Local Government Administration and the Challenges of Primary Health Care Management in Vandeikya, Nigeria

Iorhemen Iorchir Peter[1]&Orkume Sylvester Twar[2]
[1]Department of Public Administration
Veritas University, Abuja
Corresponding author: iorchiriorhemen@yahoo.com
[2]Department of General Studies
Federal Polytechnic, Wannune, Benue State

Abstract

This paper examined the management of primary health care in Nigeria with particular interest to Vandeikya Local Government Area of Benue State Nigeria. The objectives of this study are to ascertain how motivation and remuneration affected health care personnel in primary health care management in Vandeikya Local Government Area and to as well find out how health facilities constrained primary health care management in Vandeikya Local Government Area.The instrument employed by the writers was literature review and physical survey of primary health facilities, while the theoretical justification of the paper is anchored on structural functionalism theory. The finding revealed that Vandeikya Local Government Area is running her primary health care service delivery in non-compliance with minimum standard, the available health workers are unequally distributed to various health facilities, primary health centres are under-staffed and ill equipped and, finally the health education unites were being under utilized for proper education, mobilization, monitoring and evaluation of all health activities. The study recommended that, significant and adequate proportion of income at all level of government should be committed to the health sector development, local government should be more inward-looking and aggressive in the area of internally-generated revenue,priority should be given to improved living condition of the people and, there should be adequate and equipped health facilities to all communities in the local government area.

Keywords: Healthcare, Local Government, Administration, Management, Development

Introduction

The impact of local government administration on the people in Nigeria still remains a subject of intense debate and argument particularly in the area of health care delivery. Improving health throughout the world is a gigantic task requiring global cooperation. The international health care system was first recognized at the first international scientific conference in 1851 (Shunom, 2006), after which the World Health Organization (WHO) introduced a system of cooperation against the spread of diseases. A WHO conference held in Alma-Ata in 1978, proclaimed Primary Health Care (PHC), as a concept that calls for the overall promotion of health by supporting the individual, the family and the community, by defining the active participation of the community, their needs and ways to meet them (Obionu, 2007). Studies have shown that the problems confronting Nigeria in areas of health are many, ranging from poor finance, equipments, shortage of manpower to the unwillingness of few health professionals to work in rural areas (Obionu, 2007). Health is one of the major determining factors for societal development without which all spheres of human Endeavour like social-cultural, political and economic activities would be badly crippled. The need for sound health for every member of the society including those at local government areas cannot be over emphasized. No wonder the local, state and federal government as well as the international organizations like the World Health Organization and other Non-Governmental Organizations is working assiduously to ensure good health for all. Health which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmly (WHO, 1995) necessitated standard setting in the health service at the local government. The purpose for this local government health service management is to strive to achieve the highest quality of health

care possible within the resources available. Primary health is the first level of contact of individuals, the family and the community.

In Nigeria, the primary health care which is supposed to be the bedrock of the country's health care policy is currently catering for less than 20% of the potential patients (Gupta, etal 2004). The goal of primary health care (PHC) was to provide accessible health for all by the year 2020 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade. The PHC aims at providing people of the world with the basic health services. Though PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts. About two-thirds of Nigerians reside in rural (http.//www.fao.org/countryprofiles/index.asp) areas therefore they deserve to be served with all the components of PHC. Primary health care, which is supposed to be the bedrock of the country's health care policy, is currently catering for less than 20% of the potential patients (Gupta *et al*., 2004).

Benue state today and Vandeikya Local Government Area as in most parts of Nigeria is faced with high population growth, high poverty level accompanied by illiteracy and ignorance, poor nutrition, rampant superstitious beliefs, taboos and other related health risk and problems such as inadequate sanitation, unsafe drinking water and high rate of environmental pollution. These conditions have encouraged high prevalence cases of both infant and adult diseases such as measles, diarrhea, tuberculosis, cardio vascular diseases and other respiratory infections. Also, deadly diseases such as Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and other Sexually Transmitted Diseases/Sexually Transmitted Infections (STDs/STIs), are particularly worrisome in Kaduna State (Laah and Mamman, 2002). There is also growing number of child mortality aged 0-4 years, maternal mortality is also high in Vandeikya Local Government Area. Consequently, life expectancy is lower than expected. It is therefore necessary that we understand the vital role of health in both the curative and most especially the preventive services of our health care management. It is against this background that this study on local government administration and the challenges of PHC management in Vandeikya Local Government Area of Benue State is being carried out. In this study, the researcher examines critically the efforts of local government in dealing with the challenges of primary health care management in Vandeikya Local Government Area of Benue State, Nigeria between 2010 and 2015.

