

The Form and Quality of Cubical Clinic Services in Nigeria: A Case Study of Edo North, Edo State, Nigeria

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ABSTRACT This study examines the form and quality of small clinics referred to in this study as cubicle clinics. A survey of these clinics was carried out in 3 out of the six local government areas in Edo north senatorial district. In their form, two major classes of cubicle clinics were identified, first are those that operated in 1,2 or 3 room apartment and second were on the basis of the qualification of operators. Those, which operated in 2-room apartment, were more while the number of unqualified operators was also higher than the qualified. On quality, the technical aspects of the clinics and the interpersonal relationship between the client and personnel of the clinics were studied. It was observed that the clinics lack adequate qualified manpower and equipment while interpersonal relationship was lacking. On this basis the clinics were identified to lack quality service. Though these clinics cannot be said to be irrelevant in health care delivery in the study area as they have recorded some successes. However with due registration, control and acquisition of equipment, better services can be achieved.

INTRODUCTION

In the developing countries of the world, the rural areas continue to suffer poor health care due to government's inability to provide good and adequate health care services to the people. According to the World Bank Report of 1987, 70% of government spending on health in developing countries goes to urban areas while 30% goes to the rural areas where more than 70% of the total population lives. This variation in health resource allocation has led to inequality in health facility distribution and inadequacy of health care facilities in the rural areas. According to Adejuyigbe (1974) and Onokerhoraye (1978), over 60% of medical facilities in most developing countries including Nigeria are concentrated in few urban centres, leaving the rural areas almost unserved.

As areas where over 70% of the population lives, the effects of health facility inadequacy are quite enormous and includes high rate of disease infection, sicknesses and deaths among the rural people. To compliment and fill in the gap created by the inadequacy of government health facilities, private medical centres have been locating in the recent times in the study area.

Among the medical facilities been established by the private sector, the clinic is most common and ubiquitous. They are usually in a single, double or three-room apartment, a reason for

referring to them as cubicle clinics in this study. Inadequate and unqualified personnel characterize this clinic and because of this, treatment of ailments and services to patients is poor. Without adequate equipment and facilities major surgeries including appendicitis and caesarian section are usually carried out. Many rural people have lost their lives as a result of the activities of these clinics. As this menace continues, it has become imperative to identify the relevance of these clinics in health care delivery in the rural areas. To this end, this study intends to determine the form and the quality of service rendered by these clinics to the rural people Edo north in Edo State of Nigeria.

Study Objectives

The following objectives were used to determine the relevance of cubical clinics in the study area. First, the number and distribution of cubical clinics in the study area was determined. Secondly the form and quality of service rendered in these clinics was examined and thirdly the implication of the quality of service on health care in the study area was highlighted.

METHODOLOGY

The data for this study was derived from two main sources, primary and secondary sources.

The primary sources included questionnaire and interview schedule. A total of 600 were made and distributed in 30 settlements selected from each of the 10 wards of the three local government areas of this study. Settlements selected are those with at least a cubicle clinic. Table 1 is the local government areas of study, their wards and selected settlements. 20 questionnaire were randomly distributed among respondents of these selected settlements. The target population was patrons of these clinics. Interview schedule was also designed and administered on the proprietors or management of these clinics. It was among others designed to determine the number and type of personnel and equipment and the types and quality of services in the clinics. Secondary sources on the other hand were basically books, journals and other documentary sources. Data generated from both sources were analyzed descriptively.

