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LOCAL GOVERNMENT AND THE CHALLENGES OF PRIMARY HEALTHCARE DELIVERY IN KEFFI LOCAL GOVERNMENT AREA OF NASARAWA STATE

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Abstract

Primary healthcare as a decentralized medical service at the community area in Nigeria is bedeviled with challenges. In other words, this study takes a critical look at the challenges militating against primary health care delivery at the local levels in Nigeria with reference to Keffi Local Government Area of Nasarawa state. The study examines the efforts and challenges of Keffi Local Government in improving the health care service in Keffi rural communities. In reference to the methodology of this study, it adopted a survey design with relied heavily on primary source (structured questionnaire) as instrument of data collection, quantitative likert scale of data analysis and Easton's political system framework for empirical analysis. After data were collected, presented and analysed, the study revealed that primary health care delivery is fraught with challenges (such as inadequate funding, drugs, quality service, corruption and etc.) which stem from the abysmal failures of Keffi Local Government management. The study therefore recommends measures such as improved budgetary allocation, strengthening the supply chain of drugs, enhanced clinical service as conditions imperative for improved health care service delivery in Keffi rural communities of Nasarawa State.

Keywords: Health, Policy, Funding, Quality Service and Medical Service

1. Introduction

Government is the bedrock of sustainable human development. This is because government emerged from the exigencies of needs as clearly illuminated by Appadoari (1975), Government may be defined as the agency or machinery through which the will of the state is formulated, expressed and realized.

Thus, the will of the state therefore underscored the imperative and expediency of governance. To this end, governance as the primary responsibility of government is aimed at improving the social wellbeing of the people and mitigating their problems.

State as a territory of sovereign authority is made up of an aggregation of indigenes and aliens alike. The population that reside at urban and rural settlements (Okwu, 2010). This population irrespective of locations of residence is governed and daily faced with challenges of social wellbeing. Decentralization of power and responsibility becomes crucial to attain the targets of governance. Hence, Adejo (1998) therefore

embellished the fundamental purposes of what is termed "local government"

Being the lowest and nearest tier of government to the people, local governments all over the world are established to accomplish multi-purpose services in every community irrespective of political arrangement in favour of federalism or unitarism.

The idea of local government is to bring governance closer to the people in the grassroot for participation in governance, service delivery to enhance socio-economic development and good governance (Ogunna, 1996).

In this regard, local government is the government of the grassroots. It is an institution that is poised to respond to the daunting challenges of rural development. As Ugwu (2000) remarked that,

The importance of local government to rural and national development cannot be over emphasized. Acknowledged as a viable instrument for rural development and for the delivery of social services to the people. It is believed that the third tier of

government is strategically placed to fulfill the above functions because of its proximity to the rural people which enhances its ability to easily articulate and aggregate the demands of the people.

One of the social challenges of the ordinary people in Nigeria is primary healthcare. Accordingly, the goal of the National Health Policy (1987) as cited in Abdularhim *et al* (2012) indicates.

Comprehensive health care system based on primary health care that is promotive, protective, preventive, restorative and rehabilitative to all citizens within the available resources to that individuals and communities are assured of productivity, social-well-being and enjoyment of living.

To this end, decentralization of the Health Service becomes imperative in improving the health condition of the ordinary people through quality, adequate and affordable medical care.

Uzochukwu, *etal* (2014) asserted that the key vehicle to drive health sector reform is decentralization in respect of health which emerged at the wake of Primary Health Care (PHC) conference at Alma-Ata in 1978. The 1978 Alma-Ata declaration was conceived as strategy that could enable district development and inter-sectoral collaboration was closely associated with the primary health care approach.

In other words, the District Health System which is a form of decentralization was introduced in KeffiState as a policy to reform the health sector and its functionality. Thus, the local governments are responsible for primary health care delivery. They are to budget, implement, manage, monitor and evaluate primary health care within the local area. Local government is to discharge this service at affordable price using appropriate methods and technologies (Fajiobi, 2010).