Primary Health Care Development in Nigeria

The National Primary Health Care was launched by the Military Administration of President Ibrahim Badamosi Babangida in 1988, (Adeyemo, 2005:152). The scheme was to be a collaborative effort of the three tiers of government which should be more adapted to Nigeria's socio-economic and cultural context. It should be people-oriented in that it strives to develop local capabilities, initiatives and to promote self-reliance. In a way, this was for the realization of sustainable improvement in the health of the people. Health services delivery in Nigerian had its historical antecedents. It had evolved through sequential development including a succession of policies and planning which had been introduced by previous administrations.

Even though Oyewo (1991) traced the historical epoch of Nigerian health sector beyond the organized colonial period, the formal public health services in Nigeria and other West African protectorates originated from the British Army Medical Services. When the army became integrated with the colonial government, medical care was extended to local civil servants and their relatives. Eventually, it got to the local population, especially those living close to government stations (Adeyemo, 2005). At the same time, various religious bodies, especially Christian Missionaries and private organizations, made spirited efforts to establish hospitals, dispensaries and maternity centres in different parts of Nigeria.

The first Ten-year National plan (1946-1956), whose proponents were mainly expatriate officials, had a number of deficiencies, especially in the health services. It was the Second National Development Plan

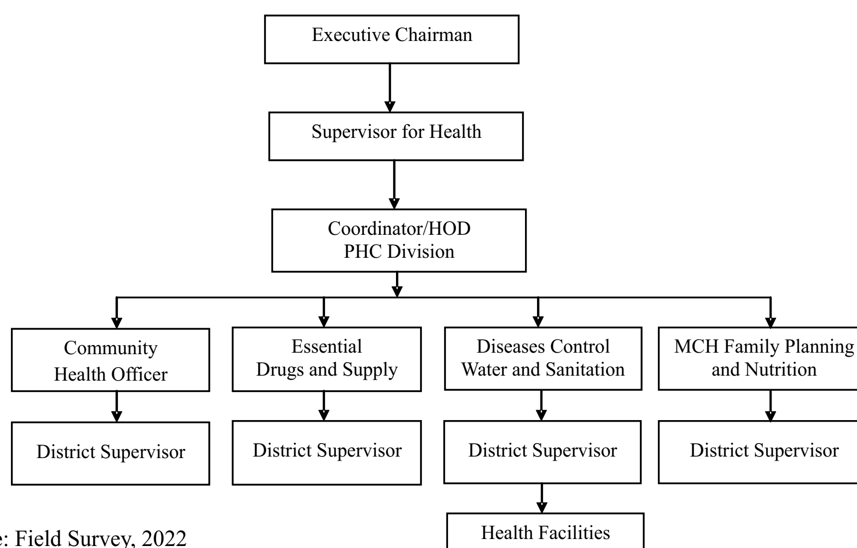
(1970-1974) that made attempts at correcting some of the deficiencies in the health services. The focal point of the Second National Development Plan was to design a comprehensive national health policy dealing with issues such as health, man-power development, provision of comprehensive health care based on basic health care service scheme, disease control, efficient utilization of health resources, medical research, health planning and management. The Third National Development Plan (1975-1980) was also targeted at increasing the proposition of the population receiving health care from 25% to 60%. The plan incorporated Basic Health Service Scheme (BHSS) policy which was: (1) to initiate the provision of adequate and effective health facilities and care for the entire population; (2) to correct the imbalance between preventive health programmes such as control of communicable diseases, family health, environmental health, nutrition and others; (3) to establish a health care system best adapted to the local condition and to the level of health technology in the country. Although greater emphasis was also made to BHSS in the fourth National Development Plan, the scheme suffered a total neglect. According to Sani (1990:3), the Federal Government in particular focused much more attention on the establishment of teaching and specialist hospitals. He further stresses that, this was reflected in the budgetary allocations for Health Capital projects and programmes as they were contained in the fourth National Development Plan. A total of N862.40 million (71.8%) was allocated to the teaching and specialist hospitals, while only N101.50 million was allocated to BHSS and other related health programmes.