Table 1: Wards, selected settlements and number of clinics

Local Government	Wards	Settlement	No. of Clinic
Owan East	1	Afuze	3
	2	Otuo	2
	3	Ikhin	1
	4	Ihievbe	2
	5	Warrake	2
	6	Okpokhumi	1
	7	Uokha	1
	8	Erah	1
	9	Igue	1
	10	Ihievbe-Ogben	1
Owan West	1	Sabongida-Ora	3
	2	Ozalla	1
	3	Sobe	1
	4	Avbiosi	1
	5	Uzebba	2
	6	Oke-Old	1
	7	Ukhuse-Oke	1
	8	Uhomora	1
	9	Eme-ora	1
	10	Eruere	1
Akoko-Edo	1	Ugbogbo	1
	2	Uneme-Nekhwa	1
	3	Lampese	1
	4	Ibillo	2
	5	Dangbala	1
	6	Okpe	1
	7	Bekuma	1
	8	Igarra	3
	9	Ogbe	1
	10	Ososo	1
Total			41

Source: Field Survey, 2006

Study Area

Edo north is one of the three senatorial districts of Edo State of Nigeria. This district comprises six local government areas. They are Owan east, Owan west, Etsako west, Etsako central, Etsako east and Akoko-Edo local government areas. This study covers only the local government areas of Owan east, Owan west and Akoko-Edo. They are located between Latitude 5°25'N and 6°50'N of the equator and longitude 7°15'E and 8°15'E of the Greenwich Meridian. They are made up of several settlements and for political administration each local government is divided into 11 wards. 1 settlement was selected from the 10 wards of each of the local government area and this brought the study settlements to a total of 30. This study area is located in the tropics and it experiences the humid tropical climate characterized by marked dry and wet seasons. The dry season is usually between November and February of each year. Wet season on the other hand lasts between March and November of each year. Temperatures are high all year round and the mean annual temperature is about 32 °C (Cocoa Research Institute of Nigeria, 2003). High temperatures and humid conditions favour the growth and spread of most tropical diseases (Ayoade, 1988). Bacteria causing diseases such as measles, typhoid, malaria and meningitis are known to survive well under hot humid conditions. These are also some of the commonest ailments in the study area. The study area is predominantly a rural area. Apart from the local government headquarters, all other settlements are rural settlements. The population of this area is estimated at 356,378 (National Population Commission 1991). The people are predominantly farmers who grow crops such as cassava, yam, vegetables, potatoes, cocoa, oranges, and kolanuts. A large population is also involved in secondary and tertiary activities. Few public health facilities exist in the study area. Most of the health care centres are private and are in the class of cubicle clinics. With such a large population depending on these clinics, it is obvious that health care is a serious problem in the study area.

The Form of Cubicle Clinics in the Study Area

Cubicle clinic in this study is that private clinic operated by either a doctor or a nurse or other personnel usually in a single, double or three-

room apartment. These clinics are located in all the settlements of the study area as shown in Table 1. Among these settlements, Afuze, Sabongida-Ora and Igarra have more clinics. As headquarters of the three local government areas with large concentration of population, social-economic activities including health facilities have been locating in recent times in these settlements. In this study 15 or 36.6% of these clinics are located in Owan east local government area, 13 or 31.7% are located in Owan west local government area while also 13 or 31.7% are located in Akoko-Edo local government area.

The type of practice in these clinics is general medicine. There is no clinic with specific area of specialization. The study revealed that 11 or 26.8% of the clinics located between 0-5 years, 15 or 36.6% located between 5-10 years, 7 or 17.0% located between 10-15 years while 8 or 19.5% started operation over 15 years ago. The summary shows that 26 or 63.4% of the clinics started operation between 0-10 years ago, which is an indication of their increasing location in recent times. The field survey shows that all the clinics are owned and operated by their individual owners. The operators are basically of three classes. Those operated by qualified doctors, those operated by qualified nurses, and those operated by untrained personnel such as roadside chemist. Table 2 shows the number of clinics operated by the various categories of operators of these clinics.

The doctors operate 12 or 29.3% of the clinics while the trained nurses operate 16 or 39% of the clinics. The roadside chemists operate 13 or 31.7% of the clinics. This number is considerably high, and portends a very high risk to health care delivery in the study area. Table 3 shows the distribution of the various clinics and their operators.