However, amid these lofty goals, the practice of primary health care is constrained as remarked by Amodu and Olapipo (2011),

The goal of primary health care in Nigeria was to provide accessible health for all by the year 2000 and beyond unfortunately, this is yet to be achieved in Nigeria and to be unrealistic in the next decade.

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).

In this discourse, the researcher examines critically the efforts of local government in dealing with the challenges of primary health care delivery in Nigeria with reference to Keffi Local Government Area.

Basically as earlier indicated, Nigeria public health system is bedeviled with problems which as remarked by National Health Policy (1999),

The health sector in any economy forms the bedrock of its growth and development. The factors that affect performance include:

- (i) Inadequate health facilities and structure
- (ii) Poor management of human resources
- (iii) Poor motivation and remuneration
- (iv) Inadequate and unsustainable health care funding
- (v) Skewed economies and political relation
- (vi) Corruption, illiteracy, decreased government spending on health, disease prevention, shortage of essential drugs and supplies inadequate health care provider etc.

In addition, strategies developed for effective implementation of national health program in the three tiers of government (Federal, State and Local government) are poorly implemented and culminated in a vicious cycle of poverty, insecurity and uncertainty (Anyika, 2014).

More cursory observation of the practice of primary health care showed abysmal performance and inadequacies. In this sense, Abdusalam, *et al* (2012) observed that most primary health care facilities were in various state of disrepair with equipment and infrastructure being either absent or obsolete and the referral system is almost non-existent.

Perhaps, these limitations may be attributed to crises of local government administration in Nigeria. In this vein, Ugwu (2000,) remarked that,

Despite the strategic importance of local government to the national development process, its contribution has been minimal

when compared to the amount of resources which accrue to it in the present dispensation.

In reference to the decentralized health system, the District Health System (DHS) is aimed at improving health system performance and its implementation relies on human capacity. In Keffi like other states of the federation is inherent with the institutional inadequacies. In this regard, Uzochukwu *et al* (2014) documented,

The health sector was ineffective, inefficient and inequitable in Keffi State as was also in the case in other parts of Nigeria. The Health infrastructure especially in the Primary Health Care centers was in state of neglect and dilapidation. This is meant that those in more remote locations where the poor had to travel long distance to access good quality health care service. This increasing the cost of cares for most citizens especially the poor that reside in these remote areas.

Primary Health Care, PHC is fraught with militating challenges occasioned with the crises of governance at local authority level. However, critical assessment of the practice of Primary Health Care in Keffi and, the role of the local government underscored the thrust of this work.

The study wills analysis the following objectives:

- i. To examine the concept, historical relevance and targets of primary health care in Nigeria.
- ii. To examine the strategic importance of local government in the primary health care delivery in Nigeria.
- iii. To examine the challenges bedeviling primary health care practice in Keffi Local Government Area.
- iv. To establish measures through which local government can respond efficiently to the challenges of Primary Health Care delivery in Nigeria.

This study is guided by the following hypothetical propositions:

Ho: There are no challenges bedeviling primary healthcare delivery in Keffi Local Government Area of Nasarawa State.

Ho: There are no factors responsible for the challenges that confront primary health care delivery in Keffi Local Government Area of Nasarawa State.

Ho: There are no adverse effects that stem from the challenges of primary health care delivery in Keffi Local Government Area of Nasarawa State.

Ho: There are no measures through which the local government can improve on the inadequacies of primary health care delivery in Keffi rural communities.

2. Literature Review

2.1 Conceptual Issues

Concept of Local Government

The term, local government is defined in various ways by scholars and practitioners of community governance, politics and development. It therefore a fact that the concept elicits plethora of perspectives among scholars of political science, public administration and development studies. In this remark, Awofeso, (2003) stressed that,

Whether described as the government of the local level", the lowest tier of government, "the government at the grassroot levels" or the closet government to the people as variedly defined by different scholars and authors.

Local government has been defined as the lowest unit of administration to whose laws and regulation, the communities who live in a defined geographical area and with common social and political tiers are subjects (Ugwu, 2000).