The General Babangida administration brought about the encouragement of Primary Health Care directorate while charged with the responsibility for formulating, developing and implementing the National Primary Health Care system in line with the recommendation of 1988 International Conference on Primary Health Care. The response of Federal Ministry of Health (FMOH) to the unacceptable health conditions in Nigeria through increased commitment and willingness was undertaken to achieve a comprehensive sector reform. A new reform commenced in 2003 within the context of the National Economic Empowerment and Development Strategy (NEEDS). The National Health policy which was revised in 2004 created the reform environment whilst the health sector reform programe of 2004 established the framework including goals target and priorities that should guide the action and work of the FMOH and to some extent, those of State Ministry of Health (SMOH) and health development partners over a four year period (2004-2007). The document describes the direction for strategic reforms and investment in key areas of the national health system (FMOH, 2004 in Obansa and Orimisa 2013:225). One of the several health policy options to be adopted would be to domesticate the sectoral transformation in order to mold globally accepted health transformation around our unique national culture and institutions. Structural transformation will emphasize on strengthening the management capacity of National Primary Health Care Development Agency (NPHDA) to coordinate Primary Health Care (P.H.C) policies (FGN, 2007).

Primary Health Care Administration in Vandeikya Local Government

The supervisor of the Health heads the health care delivery at the local government area. A Coordinator doubles as the Head of Department. He is assisted by a Deputy Coordinator who is in charge of Primary Health Care. The Coordinator reports to the Supervisor who in turn reports to the local government Chairman. The different components of the local government Primary Health Care are managed by personnels of diverse specialty. There are three levels of operation of Primary Health Care in the local government area. These include: (1) Village level; (2) District level; and (3) Local government level. The organogram shown below is a typical local government Primary Health Care organizational structure in Nigeria and its various levels of responsibilities.

Fig. 1: Primary Health Care Organogram



Source: Field Survey, 2022

There are basically thirty one (31) primary health centers owned by Vandeikya local government area distributed among the twelve council wards out of which are seven (7) Comprehensive Health Centres (CHC), Seven (7) Health Centres (HC) and Seventeen (17) Basic Health Centres respectively. Although some are community health centres, they are now taken over by the local government. Table 1 presents the primary health care facilities distribution and the various local government council wards.

Table 1: Primary Health Care facilities in Vandeikya Local Government Area and Respective Council Wards

Name of Health Facility	Council Ward	Type or Classification
L.G.H.C Mbaako-Geri	Mbadede	H.C
L.G.H.C Ihugh	Mbadede	B.H.C
C.H.C Mbabagu	Mbadede	B.H.C.
C.H.C Tyam	Mbadede	H.C.
P.H.C Kiishi	Mbadede	B.H.C.
C.H.C Abaki	Mbadede	B.H.C.
MDGs Anongo	Mbajor	H.C
C.H.C Gbagbongum	Mbajor	B.H.C
P.H.C Gbem	Tsambe	C.H.C
C.H.C Mbakough	Tsambe	B.H.C
MDGs Taatihi	Mbagbam	H.C
C.H.C Bko-Ite	Mbagbam	B.H.C
P.H.C Imoughun	Mbaikyaha	C.H.C
C.H.C Tse-kpum	Mbaikyaha	B.H.C
C.H.C Zor	Mbaikyaha	B.H.C
MDGs Natu-Achaku	Mbaikyaha	B.H.C
CSDP Aboho-Natu	Mbaikyaha	B.H.C
C.H.C Tsua	Mbagbera	B.H.C
C.H.C Mbagbatse	Mbagbera	B.H.C
C.H.C Mbaagir	Ningev	B.H.C
MDGs Bako	Ningev	H.C
FSP Idyegh	Mbakaange	C.H.C
C.H.C Aginde	Mbakaange	B.H.C
LGHC Ityemimongo	Mbayongo	H.C
C.H.C Ageva	Mbayongo	B.H.C
C.H.C Ikpo-Ikpo	Ngumagbagh	H.C
MPHC Tsar	Mbatyough	C.H.C
P.H.C Tsar	Mbatyough	C.H.C
C.H.C Mbaause	Mbatyough	B.H.C
MCH Vandeikya	Township	C.H.C
P.H.C Vandeikya	Township	C.H.C

Source: Local Government Health Office (2022)

Key

H.C- Health Centre. B.H.C.- Basic Health Centre, CHC- Comprehensive Health Centre,C.H.C- Community Health Centre, MCHC- Maternal and Child Health Clinic, MPHC- Modern Primary Health Care, CSDP- Community Service Development Project, FSP- Family Support Programme, P.H.C- Primary Health Centre, MDGs- Millennium Development Goals, LGHC-Local Government Health Centre.

The common health problems in Vandeikya local government area according to a survey conducted by Ositta in 2008, include Malaria, Diarrhoea, Mal-nutrition, Anaemia, Sexually Transmitted Infections (STIs), Inflammation's, HIV/AIDS, Huminthitis (Worms), Lower Abdominal problems, Gastroenteritis etc.