From Table 3, there is an indication that there are more doctors and roadside chemist in Owan east than Owan west and Akoko-Edo local government areas. On the other hand there are

more trained nurses in Owan west than other local government areas. Investigation on the types of services rendered shows that obstetrics and gynecology, pediatrics, medical and surgical cases are treated. The commonest ailment that affect the lives of the people of the study area which are often taken to the clinics are malaria fever, typhoid fever, measles, tatanus, filariasis, pneumonia, ulcer and diabetes. Also treated are accident cases, abortion and surgical operation of diverse types including appendicitis, hynea and delivery. From the daily registration records of the clinics, it was observed that patronage of these clinics has been high in the last few years as shown in Table 4.

It is important to note that this daily registration record is from 33 of the 41 clinics under study. The remaining 8 clinics had no medical record of any event. These classes of clinics are those operated by some nurses and chemists. The level of success which has been achieved in the treatment of some ailments especially in the clinics operated by doctors and experience nurses has in recent time led to increasing patronage of the clinics.

Quality of Service in the Cubicle Clinics

Quality medical care refers to the satisfactory supply of health care services within stipulated or required standards by health care providers. It involves methodology used to assess and ensure quality, development of guidelines regarding appropriate methods of quality assessment to improve care provided and increase overall access to health care of high quality (Nandraj and Dugal 1997). There are systems and processes for guaranteeing quality. According to Nandraj and Dugal (1997) the measures include reducing unnecessary admissions, assessing the appropriateness of average length of stay, the number of consultations and the number of days spent in hospitals.

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Table 2: Categories of operators of clinics, their number and distribution

Type of Operator	Number of Clinic	Owan East	Owan West	Akoko-Edo
Doctors	12	5	4	3
Trained Nurses	16	5	7	4
Chemist/others	13	5	4	4
Total	41	15	15	11

Source: Field Survey, 2006.

Table 3: Distribution of the cubicle clinics and their operators.

<i>Local Government</i>	<i>Ward</i>	<i>Settlement</i>	<i>No. of Clinic</i>	<i>No. of Doctors</i>	<i>No. of Nurses</i>	<i>No. of Chemists</i>
Owan East	1	Afuze	3	2	1	-
	2	Otuo	2	1	1	-
	3	Ikhin	1	-	1	-
	4	Ihievbe	2	1	1	-
	5	Warrake	2	1	-	1
	6	Okpokhumi	1	-	-	1
	7	Uokha	1	-	1	-
	8	Erah	1	-	-	1
	9	Igue	1	-	-	1
	10	Ihievbe-Ogbe	1	-	-	1
Owan West	1	Sabongida-Ora	3	1	2	-
	2	Ozalla	1	1	-	-
	3	Sobe	1	1	-	-
	4	Abviosi	1	-	1	-
	5	Uzebba	2	1	1	-
	6	Oke-Old	1	-	-	1
	7	Ukhuse-Oke	1	-	-	1
	8	Uhomora	1	-	-	1
	9	Eme-Ora	1	-	1	-
	10	Eruere	1	-	-	1
Akoko-Edo	1	Ugbogbo	1	-	-	1
	2	Uneme-Nekhwa	1	-	-	1
	3	Lampese	1	-	1	-
	4	Ibillo	2	1	1	-
	5	Dangbala	1	-	-	1
	6	Okpe	1	1	-	-
	7	Bekuma	1	-	1	-
	8	Igarra	3	1	2	-
	9	Ogbe	1	-	-	1
	10	Ososo	1	-	1	-
Total			41	12	16	13

Source: Field Survey, 2006. (Note: 1 Figure is for 1 Clinic)

Table 4: Level of patronage of clinics between the year 20001 and 2005

<i>Year</i>	<i>Number of Patrons</i>
2001	9,324
2002	9,851
2003	11,347
2004	13,699
2005	11,417
Total	55638

Source: Field Survey, 2006.

