.35 against the table value of 21.03 with degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than critical value, the above stated hypothesis is hereby rejected. Therefore, stakeholders perception of primary health care service of dental health significantly influence the realization of health for all in Kwara State, Nigeria. This implies that

the oral health care render to people by the health workers, periodic dental centres and so on have greater influence on realization of health for all in Kwara State, Nigeria.

Hypothesis Eleven (11): Stakeholders perception of primary health care service of mental health care will not have significant influence on realization of health for all in Kwara State, Nigeria

Table 25: Chi-square analysis showing stakeholders perceived influence of primary health care service of mental health care on realization of health for all in Kwara State, Nigeria

S/N	Item	SA	A	D	SD	Row Total	Cal. x^2 value	df	Crit. x^2 value	Remark
1.	The diagnostic services and treatment rendered to pregnant women with known history of delivery fit at the health center help in prevention of mental illness in them.	81 (8.2%)	497 (50.3%)	290 (29.4%)	120 (12.1%)	988	716.36	12	21.03	Hypothesis Rejected
2.	Community mental health education plays a significant role in good mental state.	90 (9.1%)	681 (68.9%)	187 (18.9%)	30 (3.1%)	988				
3.	Mental illnesses have been prevented through meaningful control of drug abuse among people.	100 (10.1%)	770 (77.9%)	76 (7.7%)	42 (4.3%)	988				
4.	The heavy campaign mounted against substance abuse has helped to minimize incidence of drug addiction in the community.	299 (30.3%)	641 (64.9%)	38 (3.8%)	10 (1.0%)	988				
5.	The sanction imposed on drug peddling and indiscriminate selling of drugs has helped to reduce the incidence of drug abuse and misuse.	107 (10.8%)	790 (80.0%	71 (7.2%)	20 (2.0%)	988				
	Column Total	**677**	**3379**	**662**	**222**	**4940**				

The analysis of hypothesis eleven (11) shows the calculated chi-square (x^2) value of 716.36 against critical value of 21.03 with the degree of freedom of 12 at 0.05 alpha level of significance. Since the calculated value is greater than critical value, the above stated hypothesis is hereby rejected. Therefore, stakeholders perception of primary health care service of mental health care significantly influence the realization of health for all in Kwara State, Nigeria. This means that the diagnostic and treatment render to pregnant women with delivery fit, community mental education given to people, heavy campaign mounted on substance abuse, sanction

imposed on indiscriminate drug peddling and so on, have greater influence on realization of health for all in Kwara State, Nigeria.

Summary of Findings

The overall finding of the study revealed that delivery of primary health care services have much influence in the realization of health for all. The findings among others show that:

1. Delivery of primary health care service of health education on prevailing health problems and method of preventing them influence the realization of health for all in Kwara State, Nigeria.
2. Delivery of primary health care service of adequate food supply and proper nutrition influence the realization of health for all in Kwara State, Nigeria.
3. Delivery of primary health care service of adequate supply of water and basic sanitation influence the realization of health for all in Kwara State, Nigeria.
4. Delivery of primary health care service of maternal and child health including family planning influence the realization of health for all in Kwara State, Nigeria.
5. Delivery of primary health care service of immunization against infectious diseases influence the realization of health for all in Kwara State, Nigeria.
6. Delivery of primary health care service of prevention and control of endemic diseases influence the realization of health for all in Kwara State, Nigeria.
7. Delivery of primary health care service of appropriate treatment of common diseases and injuries influence the realization of health for all in Kwara State, Nigeria.
8. Delivery of primary health care service of essential drugs supply influence the realization of health for all in Kwara State, Nigeria.

9. Delivery of primary health care service of dental health service influence the realization of health for all in Kwara State, Nigeria.
10. Delivery of primary health care service of mental health care influence the realization of health for all in Kwara State, Nigeria.

Discussion of Findings

The results of analysis of data generated from the study carried out revealed that implementation of primary health care services have much influence on realization of health for all in Kwara State. The result of analysis of the main hypothesis shows that provision of primary health care component services at the grassroots greatly influence overall level of health of people in Kwara State. This is evidence from the stakeholders position that provision of primary health care services within the sixteen local government areas of Kwara State have made health services affordable and accessible to the whole populace. Primary health care services according to them bring health services closer to the door step of rural dwellers by ensuring their full participation in the health centres located within the communities and ensure effective intersectoral collaboration in its implementation.

The above finding from the main hypothesis is in line with Mahler (2000) finding that health for all means process by which health care is being brought within the reach of everybody in a given country. The author stressed that the strategy for realization of health for all is full implementation of all component services of primary health care. This finding corroborates Kekki (1991) early finding that full realization of health for all demands teamwork for effective delivery of primary health care through shared utilization of knowledge and skills of various professional groups.