Methodology

The descriptive survey design was used in conducting the study, this is to ensure accurate data is collected so that the results are interpretable and generalisable. The population of the study consists of all the Two hundred and Forty Eight (248) staff in the health department of Vandeikya Local Government Area of Benue State. While the sample size are twenty (20) sample staff at the headquarters and thirty-one (31) sampled staff from the various local government controlled health facilities in the twelve (12) council wards making a total sample size of fifty one (51) representing fifteen percent (15%) of the study population. The simple random sampling formula was used.

The face and content validity of the instrument checklist was established through the expert judgment of a superior scholar paying particular attention to their relevance to the subject matter and their coverage of the entire topic of study. To ensure that the instrument used in the study meet that critical criterion, factors which can affect reliability such as selection of subject and difficulties in understanding question posed are clearly eliminated.

Findings

The findings and discussions section is accordingly presented

Table 2: Frequency and Percentage of Personnel Challenges in Vandeikya Local Government Area

Personnel Challenges	Frequency		Percentage		Total	
	Agreed	Disagreed	Agreed	Disagreed	F	%
Inadequate and inequitable distribution of health personnel in Vandeikya Local Government	47	4	92	8	151	100
Theprovider-client relationship is very poor in Vandeikya local government	30	21	59	41	151	100
There is poor in incentive and compensation for health workers in Vandeikya local government	27	24	53	47	151	100

Source: Field Survey, 2022

The table 2 reveals that each personnel challenges has above fifty percentage 50% acceptance. Inadequate and inequitable distribution indicated the highest degree of acceptance – 92%. This is followed by provider-client relationship with 59%. Similarly poor incentive and compensation for health workers scored 53%.

Table 3: Frequency and Percentage of Functional Health Facilities in Vandeikya Local Government Area

Functional Health Facilities	Frequency		Percentage		Total	
	Agreed	Disagreed	Agreed	Disagreed	F	%
P.H.C centres are badly build below standard	41	10	80	20	51	100
Vandeikya local government health system is characterized by inadequate and poorly maintained health facilities	48	3	94	17	51	100
Health workers in Vandeikya local government lack the appropriate facilities and materials to do their job	33	18	65	35	51	100
The provision of health services relies on the availability of regular supplies of drugs and equipments	49	2	96	4	51	100

Source: Field survey, 2022

The table 3 reveals that each effect of the functional health facilities has up to above 60% acceptance. The provision of health service relies on the availability of regular supplies of drugs and equipment indicated the highest degree of acceptance 96%. This followed by Vandeikya local government health system is characterized by inadequate and poorly maintained health facilities with 94%. Similarly, health workers in Vandeikya local government lack the appropriate facilities and materials to do their job scored 65%. While, P.H.C centre in Vandeikya local government are poorly build and build below standard scored 80%.

Table 4: Health Personnel Requirement Need and Gap

Category	No. Available	Location	No. Needed	Gap
Doctor	Nil	Nil	1	1
CHO	7	HQ/HF	25	18
CHEW	81	HQ/HF	105	24
JCHEW	26	HQ/HF	98	72
N/M	19	HQ/HF	74	55
LABT	6	HF	56	50
LA	4	HF	58	54
EHO	3	HQ/HF	33	30
PT	Nil	Nil	10	10
OTHERS	102	HQ/HF	115	13
Total	248		575	327

Source: Field survey, 2022

Table 4 shows that the total number of personnel needed by the local government area is put at five hundred and seventy five (575), but two hundred and fourty eight (208) was available while the gap stood at three hundred and twenty seven (327) representing fifty seven percent (57%).

Summary of Findings

The PHC facilities are in the state of disrepair; there are absent or obsolete equipment and infrastructure; very poor human resource management; Inadequate and inequitable distribution of health personnel at various P.H.C; the provider-client relationship is also poor; there is poor incentives and compensation for health workers.

Discussion

The necessity of standard setting in the health services has become widely recognized in recent times. According to Heidemann (1993), the purpose of setting health standards as a tool in health services management is to strive to

achieve the highest quality of care possible within the resources available. Standards provide degree of excellence to be pursued in a given exercise. They provide the basis for monitoring, comparison, supervision and regulation of the given service. A key reason for standardizing Primary Health Care facilities is to make them instantly recognizable to all with regard to the service provided at the different levels (NPHCDA, 2004). The standards address the different levels of Primary Health Care service delivery outlets at the settlement, village, neighbourhood community level, political ward communities all the way up to the apex local government area facility. One of the specifications includes personnel.