quality of health care, Donabedian (1988) lay emphasis not only on the technical domain (defined knowledge, judgement and skill of providers) but also on the interpersonal which according to him consists of communication between the physician and the patient. Mensch (1990) corroborates this, as she identifies that there are two parts to a comprehensive assessment of health services. The first according to her is a description of programs, which are considered part of the infrastructure, that is, equipment and facilities, staff and training,

supervision, record keeping and supplies. The second is balanced information particularly between the staff and the client. While developing a framework which defines quality care for family planning and related reproductive services, Bruce (1990) defines quality in terms of six elements and associated indicators. These are choice of methods, provider-client information exchange, provider competence, interpersonal relations, mechanisms to encourage continuity and appropriate constellation of services. To determine the quality of services rendered in cubicle clinics in the study area, the technical and the interpersonal relations of the clinics were assessed. The technical aspect assessed includes equipment, infrastructure and personnel, while the interpersonal relation was basically on communication between the patient and the personnel.

The technical aspect of the cubicle clinics suffer unavailability, obsolesce and inadequacy of equipment and infrastructure and a high level of incompetence among the personnel. On personnel for instance, it was observed that three

categories of staff exist in the clinics. The first are the doctors, nurses or the chemist who are the proprietors and operators of the clinics. The second is a class of trained and untrained or unqualified nurses while the third category is made up of orderlies and receptionist. Table V shows the categories and number of staff in these clinics.

Table 5 explains that 17 doctors are employed in the cubicle clinics in the study area. Trained nurses with the minimum nursing certificate are 34 while the unqualified but internally trained nurses are 57. The number of internally trained nurses is very high because many of the proprietors prefer to employ and trained them for cheap labour than the trained nurses whose wages they cannot afford. 12 unqualified chemists and 14 receptionists are also employed in the clinics. The total number employed in this service is 198. Pertaining to the qualification and competence of staff, majority are not qualified and therefore incompetent. Out of the 91 nurses employed in these clinics, only 34 are trained nurses, the other 57 though have received internal training, but does not qualify them as competent nurses. The ability of this category of nurses to tender patients, take readings, make reports and keep records is very low.

These clinics lack basic medical equipment. The commonest equipment found among the clinics is shown in Table 6. Also in this Table 6 it is apparent that there is general inadequacy of medical equipment in the cubicle clinics in the study area. Though some clinics have more equipment than other clinics, but the fact that a clinic could have less than 3 simple equipment means that poor quality health care services is rendered. A further study on the equipment required for better service delivery shows a wall of difference between what is present in the clinics and what is required for health delivery. Table 7 shows the minimum number of required medical

equipment for effective health care delivery in each cubicle clinic.

A comparison of the number of equipment available in the clinics shown in Table 6 and the number required shown in Table 7 shows that many of the clinics do not possess what is required to operate a good clinic.

On infrastructure, space within which the clinics operate and the internal facilities in the clinics were examined. It was observed in the study that there is gross inadequacy of space for most of the clinics. 20 or 48.8% of the clinics operate in a 2-room apartment while 11 or 26.8% operate in a 1-room apartment. Those operating in a 3-room apartment accounted for 10 or 24.4% of the clinics. With 31 or 75.6% of the clinics operating in a 1 and 2-room apartment, no better services is expected from such clinics, not especially with the large number of patients that come for treatment daily. It was observed that the trained nurses and chemists' own majority of the 1 or 2 -room apartment clinics while the doctors operate in all the 3-room apartment clinics. Table 8 shows the space available to each clinic in the study area.

Only few clinics particularly those on 3-room apartment admit patient for treatment. For lack of space out-patient services are mostly rendered. None of these clinics have a special operation theatre. The few ones that conduct surgeries do so in rooms used for other kind of services. Only 7 of the clinics are involved in surgical activities, which are usually performed in operation or examination tables. The survey shows that 19 clinics owned by both nurses and doctors perform delivery on women. None of the clinics offer laboratory services, they rely on laboratory reports from distant hospitals and privately owned laboratory service centres.