The result of hypothesis two (2) revealed that provision of primary health care service of health education on prevailing health problems and method of preventing them have much influence on realization of health for all in Kwara State. The stakeholders agreed that health talk, focus group discussions, health counselling and massive health campaign usually help in sensitizing, guiding and promoting people health and wellness at the grassroots.

The above finding is in line with Green (2010) finding that knowledge is a prerequisite to exhibition of appropriate behaviour. The knowledge of a problem often engender feeling of restriction towards it. This finding supported Udoh, Fawole, Ajala, Okafor and Nwana (2001) finding that the goal of health education is that of medicine as a whole which consist of curative and preventive care. The service according to them aimed at reducing morbidity, mortality and disability, and more recently reduce the cost of health care.

The result of data analysis on tested hypothesis three (3) shows that implementation of primary health care component service of adequate food supply and proper nutrition have greater influence on realization of health for all in Kwara State. This is clearly revealed from stakeholders responses that the nutritional service and education given by health workers on method of food preservation, processing and consumption have assisted in improving their nutritional knowledge and practices. This component service also guide the people in their decision on food and water selection, food habits/behaviour towards improving overall community nutritional status.

The above finding agreed with the finding of National Primary Health Care Development Agency (2012) that it is necessary for each household to ensure availability of adequate varieties of safe food to meet the dietary needs of its members and to enable them live active and healthy lives. This finding further confirms Ibrahim (2008) finding that the ultimate goal of nutrition

health and primary health care nutrition policies are to ensure quality health and adequate nutritional status for all Nigerians irrespective of their economic status.

The finding from analysis of tested hypothesis four (4) revealed that implementation of primary health care service of adequate supply of water and basic sanitation have much influence on realization of health for all in Kwara State, Nigeria. The stakeholders agreed that the government, non-governmental organizations and health workers have assisted different communities through regular monitoring and supervision to ensure prompt water supply and utilization among people at the grassroots. It was also discovered that government efforts at mounting campaign on general environmental sanitation and provision of public conveniences such building of toilet, placement of waste bins in different strategic locations have helped to ensure good environmental hygiene.

The above finding confirmed Akerele and Okungbowa (2002) finding that adoption of primary health care as a means of realizing health for all, ensure effective implementation of component service of safe water supply and basic sanitation for prevention and control of disease outbreak. This finding further corroborate National Primary Health Care Development Agency (2012) assertion that the major health problems in Nigeria are preventable diseases associated with consumption of unclean water and lack of proper environmental sanitation.

The result of analysis of tested hypothesis five (5) revealed that implementation of primary health care service of maternal and child health including family planning have much influence on realization of health for all in Kwara State, Nigeria. This is clearly manifested in the stakeholders responses that the health services such immunization of pregnant women and newly born babies, mounting of heavy campaign against home delivery and need to always attend clinic

or during pregnancy and after delivery, have really assisted in promotion of health of the vulnerable groups.

The finding corroborates Alabi (2002) finding that maternal and child health campaign was further strengthened by establishment of family planning programme aimed at creating awareness among the couple to promote their health and prevent death that may result from haemorrhea ruptured uterus, eclampsia, anaemia, sepsis and so on. The need to effectively implement maternal and child health services was empathically stressed by Federal Ministry of Health (2007) that serious shortage of essential obstetric care services in the country limits the capacity of the primary health care facilities to respond to delivery emergencies such that they are ineffective in reducing maternal death. This finding also buttressed early finding of Aderonke (2008) that provision of adequate screening services, appropriate training of midwives and attendants, prompt immunization would assist in reducing the current maternal morbidity and mortality rates in Nigeria.

The analysis of tested hypothesis six (6) shows that the implementation of primary health care service of immunization against infectious diseases have much influence on realization of health for all in Kwara State, Nigeria. This clearly shown in the responses of stakeholders that immunization given to the people have assisted in prevention of infections and complications common to the illnesses affecting them. The exercise often assisted them in supplementing their nutrient in take for healthy growth and development.

This finding supported the early findings of World Health Organization (2002), National Programme on Immunization (2008) and Federal Government of Nigeria (2008) that National Immunization Programme has contributed immensely to prevention and control of communicable diseases as well as reducing incidence of maternal morbidity and mortality rate.

This finding further buttress Baba (2009) assertion that national programme on immunization was adopted as a means of preventing and controlling the spread of deadly communicable diseases. Immunization services according to the experts are globally accepted as effective preventive measure against killer diseases.

The result of analysis of tested hypothesis seven (7) revealed that implementation of primary health care component service of prevention and control of endemic diseases have greater influence on realization of health for all in Kwara State, Nigeria. This clearly manifested in stakeholders responses that the effort of government, non-governmental organizations and community people in digging of boreholes, construction of toilets, distribution of free drugs and insecticide treated nets have really assisted in prevention and control of infection common to their locality.