Having acknowledged that the failure of primary health care in Nigeria can be partly attributed to the inadequate number and proportion of the various cadres of health care workers necessary to provide service in the health facilities, the National Primary Health Care Development Agency proposes the minimum number, mix and skill sets required in each facility type. The Cadres of staff, according to NPHCDA, are Community Health Officer (CHO), Nurse/Midwife, Community Health Extension Worker (CHEW), and Junior Community Health Extension Worker (JCHEW). Further, it is recommended that the cadres are matched to service based on their competence. By this standard, a comprehensive centre (C.A.C) is expected to have a minimum of twenty four (24) staff which includes: 1 Medical Officer (MO), 1 Community Officer (CO), 4 Nurses / Midwife, 3 Community Health Extension Workers, 1 Pharmacy Technician (PT), 6 Junior Community Health Extension Worker (JCHEW), 1 Environmental Officer (EO), 1 Medical Records Officer (MRO), 1 Laboratory Technician, 2 Health Attendants/Assistants (HAA), 2 Security Personnels (SP), and 1 General Maintenance Staff (M.S). Hence, Vandeikya Local Government Area with Seven (7) Comprehensive Health Centres (C.H.C) is supposed to have One hundred and Sixty Eight (168) staff managing the community health centres in the area. Similarly, by the National Primary Health Care Development Agency minimum standards for primary health care in Nigeria, a Basic Health Centre (BHC) and Health Centre (HC) is expected to have a minimum of twelve personnel which should include: 2 Midwifes or Nurse-Midwife, 2 CHEW, 4 JCHEW, 2 HAA and S.P. Hence Vandeikya local government area with a total number of 24 BHC and HC is supposed to have two hundred and eighty eight (288) personnel servicing the BHC and HC. The total number of personnel expected to be servicing the thirty one distributed health facilities in Vandeikya local government area is supposed to be four hundred and fifty six (456) excluding those expected at the local government head quarter.

As indicated in table 3:1 the number of health personnel required fall grossly short of those available.

From table 1.2 and 3, it was observed that the problem of inadequate personnel has informed the unfair distribution of health worker to the various facilities even though it was claimed that the distribution was based on location as shown below.

Table 5: Health Personnel Distributions in Vandeikya Local Government P.H.C

Health Facilities	Doctor	N/M	CHO	CHEW	JCHEW	EHO	SSCE	HATT	BATT	LT	TYPE
LGHC Mbaakon - Geri	-	-	-	4	-		1	-	3	1	HC
LGHC Ihugh	-	2	1	5			1	2		1	BHC
CHC Mbabagu	-	-	-	2	1	-	1	1	-	-	BHC
CHC Tyam	-	-	-	1	-	-	-	-	2	-	BHC
P.H.C Kiishi	-	1	-	2	-	-	-	-	-	1	HC
CHC Abaki	-	-	-	2	-	-	-	-	-	-	BHC
MDGS Anongo	-	-	-	2	-	-	-	-	3	2	HC
CHC Gbagbongom	-	-	-	2	1	-	-	-	1	1	BHC
P.H.C Gbem	-	-	1	8	2	-	-	-	1	2	CHC
CHC Mbakough	-	-	-	2	1	-	-	-	-	1	BHC
MDGS Taatihi	-	1	-	1	1	-	-	2	-	-	BHC
CHC Bako-Ute	-	-	-	3	-	-	1	-	1	-	BHC
P.H.C Imoughun	-	-	1	2	1	-	-	-	-	2	CHC
CHC Tse-Kpum	-	2	-	-	-	-	4	1	-	-	BHC
CHC Zor	-	-	-	-	2	-	-	-	1	-	BHC
MDGS Natu-Achaku	-	1	-	1	-	-	3	-	-	-	BHC
CSDP Aboho-Natu	-	-	1	-	-	-	-	-	-	-	BHC
CHC Tsua	-	-	-	2	2	-	2	-	-	1	BHC
CHC Mbagbatse	-	-	-	3	-	-	-	-	3	1	BHC
CHC Mbaagir	-	-	-	3	-	-	-	-	2	-	BHC
MDGS Bako-Ningev	-	1	1	1	2	-	1	2	-	-	HC
FSP Idyegh	-	-	-	2	1	-	2	-	1	1	CHC
CHC Aginde	-	-	-	2	-	-	-	-	-	1	BHC
LGHC Ityemimongo	-	1	-	3	-	-	-	-	2	-	HC
CHC Ageva	-	-	-	-	2	-	-	2	-	-	BC
CHC Ikpo-Ikpo	-	-	-	1	1	-	-	-	-	1	HC
MPHC Tsar	-	2	-	4	1	-	-	-	1	1	CHC
PHC Tsar	-	1	1	1	3	-	-	2	-	1	CHC
MCH Vandeikya	-	2	-	6	3	-	2		3	-	CHC
P.H.C Vandeikya	-	4	-	5	3	-	1	2	5	-	CHC
CHC Mbaause	-	1	-	2	-	-	-	2	-	-	BHC
L.G. HQS	-	2	2	15	1	-	10	5	-	-	HQ

