

PECULIARITIES AND PROSPECTS OF RURAL HEALTH PRACTICE IN NIGERIA

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ABSTRACT

Delivery of quality health services to all and sundry including persons living in our numerous communities in Nigeria is a pre-requisite to improving national health indices. Strengthening the capacity of rural health practice centers to deliver health services to people in their domain is very vital in this regard. The peculiar characteristics of practicing health care in rural communities such as small defined geographical areas and the corresponding socio-cultural *milieu* can be harnessed to improve the health indices of rural communities. On the other hand, providing the necessary support to address manpower shortage and infrastructural deficit in these setting is a task that government and other stakeholders must undertake. This paper focuses on the peculiar nature of delivering health care services in rural settings and draws attention to how these peculiarities may be harnessed for the benefits of rural communities.

Key words: Rural health, health worker, community, infrastructure

Received: 23rd December, 2015

Accepted: 21st January, 2016

Published: 31st January, 2016

INTRODUCTION

The concept of rural health care though commonly used in literature has no clear definition but loosely used to refer to delivery of health care services in rural areas. However, characteristics common to rural health practice such as provision of health care services to small, underserved and often remote communities with shortage of health manpower against a background of low socio-economic status are often described in literature. (American Psychological Association, 2016; Buchan *et al.*, 2013)

Over the years, the term rural health has been modified to rural and remote health which is now commonly used in literature. This area of health care delivery consists mainly of primary health care services rendered in facilities that are generally

smaller, providing a broad range of services (including community and aged care), having less infrastructure and locally available specialist services, and providing services to a geographically more dispersed population (Australian Standing Council on Health, 2012). NB

In Nigeria, rural health practice refers to the system of health care service delivery available in rural communities commonly referred to as villages. Due to the better distribution of public primary health care (PHC) facilities compared to secondary and tertiary health facilities, majority of health care facilities in rural and remote communities are PHC centers, clinics and health posts.

Bridging the gaps of inequality in health care service delivery systems has featured prominently in almost every global health reform or development strategy.

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From the health for all declaration in Alma Ata in 1978 to the calls for universal health coverage in 2010 and then to the recent declaration of the sustainable development goals in New York in September, 2015, the need to ensure that every one-rich and poor, men and women, urban and rural residents alike, have access to quality health care services has featured prominently (Baum, 2007; Evans and Etienne, 2010; Buse and Hawkes, 2015) Thus, delivery of health care services in rural communities is important to the over-riding goal of achieving quality health care for everyone.

The proportion of people living in rural communities in Nigeria is higher than that of persons in urban areas, ranging from 56.2% to 63.5% (National Population Commission (NPopC) [Nigeria] and ICF International, 2014; National Bureau of Statistics, 2013) This fact further portray the need to give due attention to what happens to health care practice in rural communities in Nigeria.

PECULIARITIES OF RURAL HEALTH PRACTICE

Delivering health care services in rural communities is characterized by some distinctiveness that is usually not the norm in urban areas. These issues involve the health care system, health facilities and the community itself.

Rural communities are usually small-sized covering small geographical areas as a whole or as units (quarters, family compounds) of the whole. This among other factors, promotes knit community relationships that enhance information dissemination thus making family members, peers and friends, important sources of health information (Ogbe, 2011) It is not uncommon for a patient to volunteer information on who has similar ailments to his while taking a history during consultations because the communal lifestyle of the people provides a means for information sharing on health and health-related matters. Deriving from this scenario, the doctor, nurse or other health worker can leverage on the information volunteered to get a clearer picture of the health situation in the community.

In rural health facilities, there are usually opportunities for patients and clients to discuss related social issues in addition to their primary illness with their health care provider. Where the health care worker is courteous enough to listen and

comment in such interactions, the patient feels reassured and accepted. This process enhances counseling and psychotherapy. Such robust interpersonal communication between patient and client are known to improve outcomes and enhance better utilization of health services (Negri et al., 2011). It is the health worker who interacts with his client in this manner that is the beneficiary of much appreciation from the individual patient/client and the community as a whole (Warburton, et al, 2014). Many times, the appreciation goes beyond verbal to gifts-money, food items, and voluntary rendering of domestic services such as washing and cleaning. This form of community support in turn serves as encouragement for rural practice (Dolea, 2009).

Rural communities are the custodians of strong cultural practices in a fast-modernizing world. There are strong socio-cultural factors that influence morbidity, health seeking behavior and health service outcomes (Cooper-Patrick et al, 1999). Generally, health care delivery is practiced in social and cultural contexts just as the cultural beliefs of a community shape healthcare practices and local ideas about illness (Armenakis and Kiefer, 2007). All forms of health intervention including providing a health care facility must take into cognizance the existing socio-cultural situation. Rural dwellers attach much importance to market days, festivals, and sacred days. The health worker needs to bear all of these factors in mind when giving appointments for follow-up visits and home visits. A hypertension patient may ask you to extend his medications beyond a certain date because the family will be mourning the death of a member and so cannot go out of the house during the period. The mother of a child on anti-malarial injection may request for an earlier time so she can take her wares to the market.