The finding above agreed with similar finding of World Health Organization (2004) and National Planning Commission (2005) that high level of mortality in young children are due mainly to illnesses that can be easily prevented or can be treated with known remedies, such as malaria, diarrhoeal diseases, acute respiratory tract infections which are deadly in nature. This finding is in accordance with Benson (1995) report that there have been reduction in the incidence of communicable diseases as a result of effective environmental health control measures such as clean water supply, adequate sanitation, vector control, immunization and so on.

The result of analysis of tested hypothesis eight revealed that implementation of primary health care service of appropriate treatment of common diseases and injuries have much influence on realization of health for all in Kwara State, Nigeria. This is evidence in the stakeholders responses that the citing of health centres, training and retraining of traditional birth

attendants/village health workers; home visiting and outreach services by primary health care providers are all aimed at bringing health care to the door step of people.

This finding is in line with the finding of Mark (1991) that annual health report and implementation from local government areas nation-wide shows that inclusion of primary health care component service of appropriate treatment of common diseases and injuries has helped in reduction of complications that may result from the health problems. The finding affirms National Primary Health Care Development Agency (2012) finding that there have been remarkable improvement in disease prevention, control and treatments initiated by the trained community health practitioners.

The result of analysis of tested hypothesis nine (9) shows that implementation of primary health care service of essential drugs supply have much influence on realization of health for all in Kwara State, Nigeria. This clearly manifested in the stakeholders responses that the joint efforts of government and people in the community on operation of drug revolving scheme through bulk purchase and distribution of drugs to people; and free drug distributions have assisted, in the treatment and prevention of some infectious diseases.

The finding above confirms early finding of Ayetoro (2011) that there has been a steady increase in the rate of contribution of drug revolving fund towards effective treatment of illness in Nigeria. This finding affirms the finding of Ayanbeku and Sorungbe (2002) that one of the key indicators of the successful implementation of a nation's primary health care strategy is availability of essential drug to the entire population for treatment of various ailments.

The finding from analysis of tested hypothesis ten (10) shows that the implementation of primary health care service of dental health service have much influence on realization of health for all in Kwara State, Nigeria. This clearly shown in the responses of stakeholders that the

dental health care provided in the health centres, regular dental check up often helped in ensuring clean and healthy teeth.

The finding is in line with the early findings of Peterson, Bourgeois, Ogawa, Estupinan-Day and Ndiaye (2005) and World Health Organization (2004) that globally dental caries and chronic periodontal diseases are known to be the commonest diseases of the oral cavity and these diseases have similarly captured the attention of health care planners and professionals in Nigeria. This finding further established the need for adoption of oral health care for implementation of primary health care as posited by Bankole, Aderinokun and Denloye (2005) that in developing countries such as Nigeria, less priority is accorded oral health perhaps due to the relatively high burden of communicable diseases which threaten people survival and increase morbidity.

The result of the analysis of tested hypothesis eleven (11) revealed that the implementation of primary health care service of mental health care have much influence on realization of health for all in Kwara State, Nigeria. This finding reflect responses of majority of stakeholders that the diagnostic and treatment services provided by health workers on mental health, heavy campaign mounted against substance abuse, sanctions imposed on drug peddling, community mental health education given by health workers have contributed to promotion of good mental health.

This finding agreed with the finding of National Primary Health Care Development Agency (2012) that the provision of primary health care service of mental health is an integral part of measure aimed at ensuring health for all. According to the agency, it is concerned with the promotion of mental well being, prevention of mental disorders, early diagnosis and rehabilitation of the mentally ill. Also, this finding supports World Health Organization (2001)

finding that one in every four people or 25% of individuals develops one or more mental or behavioural disorders at some stages in life both in developed and developing countries. The body added that the mental health situation in Nigeria was consistent with the projected estimates of most developing countries.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter gives an abridgement of the whole study. It focuses on summary of findings, conclusion, recommendations and suggestion for further studies.

Summary

This research work investigated stakeholders perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria. The study covers five chapters involving different procedures such as background to the study, statement of problem, research questions, research hypotheses, purpose of the study, significance of the study, scope and delimitation of the study, operational definition of terms, review of related literature, research methodology, results presentation and discussion of findings.

The study examined and reviewed current and relevant works of renowned experts on the study carried out. The study vividly present the conceptual framework and established theoretical basis for the exercise. Also, current research reports were reviewed on the main objectives set for the investigation.

The study adopted descriptive research design of survey type. The population of the study comprised of stakeholders such as members of local government primary health care committees, members of all the health facilities committees, all the village heads within the sixteen local government areas of Kwara State. Multi-stage sampling technique consists of stratified, cluster, proportionate and purposive sampling techniques were used to select nine hundred and eighty-eight respondents for the study. The investigation was carried out with the use of focus group discussion items and self developed questionnaire adequately validated by

three experts from department of epidemiology and community health; and Health Promotion and Environmental Health Education in University of Ilorin, Nigeria. The responses to qualitative focus group discussion item were employed to improve on the quantitative questionnaire items used for the study.