In similar sense, Ogunna (1996) indicated that, "Local government is a form of devolution of political powers of the state. It is the government of the grassroots which is designed to serve as an instrument for rural development".

Furthermore, Awofeso (2003) identified the definitional attributes of local government, as obvious under the following:

- (i) An organized entity with distinct territorial boundaries.
- (ii) A corporate and legal personality with powers to perform some specified functions.
- (iii) A system of representation through election of principal officers, effective citizen participation and in-built accountability.
- (iv) Substantial autonomy over finance and staffing with limited and complementary central control.
- (5) Local government is said to provide local people a classroom for political education in a citizenship and in training future leaders.
- (6) It affords a considerable opportunity for contribution to national development.

Similarly, Local Government Administration Bye-laws (2010) outlined the fundamental roles of local government in Nigeria federation.

To this extent, local government is administrative machinery established to govern and develop the people at the community or local level. Hence, local government is established to mobilize rural people towards governance and stimulate socio-economic and industrial development of the rural areas.

Precisely, local government is a purposeful institution. It is therefore created to respond to peculiar challenges and expectations. In this vein, Fajiobi (2010) explicitly outlined the need or purpose for local government:

- (1) Government at the Door Steps: By the creation of local government, the local communities are thus afforded the opportunities having a self-government at their door step or within their reach.
- (2) Local Talents: when local people do things themselves; local talents will be identified and those will be used for considerable advantages at a comparative level.
- (3) Local government plays an important role in the provision of essential services to its people e.g. markets, dispensaries, roads etc.
- (4) Community projects are often developed and undertaken since the central government cannot provide all the services needed by the people. This may be due to transport difficulties, cultural differences and of course ignorance of the government officials. Thus, local government makes for flexibility and experimentation in that it allows local communities to discretionally provide services for their peculiar needs through communal efforts.
1. The main functions of a Local Government Council are as follows:
 - (a) The consideration and the making of recommendations to the state commission on Economic Planning or any similar body on:
 - (i) The economic development of the state, particularly in so far as the areas of authority of the council and of the state affected, and
 - (ii) Proposals made by the said commission or body.
 - (b) Collection of rates, radio and television licenses
 - (c) Establishment and maintenance of cemeteries, burial grounds and homes for the destitute and infirm;
 - (d) Licensing of bicycles, trucks (other than mechanically propelled trucks), canoes, wheel barrows and carts;
 - (e) Establishment, maintenance and regulation of slaughter house, slabs, markets, motor parks and public conveniences;
 - (f) Construction and maintenance of roads, street lighting, drains and other public highways, parks, gardens, open spaces or such public facilities as may be prescribed from time to time by the House of Assembly of a state.
 - (g) Naming of roads and streets and numbering of houses.
 - (h) Provision and maintenance of public conveniences, sewage and refuse disposal;

- (i) Registration of all birth, deaths and marriages;
- (j) Assessment of privately owned house or tenements for the purpose of levying such rates as may be prescribed by the House of Assembly of the state, and
- (k) Control and regulation of
 - (i) Outdoor advertising and hoarding
 - (ii) Movement and keeping of pets of all description
 - (iii) Shops and kiosks
 - (iv) Restaurants, bakeries and other places for sale of food to the public
 - (v) Laundries and
 - (vi) Licensing, regulation and control of the sale of liquor

2. The functions of a Local Government Council shall include participation of such council in the Government of a state as regards the following matters:

- (a) The provision and maintenance of primary, adult and vocational education.
- (b) The development of agriculture and national resources other than the exploitation of minerals.
- (c) Such other functions as may be conferred on a Local Government Council by the House of Assembly of the state.

A cursory examination of the established functions indicate that local government emerged to respond to the needs of the community people through administration of social welfare and socio-economic development of the rural people. And one of such expectation is ensuring adequate health care service for the community people

To achieve these laudable targets, local government operates broad organizational framework termed as the structure of local government. The structure of a local government system refers to the territorial organization of the local government. It is a crucial factor as it affects its finance, functions and personnel. The local government structure is concerned with the size of a local government area and the number of tiers of a local authority (Ogunna, 1996).