Source: Field survey, 2022

In view of the population and ruralized nature of the local government area, its associated inadequate health personnel have necessitated the unfair distribution of health workers. It is a clear indication that some of the targeted beneficiaries of health services were not serviced. This constitutes a major problem. The WHO (2004) acknowledged that in recent years, the gap in human resources for health and its attendant implications on health outputs has become a major concern in developing countries. Thus, the hypothesis one which says that, inadequacy of health personnel constitute a major problem to the management of Primary Health Care in Vandeikya Local Government Areas is upheld in this study.

Record of a few past efforts to develop a minimum package of Primary Health Care services equipment and infrastructure are (i)the NPHCDA ward minimum health care package in Nigeria, (ii)the Basic Health Services Scheme contained in the Nigerian experience document, (iii)the WHO minimum district health package document, (iv)the background and status of P.H.C activities by 2000 in Nigeria document, (v)the NPHCDA/FMOH/WHO Draft Plan of action for the delivery of the ward minimum health care package in Nigeria, (vi)the FMOH/NPHCDA Operation Training and Guidelines for PHC in Nigeria and Natrategic Health Development Plan 2010-2015 (NPHCDA, 1988). These health frameworks provide specifications on expected equipments and infrastructure for all the Primary Health Care facilities including the Local Government Area Primary Health Care

office.

The minimum infrastructural standard for Basic Health Centre (BHC) and Comprehensive Health Centre were well spelt out in minimum standard for primary health care in Nigeria particularly in respect to building and premises. A Basic Health Centre is expected to be built on:

A minimum 1 and area of 2,475 square metres; Colour: Blue; A detached building with at least 5 rooms; Walls and roof must be in good condition with functional doors and netted windows; Functional separate male and female toilet facilities with water supply within the premises; Availability of a clean water source; at least motorized borehole; Be connected to the national grid and other regular alternative power source; Have a waste disposal site; Have a sanitary waste collection point; Be clearly signposted-visible from both entry and exit points; Be fenced with gate and generator houses; Staff accommodation provided within the premises: 2 bedroom apartment (FMOH/NPHCDA, 2004).

Fig. 1 A Minimum Standard for B.H.C

Source: FMOH/NPHCDA, 2004

Figure 1 presented above shows the minimum standard of a B.H.C, while figure 3:2 shows what is on ground in a typical B.H.C in Vandeikya local government area.

Fig. 2: A Typical B.H.C in Vandeikya Local Government Area

Source: Field Survey, 2022

Fig. 2 which represents Basic Health Centre in Vandeikya local government lacks about fifty five percent (55%) of infrastructures needed to measure minimum infrastructural standard for B.H.C. These includes; clean water source, fenced with gate and generator house, staff accommodation, functional separate male and female toilet facilities with water supply (toilet as insert) etc. and is below the minimum standard.

A Comprehensive Health Centre is expected to be built on a:

Minimum land area of 4,200 square metres ; Colour: Green (c) a detached building of at least 13 rooms; Walls and roof must be in good condition with functional doors and netted windows; Functional separate male and female toilet facilities with water supply within the premises; Have a clean water source from a motorized borehole; Be connected to the national grid and other regular alternative power source; Have a sanitary waste collection point;

Have a waste disposal site; Be clearly signposted-visible from both entry and exit points; Be fenced with generator and gate houses; and (l) staff accommodation provided within the premises: 2 units of 1 bedroom flats (N.P.H.CDA 2007).

Fig. 3: A Minimum Standards for C.H.C

Source: FMOH/NPHCDA; 2004

Figure 3 presented below shows the minimum standard of a C.H.C, while figure 3:4 shows what is on ground in a typical C.H.C in Vandeikya local government area.