The researcher obtained permission from the university ethical review committee to carry out the study. The researcher also sought and obtained approval and permission to carry out the investigation from primary health care coordinators in the sixteen local government areas of Kwara State. The data generated for the study were analysed using frequency count and percentage for demographic data of respondents; use of non-parametric statistical method of chi-square to analyse the null hypotheses formulated and tested for the study and thematic method to analyse focus group discussion data. The results of data analysis revealed that implementation of all the component services of primary health care have much influence on realization of health for all in Kwara State, Nigeria.

Conclusion

The overall results of the investigation clearly shown that implementation of primary health care services at grassroots in Kwara State have greater influence on realization and actualization of health for all. Based on this overall finding, the study specifically concludes that:

i. Implementation of primary health care service of health education on prevailing health problem and method of preventing them have created awareness and arouse people interest towards improving their health practices and ensure healthful living;

ii. Implementation of primary health care service of adequate food supply and proper nutrition have shown that the nutritional services and nutrition education given to people really assisted in improving their nutritional practice and nutritional status;

iii. Implementation of primary health care service of adequate supply of water and basic sanitation revealed that government, non-governmental organization and health workers have assisted different communities in ensuring adequate water supply and utilization including prompt environmental sanitation for healthful living;

iv. Implementation of primary health care service of maternal and child health including family planning really helped in the provision of effective care before, during and after pregnancy and delivery. The study also revealed that the services helped in discouraging home delivery and promote health of vulnerable groups through adequate child spacing care;

v. Implementation of primary health care services of immunization against infectious diseases really influence realization of health for all as clearly demonstrated in the stakeholders responses that the exercise helped in prevention of infections and complications of illnesses affecting them. It also helped in supplementing people nutrient intake for healthy growth and development;

vi. Implementation of primary health care service of prevention and control of endemic diseases have assisted in averting and reducing outbreak of infections common to people within their localities. This manifested in the complimentary services provided by government and non-governmental organizations including community self development projects such as construction of toilets, digging of boreholes, distribution of free drugs and mosquito treated nets to the people within the community.

vii. Implementation of primary health care service of appropriate treatment of common diseases and injuries have to some extent assisted in ensuring optimal level of health for people of Kwara State, Nigeria. The citing of health centres, training and retraining of health workers, home visiting and outreach services are all clear efforts directed at ensuring prompt treatment of common diseases and injuries.

viii. Implementation of primary health care service of essential drug supply greatly influence realization of optimal health for people of Kwara State, Nigeria. This clearly shown in the operation of drug revolving scheme and distribution of free drugs for treatment of different ailments and infections;

ix. Implementation of primary health care service of dental health care have much influence on attainment of health for all in Kwara State, Nigeria. This is seen in the responds of stakeholders that regular teeth test or check-up and treatment of existing dental problems promote good oral health.

x. Implementation of primary health care service of mental health care have much influence on realization of health for all in Kwara State, Nigeria. The provision of this service engender prompt diagnosis and treatment of symptoms of mental illness and health education against substance abuse and indiscriminate use of drugs really helped in promotion of good mental health.

Recommendations

Based on the inferences drawn from findings on the investigation carried out, it is recommended that;

i. The local government primary health care committees within the state should ensure proper coordination and implementation of all the component services by employing different strategies like cohesive health team approach, situation analysis, community mobilization for active participation, intersectoral collaboration, community diagnosis and advocacy;

ii. Health workers and local government primary health care committees should initiate health talk and awareness campaign in prevention and control of health and health related problems hindering attainment of optimal wellness;

iii. Local government primary health care committees through their various coordinators should encourage adoption of proper nutrition by mounting campaign and demonstrations on needs for intake of foods rich in all the essential nutrients.

iv. Environmental health officers non-governmental organizations and other health workers at the grassroot should initiate action aimed at ensuring adequate water supply through digging of boreholes, construction of well, and ensure prompt environmental health inspection to prevent diseases outbreak;

v. Local Government Authority should employ competent midwives and primary health care providers to deliver adequate maternal and child health care services to pregnant women, nursing mothers and their children;

vi. The local government primary health care committee and health care providers should try as much as possible to beef up and revitalize routine immunization to address the pitfalls of the general immunization exercise. There should also be improvement on provision and distribution of nutrients supplement to people to prevent deficiency diseases or disorders;

vii. The governments, health workers and people at the grassroots should build and construct public conveniences such as toilets, sanitary well and boreholes, placement of waste bin, distribution of insecticide treated nets that will ensure effective prevention and control of disease outbreak;

viii. The local government primary health care committee and coordinators of different component services should from time to time organize training and retraining programme for all primary health care providers to enhance their performances in provision of effective curative services. The health workers should carry out home visit to discover cases of new illnesses and treat them promptly;

ix. The local government primary health care committee and members of health facilities committees should try as much as possible to revitalize dead drug revolving scheme to ensure prompt treatment of ailments or health problems;

x. Health care providers at the grassroots should mount heavy campaign against poor oral hygiene and encourage people to try as much as possible to do dental check-up at least twice in a year. The dentist and dental health technicians/assistants should ensure prompt treatment of established dental problems.