Man power shortage is a common feature in rural health centers (Ebuehi and Campbell, 2011). The widespread perception that life in the rural community is not exciting discourages health care workers from taking up jobs in rural practice centers, and even when they are posted there by administrative orders, they soon begin to find ways of returning to urban centers. But the fact is there are challenges in living in rural communities as far as finding quality schools for your children and access to other basic amenities necessary for a comfortable life are concerned. Except government and other stakeholders make adequate compensatory arrangements for such health care workers, the



tendency to avoid working in rural health centers will persist. The persistent cycle of “post in and transfer out” make the available manpower unstable resulting in great limitations to capacity building and retention of experienced hands in the affected health facilities.

Many rural communities in Nigeria are lacking in important infrastructure (Ogungbemi et al, 2014) that supports delivery of quality health care services. Roads even up to the ones leading to available health facilities are often in disrepair and not passable. The medical, nursing and other personnel work-related stress is worsened by lack of electricity, potable water supply and recreational facilities. Vaccines and other drugs quickly lose potency when they are not properly stored due to lack of power supply while referral and supervisory duties are hampered by poor roads and lack of vehicles. Sanitation of the health facilities, including hand hygiene, is poor done or not often done at all due to lack of water thereby putting both personnel and patients at risk of healthcare associated infections (HAI). Lack of perimeter fencing with secure doors, gates and fence raises important security concerns. Physical and sexual assault of health care workers in rural and remote communities have been reported (Perrone, 1999). Infrastructural deficit, though a national problem, is more rampant in rural communities where health workers engage in rural practice.

PROSPECTS OF RURAL HEALTH PRACTICE

Despite the many features and limitations that characterize rural practice facilities and delivery of health services in rural communities, there are inherent potentials that can be explored to improve the health indices of these communities. By extension, the overall national healthcare system will be improved and morbidity and mortality rates reduced.

Rural health facilities bring healthcare delivery close to members in rural and remote communities. Though usually few, these facilities together with the services rendered in them and through them are the connection rural dwellers have with the national health system (Olise, 2012). Many of such health facilities are close enough to households as to permit walking, riding on an animal, or riding on a bicycle to seek healthcare. This is in contrast to urban facilities that are often sited in the heart of towns and cities or far away in the outskirts where high-density traffic and distance become significant barriers to

accessing health care respectively. The proximity of rural health centers to host community members transcends physical nearness to psychological proximity, a perception that results from the close interaction between medical and nursing staff on the one hand and clients and community leaders on the other.

The basic principles of primary health care-community participation, affordability, appropriate technology, inter-sectoral collaboration, equity and social justice (National Primary Health Care Development Agency (NPHCDA), 2012), serve as the basis of rural health practice. To achieve universal health coverage, no one is to be left without the required health care services. Many of the common issues of morbidity in rural communities can be addressed by such elements and practices of PHC as health education, nutrition counseling and rehabilitation, immunization, adequate water supply and sanitation, maternal and child health and treatment of common ailments. Primary health care services are cost-effective and require skills that are readily available to administer them even in the rural environment. These skills can be found in doctors, nurses, midwives, Community Health Extension Workers (CHEWS), health educators and village health workers (VHWs) among others. For example, home visits and distribution of health care commodities such as ORS and family planning materials which are important in rural communities can easily be handled by VHWs while nurses and CHEWs are very useful for health education and community mobilization.

The system of governance and community organization in rural areas makes for effective community mobilization that allows the people to progressively move through the stages from co-option to collective action (ACCESS Program, 2007). For example, in Esan land in the Central Senatorial district of Edo State, every community has an “Odionwelle” and other elders at the helm of affairs and who in turn report to the “Onogie” (king). Therefore, for any health intervention, such leaders of the community are very useful in providing the necessary platform to communicate with their subjects on important issues bothering on their health. This form of collaboration on health programmes have been reported elsewhere (Aigbiremolen, 2013).



Many rural health practice facilities are small-size compared to the big urban centers. The smallness of rural facilities, as it were, makes them manageable and excludes the many bureaucracies that characterize urban facilities. Patients and clients are usually able to go through registration, consultation, laboratory and pharmacy within a short time. Apart from the patient education that happens in the consulting room, patients are exposed to health education sessions while waiting to be registered.

CONCLUSION

Health care practice in rural communities is essential to achieving universal health coverage and improving national health care indices. To ignore the delivery of health care services in rural communities is to waste the great potentials inherent in it. Therefore, the critical issues of manpower, infrastructure and motivation need to be systematically addressed by relevant health authorities and other stakeholders to ensure sustainable and quality health care delivery in rural practice centers.

ACKNOWLEDGEMENT

The authors acknowledge the experiences shared with colleagues, students and patients at various times while practicing in rural health facilities.

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AUTHORS' CONTRIBUTIONS

AAE and AAO conceptualized and wrote the initial draft while all authors reviewed it. The final draft was written by AAO.