Fig. 4: Typical C.H.C in Vandeikya Local Government Area

Source: Field Survey, 2022

Fig. 4 which represents a typical Comprehensive Health Centre in Vandeikya local government lacks about fifty five percent (55%) of infrastructures needed to measure minimum infrastructural standard for a CHC. These include functional doors and netted windows, functional separate male and female toilet facilities with borehole, fenced with generator and gate house, staff accommodation within the premise.

The performance of Primary Health Care is assessed yearly to find out whether there is progress in terms of dealing with or alleviating the health problems of people. This is assessed from the records of the eight aspects of P.H.C which act as the benchmark and rules to adhere to. Therefore, the performance of P.H.C in Vandeikya local government area within the period under study is in line with the Alma-Ata declaration, namely education, promotion of nutrition, sanitation, maternal and child care, immunization, prevention of endemic diseases, treatment of common disease and provision of essential drugs for treatment of injuries. The functionality of these aspects is assessed by referring to the percentages reflected in table 3:3. The health workers clearly highlighted that even though P.H.C has got eight components in all, it has not been possible for them to deliver all the service equally due to some problems which include lack of ambulance, functional bicycles and functional motorcycles. Lack of facilities or essential equipment is another problem encountered by health workers. They

have bad health centre infrastructure, unhealthy toilets and no refrigerators for the storage of strong vaccines.

Table 5: Performance Indicators of Primary Health Care in Vandeikya LGA

PHC aspec ts and indicators	2010	2011	2013	2014	2015
Education	30%	23%	17%	15%	10%
Promotion of nutrition	7%	5%	5%	3%	3.4%
Sanitation	82%	73%	56%	34%	28%
Maternal and Child care	61%	47%	46%	47%	40%
Prevention of endemic diseases	-	-	-	-	-
Treatment of common diseases	21%	42%	20%	20%	20.4%
Immunization	40%	50%	52%	71%	74%
Provision of essential drugs	55%	50%	61%	52%	56%

Source:*Statistic Year book, PHC LGA HQ (2015)*

Education about prevailing diseases found to be a functional area in the P.HC, had approximately 10% success rate in 2015. Such it could not equipped many community members with knowledge to reduce susceptibility to the prevailing diseases that could infect and affect them adversely. This item witnessed tremendous decrease considering the fact that it had an approximately 30% success rate in the year 2010. The only item that witnessed tremendous increase and steady improvement on table 3:3 was immunization. This is because it is basically a cooperation of Federal, State and Local Government in response to the Federal Government Extended Programme on Immunization. Thus, hypothesis two which says that, "lack of functional health equipment and infrastructure has affected the performances of Primary Health Care in Vandeikya Local Government Area" is upheld in this study.

Conclusion and Recommendations

The study examined local government and the management of Primary Health Care in Vandeikya Local Government Area of Benue State. The roles of local government at the various levels of fixed health facilities were examined. These include the minimum standards for P.H.C structures; systems; staffing; infrastructure; equipment and P.H.C service delivery to improve access and quality of services. The findings of the study show that the Local Government Area is running her Primary Health Care Service Delivery in non-compliance with minimum standards for primary health care in Nigeria. The available health workers were unequally distributed to the various health facilities. Comparatively, the Local Government Area Primary Health Care programme is under-staffed and ill equipped compared to some other local government areas in the country. The health education units were being under utilized for proper education, mobilization, monitoring and evaluation of all health activities. The finding of the study also shows that the status of performance of health service in Vandeikya local government leaves much to be desired. There is room for improvement.

On the whole, Vandeikya can be adjudged as a local government where Primary Health Care is not given adequate attention. There exist major problems which vary from personnel scarcity to uneven distribution of resources. This study has argued that the state of Primary Health System in Nigeria and especially in Vandeikya Local Government is critically a function of her persistent failure to demonstrate her real commitment to the attainment of the desired level of health that would enable all Nigerians to achieve socially productive lives. Lack of basic infrastructure and equipment, poor human resources and management as well as inadequate and inequitable distribution of health personnel at various health facilities are some of the basic challenges which are cogs in the wheel of progress of the Local Government Primary Health Care in Vandeikya in particular and Nigeria at large.

Based on the findings of the study, the following recommendations are made.

The local government as well as other tiers of government should ensure that significant and adequate proportion of its income is committed to the health sector development. Also related to this recommendation is the fact that local

government should be more inward-looking and aggressive in the area of internally-generated revenue. The merger nature of internally-generated revenue by (Vandeikya) local government area can do nothing in financing health services, hence stepping up will reduce the dependence on the federation and state account in financing health programmes. This will perhaps make the goals of Primary Health Care attainable.