xi. The primary health care providers and community mental health specialists should always ensure early diagnosis and treatment of problems and symptoms of illnesses that can predispose to mental health problems. The health workers should mount serious campaign against indiscriminate use of psycho-active drugs and substance abuse.

Contribution of study to Existing Knowledge

This study will exerts much influence in the area of administration of community health care delivery system at the grassroots;

- This outcomes will be useful in the training and retraining of primary health care providers at the grassroots on different component of PHC and aspects that need improvement;
- This study outcomes will provide ample opportunity for future researchers to serve as guide to further study in PHC as a means of achieving health for all;\
- This reports will make meaningful contributions to local, national and international health organization by publishing it in reputable journal outlets;
- This study outcomes will have immense contributions to level of community awareness on the mode of operation of PHC and responsibilities of the entire members of the communities at the grassroots.

Suggestions for Further Study

This study investigated stakeholders perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria. This implies that the study covers a section of the country geo-political zones that is part of north central zone in Nigeria.

Based on the above, the following suggestions are made for further study:

- Future researchers may expand the scope of the study on PHC to cover two states or the entire north central zone;
- Future researchers may carry out study on hinderances to effective implementation of PHC services in Nigeria.

- Future researchers may investigate factors affecting underutilization of primary health care centres in some selected health centres in Kwara State;
- Future researchers may carry out study on perceived implementation problems of resources mobilization for effective PHC services.

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APPENDIX I

UNIVERSITY OF ILORIN

FACULTY OF EDUCATION

DEPARTMENT OF HEALTH PROMOTION AND ENVIRONMENTAL HEALTH EDUCATION

QUESTIONNAIRE ON STAKEHOLDERS' PERCEIVED INFLUENCE OF PRIMARY HEALTH CARE SERVICES ON REALIZATION OF HEALTH FOR ALL IN KWARA STATE, NIGERIA

Dear Respondent,

I am a postgraduate student at the University of Ilorin. I am carrying out a study entitled "Stakeholders' Perceived Influence of Primary Health Care Services on Realization of Health for All in Kwara State, Nigeria". This questionnaire is designed mainly for academic purpose. The researcher assures you that your responses will be treated with utmost confidentiality.

The questionnaire consists of two sections (Sections A & B). Please, note that your sincere and candid responses will be highly appreciated. Thanks for your anticipated cooperation.

Yours faithfully,

BABA, Dare Abubakar

MATRIC NO: 03/25OP021

Consent Section

Instruction: Please, indicate your willingness or otherwise participation in the study. Mark (√) in one box.

* I wish to participate in the study ( )

* I am not interested in the study ( )

Section A: Demographic Information of the Respondents

Instruction: Please tick (√) the appropriate option in the option boxes provided against each characteristic:

1. **Gender**: Male ( ); Female ( )
2. **Age**: 20-29yrs ( ); 30-39yrs ( ); 40-49yrs ( ); 50-59yrs ( ); 60yrs & above ( )
3. **Educational background**: Primary ( ); Secondary ( ); Higher Education ( ); Informal education ( )
4. **Occupation**: Public Servant ( ); Self-employed ( ); Unemployed ( ); Farmer ( ); Trader ( ); Artisan ( ); Others (Specify) ----------
5. **Religion**: Islam ( ); Christianity ( ); Traditional Religion ( ); Others (Specify) ----------
6. **Ethnicity**: Yoruba ( ); Hausa ( ); Nupe ( ); Baruba ( ); Igbo ( ); Fulani ( ); Others (specify) ----------
7. **Social Status**: Community leader ( ); Religious Worker ( ); Member of Health Committee ( ); Health workers ( ); LGA Council member ( ); Others ( ), specify --------
8. **Domicile**: Rural ( ); Urban ( )
9. Local Government Area of Origin or Domicile: ----------

Section B

Instruction: Tick (√) the appropriate option from each of the statement below:

Strongly Agree (4)

Agree (3)

Disagree (2)

Strongly Agree (1)

S/N	ITEMS	SA	A	D	SD
I	**Perceptions of Stakeholders on Primary Health Care Services towards realization of Health for all**				
1.	Health services rendered to the people at primary health care centre are affordable target at improving the health status of the people				
2.	Primary health care allows for full participation of people in its implementation				
3.	Primary health care services ease the peoples' burdens of having to go to different hospital to obtain the required services or care hospitals				
4.	Primary health care bring health services to the door step of people through citing of clinics, health centres, health posts and placement of clinic master cards to all households in the community.				
5.	The health services rendered by primary health care providers utilize local technology and materials abound in the community for card and management of sicked people.				
6.	Primary health services are accessible to all categories of people and age groups, and at distance not far from house.				
7.	The types and hours of operation in primary health care centres has been adjusted to meet the needs of community members.				