Also most of these clinics lack internal facilities such as water, toilets and bath/showers. Only 8 or 19.5% of these clinics have w/c toilets,

Table 5: Category and number of staff in the clinics

<i>Categories of Staff</i>	<i>Number</i>	<i>Qualification</i>
Doctors	17	MBBS
Qualified Nurses	34	Nursing School Certificate/Secondary and Primary school certificate. (Internally trained)
Unqualified Nurses	57	Primary School Certificate
Orderlies	76	Secondary or Primary School Certificate
Receptionists	14	School certificate
Chemists	12	
Total	198	

Source: Field Survey, 2006.

Table 6: Simple equipment and number in the cubicle clinics

<i>Clinics</i>	<i>Sterilizers</i>	<i>Operation Tables</i>	<i>Thermometers</i>	<i>Stethoscopes</i>	<i>Examination Tables</i>	<i>Weighing Scales</i>	<i>Delivery Tables</i>	<i>Drip Stands</i>	<i>Total</i>
<i>Owan EastWard/Clinic</i>									
1	7	1	5	3	3	3	2	3	27
2	3	1	2	2	2	1	1	1	13
3	1	-	1	-	-	1	-	-	3
4	4	-	-	1	1	1	1	1	9
5	3	1	2	1	2	1	1	1	12
6	1	-	3	-	1	-	-	-	5
7	1	-	-	-	1	1	1	1	5
8	1	-	-	-	1	-	-	-	2
9	1	-	1	-	1	-	-	-	3
10	1	-	1	-	1	-	-	-	3
<i>Owan WestWard/Clinic</i>									
1	5	1	7	3	1	2	1	1	21
2	1	-	1	1	1	1	1	1	7
3	1	-	1	-	1	1	-	-	4
4	1	-	1	-	-	1	-	-	3
5	3	-	1	1	2	-	-	-	7
6	1	-	1	-	-	-	-	-	2
7	1	-	-	-	-	1	-	-	2
8	1	-	-	1	1	1	1	1	6
9	1	-	1	-	1	1	1	1	6
10	1	-	-	-	-	1	-	-	2
<i>Akoko EdoWard/Clinic</i>									
1	1	-	-	-	1	-	-	-	2
2	1	-	1	1	1	1	-	-	5
3	1	-	1	-	1	1	-	-	4
4	4	1	5	2	1	2	1	1	17
5	1	-	1	1	-	-	1	1	5
6	1	-	1	1	1	1	1	1	7
7	1	-	2	-	-	-	-	-	3
8	7	1	5	3	2	2	1	1	22
9	1	-	1	-	-	-	1	-	3
10	1	-	1	1	-	-	-	1	4
Total	58	6	46	22	27	24	15	16	214

Source: Field Survey, 2006.

Table 7: Minimum number of required medical equipment for effective health care delivery in the cubicle clinics.

<i>Type of Equipment</i>	<i>Number Required</i>
Sterilizers	2
Circumcision Scissors	3
Thermometers	3
Stethoscopes	3
Examination Tables	1
Baby Scale	2
Adult Scales	2
Delivery tables	2
Operation Tables	1
Drip stands	4

Source: Field Survey, 2006.

others have the dug pit toilet. On the other hand, 26 or 63.4% have bathroom facilities, however only 2 or 7.7% of these bathrooms are bath/showers, others are ordinary or open bathrooms. The condition of the buildings and environment under which these clinics operate is also very

worrisome. For example the condition of the ceiling, floors, walls, ventilation and the general environment of some of the clinics is deplorable.