In other to enhance better healthy living, priority should be given to improved living condition of the people. This could be done by intensive and effective health education to enable people to prevent and control some diseases even when they have been infected. This is possible because now they have some knowledge necessary with regards to what to do and what not to do. The information provided should be expressed in a simple but quantitative form, starting from simple matters such as personal hygiene, and gradually progressing towards more comprehensive health education, fostering behavioural changes and community action for health.

Health facilities should also be made adequate to all communities in the local government. They should be equipped with the necessary infrastructure, facilities and tools in line with the minimum standards for Primary Health Care in Nigeria. Adequate supervision, monitoring and evaluation of programmes should be pursued with vigor and required manpower provided. Special priority should be given to the training of more rural health workers, so as to prevent the drift of rural health workers from the rural communities to the urban centres.

References

Abdulkarim, S.B. and Saleh, L. (2007). Public health care policy in Katsina State: problems and challenges. *The Nigerian Journal of Administration Studies 5(2),* 1-11.

Abdulraheem, I.S. Olapipo, A.R. & Amodu, M.O. (2012). Journal of Public Health and Epidemiology *4*(1), 5 – 13.

Adeyemo, D.O. (2005). Local government and health care delivery in Nigeria: A case study *J. Hum. Ecol.2* (18),149-160.

Awofeso, O. (2005). *Element of public administration.* M.C. Grace Academic Resources Publishers

Durkheim, F. (1933). *Division of labor in society.* G. Simpson. Trans. Macmillan

Federal Government of Nigeria (1979). *The constitution of the federal republic of Nigeria.* Lagos: Government Press

Federal Ministry of Health (1987). *National Health Policy,* Nigerian National Health Bill.

FGN (1996). *Guidelines for local government reform*. Kaduna Government Printer

FMOH/NPHCDA(2004) Operational training manual and guidelines for the development of P.H.C system in Nigeria, Abuja.

Gboyega, A. (1987). *Political value and local government in Nigeria.* Malthouse Press Ltd.

Gupter M.D., Gauri, V. and Klumani, S. (2004). Decentralized delivery of Primary Health Services in Nigeria: Survey evidence from the state of Lagos and Kogi. The World Bank.

Hilhorst, T. and Baltissen (2007). *The contribution of local government to economic development in rural areas: First draft for discussion*. Amsterdam: Royal Tropical Institute.

Holmwood, J. (2005). Functionalism and its critics. In Harrington, A. (ed) *Modern social theory: An introduction.* Oxford University Press

Mackenzie W.J.M. (1964). *Exploration in government.* Macmillan

Malinowski, B. (1922). *Argonauts of the Western pacific.* Dutton

Merton, R. (1957). *Social theory and social structure revised and enlarged.* The free Press of Glencoe

National Population Census (2006). Federal republic of Nigeria official Gazzete.

Obansa, S.A.J. & Orimisan (2013). Health care financing in Nigeria: Prospect and challenges. *Mediterranean Journal of Social Science* 1 (4), 221-235.

Obioha, E. F. and Molale, M.G. (2011). Functioning and challenges of primary health care programme in Roma Valley. Lesotho. *Journal of Ethno-Medicine 2*(5)73-88.

Ola, R.F. (1984). *Local government in Nigeria.* Kegan Paul International

Oyewo, A.T. (1991). *The application of presidential system into Nigeria local government.* Jator Publishing Co.

Persons, T. (1951). *The social system.* Routlege

Radeliff-Brown, R. (1952). *Structure and function in primitive society.* The Free Press

Sani, M. (1990). *Integrating federal health resources at the local level: A case study of the development of national primary health care delivery system.* M.P.A. field report: Obafemi Awolowo University, Ile-Ife

Schultz, E. & Lavenda, R. (1995). *Anthropology*. Californian: Mayfield Publishing Company

Strauss, J. and Thomas D. (1998). Health nutrition and economic development. *Journal of Economic Literature*, 2 (36), 766-817.

Tones, K. (1995). The health promoting, *Hospital Health Education Research* 10 (2).

Turner, J. (1985). *Herbert Spancer: A renewed appreciation.* Beverly Hills: Sage

Ugoh, S.C. & Ukpere, W.I. (2009). Problems and prospects of budgeting and budget implementation in local government system in Nigeria. *Africa Journal of Business Management* 17(3), 838-846.

Vandeikya Local Government (2016). Statistic yearbook. P.H.C Head office.

Whitaker, T.R. (1970). The politics of tradition continuity and chance in northern Nigeria, Princetor

World Health Organization (1978). Primary health care. *Report of the international conference on primary health care: Alma-Ata.* USA. 6-2 September