S/N	ITEMS	SA	A	D	SD
8.	The services provided in most of the primary health care centres within the communities in the Local Government are adequate and meet people health needs.				
9.	Almost all the services at primary health centres are rendered by qualified health workers and trained volunteers in the community.				
10.	Most of related sectors and units such as agricultural, water resources, information, environment etc assist the Local Governments in the implementation of both primary health care vertical and intervention programmes.				
II	**Perceptions of Stakeholders on Health Education and the Realization of Health for all**				
11.	Health education components of primary health care provides avenue for determining health seeking behaviour of people within the community with a view of promoting their health and well being.				
12.	Massive campaigns usually organized by primary health care providers help in sustaining health and wellbeing of people in the community.				
13.	Health talks given to people at clinic levels help in improving and promoting their health.				
14.	The focus group discussion that are organized in the community often help to sensitize people on need to adopt healthful lifestyles that improve their health and wellbeing.				

S/N	ITEMS	SA	A	D	SD
15.	The health education given to people both in the health centres and community level usually change their attitudes to desirable health behaviours.				
III	**Perceptions of Stakeholders on Food Supply and Basic Nutrition and the Realization of Health for all**				
16.	Current education and information on methods of food inservation, preparation, handling and consumption are sufficient in ensuring adequate and proper nutrition of people in the community.				
17.	Food Supply and Basic Nutrition afford the people opportunity to get access to food that provides basic needs for the people.				
18.	Food Supply and Basic Nutrition ensures good consumerism among the regular.				
19.	The services rendered by health workers in ensuring adequate food preservation and processing have improved the knowledge of people on food spoilages and loss of nutritional values derivable foods we eat.				
20.	Food Supply and Basic Nutrition provide adequate knowledge of nutritional education to the people.				
IV	**Perceptions of Stakeholders on Water Supply and Rural Sanitation and Realization**				
21.	Government efforts at various levels, especially at LGAs have helped in ensuring adequate and supply of drinkable water through digging of boreholes and hand-pumps water supply.				

S/N	ITEMS	SA	A	D	SD
22.	Regular monitoring and supervision of water by the environmental health officers and community health care providers have helped in maintenance of and ensuring consumption of good clean water.				
23.	The establishment and mounting of heavy campaign on environmental sanitation both in rural and urban centres have helped in ensuring clean environment devoid of infection or diseases agents.				
24.	Some government and non-government organizations have helped in the digging of boreholes and provision of Ventilated Improved Pit (VIP) Latrine promote the health of people.				
25.	Provision of effective means of refuse disposal on basis of size of communities through methods such as control tipping, incineration, composting have assisted in reduction of spread of infections.				
V	**Perceptions of Stakeholders on Primary Health Care and Maternal /Child Health**				
26.	The health services rendered to pregnant women have assisted in ensuring smooth delivery in the health centres.				
27.	The immunization and vaccinations given to pregnant women often help in ensuring safe delivery and promotion of health of both the mothers and the babies.				

S/N	ITEMS	SA	A	D	SD
28.	The health services rendered to nursing mothers and the babies usually assisted in promotion of their health and wellness.				
29.	The attitudes of health workers towards the pregnant women and nursing mothers during ante-natal and post-natal section in the health centres reduce patronage.				
30.	The heavy campaigns mounted on home delivery and need for pregnant women to attend antenatal clinics have helped in reducing illness rates and death of potential mothers and their babes and ensure adequate maternal nutrition.				
VI	**Perceptions of Stakeholders on Primary Health Care and Immunization**				
31.	The general vaccinations given in the health centres and hospitals have helped in reducing infections that are preventable.				
32.	The immunization of women has helped in reduction of mortality that may likely result from pregnancy and delivery.				
33.	Mass immunization carried out on children by the government at the grassroot has contributed to prevention and control of some deadly diseases such as tuberculosis, diphtheria, pertussis, tetanus, hepatitis and so on.				
34.	The general immunization given also assisted in reducing suffering and complications that may likely result from ailment such as tetanus, paralysis, coughing and chest pain.				