The overall assessment of this technical aspect of the cubicle clinics is that of general inadequacies and incompetence. With this amount of limitation it is apparent that quality service is not rendered in these clinics. This of course is manifested in the increasing cases of deaths and complications from treatments. Investigation revealed that over 35 deaths have been recorded in the last five years in these clinics. 23 of these deaths occurred in the clinics operated by quacks that pretend to be nurses and chemists while only 12 occurred in the clinics operated by doctors. The study shows that most of these deaths occurred from accidents, food and chemical poison, abortion, malaria fever and childbirth. Complications from treatment in these clinics are also widespread in the study area. The

Table 8: Space available to each cubicle clinic (per room)

<i>Local Government</i>	<i>Ward</i>	<i>Settlement</i>	<i>No. of Clinic</i>	<i>1 Room Apartment</i>	<i>2 Room Apartment</i>	<i>3 Room Apartment</i>
<i>Owan East</i>	1	Afuze	3	-	1	2
	2	Otuo	2	1	1	-
	3	Ikhin	1	1	-	-
	4	Ihievbe	2	-	2	-
	5	Warrake	2	1	-	1
	6	Okpokhumi	1	1	-	-
	7	Uokha	1	-	1	-
	8	Erah	1	1	-	-
	9	Igue	1	-	1	-
	10	Ihievbe-Ogbe	1	-	1	-
<i>Owan West</i>	1	Sabongida-Ora	3	1	1	1
	2	Ozalla	1	1	-	-
	3	Sobe	1	-	1	-
	4	Abviosi	1	1	-	-
	5	Uzebba	2	-	1	1
	6	Oke-Old	1	-	1	-
	7	Ukhuse-Oke	1	1	-	-
	8	Uhomora	1	-	1	-
	9	Eme-Ora	1	-	1	-
	10	Eruere	1	1	-	-
<i>Akoko-Edo</i>	1	Ugbogbo	1	1	-	-
	2	Uneme-Nekhwa	1	-	-	1
	3	Lampese	1	-	1	-
	4	Ibillo	2	-	1	1
	5	Dangbala	1	-	1	-
	6	Okpe	1	-	-	1
	7	Bekuma	1	-	1	-
	8	Igarra	3	-	2	1
	9	Ogbe	1	-	-	1
	10	Ososo	1	-	1	-
Total			41	11	20	10

Source: Field Survey, 2006

inability to prescribe and administer necessary drugs, poor surgical services and abortion are the areas where complications have resulted. 243 or 40.5% of the respondents agreed that they have had complications as a result of poor prescription and administration of drugs and other services by the unqualified or untrained personnel. Some of these complications have caused permanent damage such as infertility especially among women and abscess or limb damage due to incorrect administration of injection.

On the basis of interpersonal relation, general dissatisfaction was expressed by patrons of these clinics. Of the 600 patrons interviewed by questionnaire, 93 or 15.5% agreed that they were satisfied with the quality of services in the clinics while 507 or 84.5% registered their dissatisfaction. On the level of reception 156 or 26% agreed that they were always well received and treated by staff while 444 or 74% were of the contrary view. They remark of the hostile posture that most medical staff put on when they come with ailments

that are particularly infectious or contagious or even during delivery. Apart from this, most patrons complained that they spend longer time in these clinics when they come for treatment. According to them poor reception by the staff and the large number of patients who have to see the only doctor in the clinic is responsible. This problem is prevalent in the clinics where you have doctors. Many respondents also frowned at the delegation of treatment by some doctors and nurses to their untrained nurses and orderlies particularly when they go for check-up or when they go for the treatment of ailments such as malaria fever.

Implication of Findings

Over the years though, some level of success have been recorded in the treatment of some ailments. For example, available records show that over 75% success has been recorded in the treatment of malaria fever, stomach disorder and

typhoid fever in these clinics. This success has however been beclouded by the increasing cases of deaths and complications from treatments in these clinics. With inadequate materials and qualified personnel it is obvious that these clinics are incapable of delivering qualitative services to the rural people of the study area. The implication therefore is that the rural dwellers of the study area may never get the desired quality health care. Until something urgent is done, the number of the sick and dead will keep increasing and so will be cases of complication or after service effects.

The wealth of a nation or a people is dependent on the health of its citizenry. For a people that are sick, it is obvious that the full potential of their resources cannot be exploited for their overall wellbeing. Therefore, poverty, deprivation, diseases and decay is seen to loom among such people. This is the situation in the study area. To be able to fully exploit the potential of the rural people for overall development, it is important that quality health care is pursued with vigour.