S/N	ITEMS	SA	A	D	SD
35.	Immunization exercise afford people of the opportunity for supplement deficient nutrients and other materials needed for body utilization such as vitamin C, iron supplement and growth monitoring for children and so on.				
VII	**Perceptions of Stakeholders on Primary Health Care and Control of Endemic Diseases**				
36.	The distribution of ivermectin drug to prevent and control on-cocerciasis has helped in reducing its incidence in the community.				
37.	Mass administration of supplement drugs such as folic acid ferrous sulphate, yeast tablets and so on contribute to prevention and control of health problems such as anaemia, dizziness and shock to mention but few efforts.				
38.	The effort of government and non-governmental organizations in digging of boreholes and water purification enlightenment programmes have assisted in reducing infection resulting from intake of impure water.				
39.	The efforts put up by government and people of this community in ensuring adequate toilet facilities and determine have contributed to reduction of diseases that often resulted to food poisoning and worm infestations.				
40.	The general housing scheme and environmental protection programmes initiated by government within the community have helped in prevention of diseases such as cerebro-spinal meningitis, malaria, food poisoning and so on.				

S/N	ITEMS	SA	A	D	SD
VIII	**Perceptions of Stakeholders on Primary Health Care and Treatment of Common Ailments and Injuries**				
41.	The citing and establishment of health posts, clinic and health centres through governments and communal efforts in various villages have made treatment of minor infection and health problems easy.				
42.	The training of traditional birth attendants and village health workers nominated by the community has assisted in the identification and treatment of minor health problems.				
43.	The home visiting carried out by community health providers has contributed to the discovery of some simple and preventable ailments and their subsequent treatment.				
44.	The inadequate supply of diagnostic materials has impeded effective diagnostic and confirmation of some common ailments.				
45.	Insufficient number of qualified and trained personnel hinders effective management of minor infections and injuries.				
IX	**Perceptions of Stakeholders on Primary Health Care and Provision of Essential Drugs Services**				
46.	The existence of village health workers has made the sales of essential drugs to teeming rural dwellers easy and accessible.				
47.	The joint communal efforts on drug revolving scheme contribute immensely to prompt supply and availability of common drugs used for treatment in the health centre.				

S/N	ITEMS	SA	A	D	SD
48.	The non-challant attitudes of governments at grassroot on supply and availability of drugs in the clinics and health centre often hindered effective health care services.				
49.	The current free drugs distribution to patients after treatment in the health centres within the community account for increased patient attendance or patronage.				
50.	The management approach used in strengthening drug revolving scheme has assisted in controlling circulation of fakes and substandard drugs.				
X	**Perceptions of Stakeholders on Primary Health Care and Dental Health**				
51.	Oral health care services provided to people at health centres have considerable impact in maintaining clean teeth and mouth.				
52.	Dental health care helps to minimize the effects of oral health problems on health of people.				
53.	Regular dental check-up often reduced incidence of dental caries and diseases of gum through intake of low sugar foods.				
54.	The modern dental care has contributed to reduction in teeth accidents and injuries such as teeth dislocation, removal of teeth, poor teeth alignment, cracked teeth and so on				
55.	Regular dental check up afford people the opportunity to know strategies and measures necessary in ensuring effective oral hygiene.				

S/N	ITEMS	SA	A	D	SD
XI	**Perceptions of Stakeholders on Primary Health Care and Mental Health**				
56.	The diagnostic services and treatment rendered to pregnant women with known history of delivery fit at the health center help in prevention of mental illness in them.				
57.	Community mental health education plays a significant role in good mental state.				
58.	Mental illnesses have been prevented through meaningful control of drug abuse among people.				
59.	The heavy campaign mounted against substance abuse has helped to minimize incidence of drug addiction in the community.				
60.	The sanction imposed on drug peddling and indiscriminate selling of drugs has helped to reduce the incidence of drug abuse and misuse.				

APPENDIX II

Study Title: Stakeholders perceived influence of primary health care services on realization of health for all in Kwara State, Nigeria

Facilitator: Baba Dare Abubakar

Degree in view/Area of specialization: Ph.D. health Education

Department: Health Promotion & Environmental Health Education

Institution: University of Ilorin, Ilorin, Kwara State, Nigeria

Duration: 45 minutes – one (1) hour

Number of participants per group: 9

Points for discussion

1. Do you have a formidable health facility committee in this community?
2. What are the composition of the existing health facility committee?
3. Are community development association allowed to participate fully in the implementation of primary health care programmes and activities.
4. Are the funding system of primary health care services adequate enough for it full implementation of component services.
5. Are the traditional and community leaders involve in the implementation of primary health care services.
6. Did your health facility operating Drug Revolving Scheme (DRS) at the health facility level?
7. Are you aware that your primary health care centre provide different care services at the same time, under the same facility?

8. Do you normally visit primary health care centre when ill or private hospital within the community?
9. How would you describe the relationship between the health centre staff and community people?
10. How effective are the services rendered to people by health workers within the community?

APPENDIX III

THEMATIC ANALYSIS OF QUALITATIVE DATA ON STAKEHOLDERS PERCEIVED INFLUENCE OF PRIMARY HEALTH CARE SERVICES ON REALIZATION OF HEALTH FOR ALL IN KWARA STATE, NIGERIA

SN	ITEMS	FREQUENCE	PERCENTAGE %
QUE1	**Record of existing health facility committee**		
1.	There is formidable health facility committee in the community health care	15	50
2.	There is existing health facility committee but not effective	9	30
3.	There is no health facility committee in the health centre	6	20
	Total	**30**	**100**
QUE2	**Composition of health facility committee**		
1.	Health facility committee members are constituted jointly by the health workers and community people	18	60
2.	Health facility committee members comprised mainly of health care providers within the community	9	30

3.	Health facility committee members are drawn from community development committee	3	10
	Total	**30**	**100**
QUE3	**Level of participation of community development association towards PHC implementation**		
1.	Members of community development association participate actively in implementation of primary health care	12	40
2.	Members only participate in the execution of communal project aims at effective implementation of PHC	12	40
3.	Members of community development association are not usually allowed to participate in implementation of PHC programmes	6	20
	Total	**30**	**100**
QUE4	**Level of funding of PHC programmes**		
1.	The funding system of PHC programmes are adequate	15	50
2.	The funding system of PHC programmes are not adequate	12	40

3.	PHC programmes are jointly funded by government and members of the community	3	10
	Total	**30**	**100**
QUE5	**Level of involvement of community leaders and traditional leader in PHC implementation**		
1.	Traditional and community leaders are allowed to participate in the full implementation of PHC programmes	18	60
2.	Traditional and community leaders are not allowed to participate in the implementation of PHC programmes	9	30
3.	Traditional and community leaders occasional participate in implementation of PHC intervention programmes	3	10
	Total	**30**	**100**
QUE6	**Development of operation of drug revolving scheme in PHC centres**		
1.	Drugs are always available at the health centre due to joint efforts of health facility committee	15	50
2.	Most of the drugs needed for treatment of	9	30

	patients problems are not available at the health centres		
3.	Drugs are made available during implementation of intervention programmes	6	20
	Total	**30**	**100**
QUE7	**Types of health care service rendered at PHC centres**		
1.	The health centres render all the component services at the same time	18	60
2.	The PHC centre render health services based on the health manpower	9	30
3.	The health centre render mainly curative service	3	10
	Total	**30**	**100**
QUE8	**Mode of obtaining health care**		
1.	I always visit PHC centres when ill or need medical care	12	40
2.	I prefer private hospital to public hospital when ill or seeking for health care	12	40
3.	I visit herbal home when ill and need treatment	6	20
	Total	**30**	**100**

QUE9	**Existing relationship between health workers and people within the community**		
1.	The relationship is cordial	15	50
2.	The relationship is not cordial	9	30
3.	There is communication gap because of non involvement of people in implementation of PHC programmes	6	20
	Total	**30**	**100**
QUE10	**Effectiveness of services rendered by health workers to people in the community**		
1.	The services rendered are effective	15	50
2.	The services rendered are not effective	9	30
3.	The services provided are within the health centre only	6	20
	Total	**30**	**100**

APPENDIX IV

The Budget/Estimate for the Research

S/N	Items	Expected Expenditure
1.	Preliminary field survey	₦20,000.00K
2.	Two (2) seminars presentation	₦35,000.00K
3.	Editorial works (for 2 seminars and thesis)	₦25,000.00K
4.	Proposal defense	₦30,000.00K
5.	Production of copies of questionnaire	₦18,000.00K
6.	Refreshments and lunch for research assistants during training section	₦4,200.00K
7.	Transportation fare for research assistants during training at three (3) strategic location (Onifadi Health Centre, Shao Basic Health Centre and Oluyemo Health Centre Offa)	₦36,000.00K
8.	Refreshment for participants during focus group discussion section	₦7,200.00K
9.	Ethnical clearance and permission to carry out the study	₦80,000.00K
10.	Honorarium for the research assistants for administration and retrieval of copies of questionnaire; and participation in FGD	₦120,000.00K
11.	Post field defense	₦50,000.00K
12.	Oral defense	
13.	Production of four (4) hard copies of the thesis	₦17,000.00K
	Grand Total	**₦442,200.00K**

*The Estimated Amount is Four Hundred and Forty Two Thousand and Two Hundred Naira

APPENDIX V

Focus group discussion carried out in Moro LGA, Kwara State

Focus group discussion carried out in Ilorin West LGA, Kwara State

Focus group discussion carried out in Offa LGA, Kwara State

Focus group discussion carried out in Ilorin East LGA, Kwara State