RECOMMENDATIONS

These inadequacies notwithstanding, the clinics are contributing to the development of health care in the study area in particular and Nigeria in general. They are standing in the gap as alternative to government health care centres that are not available in the rural areas. The large number of rural people who attend these clinics is an indication that they have been accepted as treatment centres in the place of no other. Because of this role, these clinics at this moment are relevant and should not be faced out. What is therefore required at this stage is to inject measures that will bring about effective and quality health care services. Such measure should include taking an inventory of all private health care outlets in the study area so as to determine their types, number, location and the nature of their activities. Also all private clinics should henceforth be registered with the local or state ministry of health. This registration which will stipulate the minimum standards and requirements for the operation of health clinics will go a long way in checking the incessant and uncontrolled manner of location and operation of these clinics.

In view of the contribution of some of these clinics to health care in the rural areas, this study is of the view that only clinics operated by doctors should be given licenses to operate. All clinics

operated by quacks in the name of trained nurses or chemist should be closed down with immediate effect. The study has revealed that the operators of this category of clinics not only extort money from the rural people but endanger their lives as well. A number of people have either lost their lives or had complication in these clinics.

Government at all levels should see it as a priority to take charge of the health care of the rural people in view of the fact that majority of the people of this country live in the rural areas where most of the economic wealth are located. Without delay therefore, hospitals, health centres and other health institutions should be located, this will not only improve the health care of the rural people but will check the excesses of the private health centres in the study area.

According to Okafor (1984), health care services go beyond the mere provision of hospitals and clinics, rather it should include the provision of portable water supply, electricity, roads and other infrastructure, sanitation and sound health education. These according to him are necessary ingredients to fulfilling an overall health development for rural people. In view of this, it is recommended that the study area, which has been lacking in infrastructure development, be massively provided.

For overall health care development, research effort should be put in place to promote traditional medicine, as a supplement to orthodox. The rural people are very well use to traditional medicine therefore attention is needed to be given for its promotion and development by government and the private sector. It is of the opinion that if these few recommendations are well implemented, health care development in rural Nigeria would improve greatly.

REFERENCES

- Adejuyigbe, O. :Providing Health Centres in Rural Areas of Western State of Nigeria. *Nigeria Medical Journal*, **4**: 5-9 (1974)
- Ayoade, J.O: *Introduction to Climatology for the Tropics*. Spectrum Books Ltd. Ibadan (1988).
- Bruce, J: Fundamental Elements of Quality of Care. A Simple Framework. *Studies in Family Planning*, **12(2)**: 32-37 (1990)
- Cocoa Research Institute of Nigeria. Meteorological Division Udonmora, April 18th 2003 (2003).
- Donabedian, A.: Quality Assessment and Assurance. Unity of Purpose,Diversity of Means. *Inquiry*, **25**: 173-192 (1988)
- Mensch B.: An Assessmnt of Quality of Services. *Studies in Family Planning*, **12(2)**: 64-76 (1990)

- Nadraj, S. and Duggal, R.: Physical Standards in the Private Health Sector. A Case Study of Rural Maharashtra. Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai (1997).
- National Population Commission. Data Processing Unit, Benin City, 21st April, 1991 (1991).
- Okafor, F. C.: Accessibility to General Hospitals in Rural Bendel State of Nigeria. *Social Science and Medicine Journal*, **18(8)**: 661-666 (1984).
- Onokerhoraye, A. G.: Spatial Aspects of the Health Care Problems in Nigeria. A Case Study of Kwara State. *Quarterly Journal of Administration*, **12**: 241-255 (1978)
- World Bank: *Financing Health Services in Developing Countries. An Agenda for Reform; A World Policy Study*, World Bank, Washington USA (1987)
- World Bank: *Better Health in Africa: Experience and Lessons Learned*. World Bank, Washington, D.C (1994).