2.2 Empirical Review

The Evolution and Challenges of Local Government System in Nigeria

The development of local government in Nigeria has a long history. Its structures and process are entrenched during the British colonial administration. However, some other scholars traced the evolution of local government to the period of pre-colonial period as Minna (1993) indicated that the genesis of the local government system in Nigeria dates back to the pre-colonial era and the formative period of large-scale kingdoms and powerful empires in the country. The existence of provincial systems, which operates in Borno and Oyo empires as well as the emirate system of Sokoto Caliphate exhibited rudimentary conception of local government administration.

Local government system has taken different forms from one period to other in Nigeria. We have pre-colonial experience culminating in different traditional political systems, viz: the Yoruba, Igbo and Hausa political systems. We had the indirect rule system whereby such governments were being run through the traditional rulers, the chiefs or the warrant chiefs. After these, there had been series of reforms in the Nigerian local government system. For instance, in the Eastern Region, we had the local government reforms of 1955, 1958, and 1960. In Western Region, we had the 1952 local government law, 1957 local government law, the Sole Administrators regime during the military system of local government in 1976, etc. (Fajiobi, 2010).

Significantly, the 1976 local government reform is a watershed in the development of local government system in Nigeria.

The objective of the reform set out briefly in the guidelines to the 1976 Local Government Reforms is stated as follows:

The reform of our system of local government is not only important and desirable in itself but it is a crucial element in the political programme of the Federal Ministry of government which was essentially motivated by the necessity to stabilize and rationalize government at the local level. This must of necessity, entail the decentralization of state

governments to local levels in order to harness local resources for rapid development. local government should do precisely what the word government implies, that is governing at the grassroots or local level.

Accordingly, Ugwu (2000) remarked that the 1976 reform was a landmark in the development of local government system in Nigeria. It had the following significant features:

- (a) There should be a local government council which would operate through a uniform single tier local government structure all over the country.
- (b) Complete democratization of local government system. This system tactfully removes the control of local government from traditional rulers.
- (c) The abolishing of provincial and divisional administrations which in essence means the removal of the control of local governments from state government.
- (d) The local government councils operated through Chief Executives.
- (e) The creation of 307 local government councils.
- (f) Provision was made for the first in the history of local government in Nigeria for the statutory allocations to be made by both the federal and state governments to the local governments.
- (g) The establishment of local government service Board, which is charged with the responsibility for recruitment, posting, promotion and discipline of senior staff in the local government.

After this remarkable period, there has been series of reforms initiated by successive military regimes to reform and reposition Nigeria local government system for efficient and effective service delivery at the rural or community levels.

Beside these strides, local government system in Nigeria has not performed efficiently and effectively towards the plights and expectations of the rural people. In this regard, Fajiobi (2010) indicated.

Lack of adequate funds and appropriate institution had continued to make local government system ineffectual. Moreover, the staffing arrangement system had been inadequate. Excessive politicking had made even modest progress impossible. Consequently, there has been a divorce between the people and government of their most basic level.

Furthermore, Udentia (2007) explicitly identified militating conditions towards community development which invariably underscore the failure of local government. These include:

- (i) Underdevelopment-which is a major obstacle as the technological technical devices and base/backstopping are not there.
- (ii) The intellectual bankruptcy of the leaders and the led. Ignorance is dangerous, though it is terrible bliss.
- (iii) High level of poverty - which flows from the foregoing factors already raised.
- (iv) High unemployment rate which makes people vulnerable to criminal and disruptive tendencies. It may rise to the psychopathology involving much grievance against the community to the point of hatred for community and involvement, therefore, in anarchist, terrorist activities.
- (v) Intra and inter-communal crises which disturbs and creates much turbulence for the whole concept of community. Sometimes, the intra and inter-communal crises are such that the damages inflicted require several decades and scores of years as regards the healing of wounds.

Concept of Primary Health Care

It is expedient to note that health/health sector is one of the viable pillars for sustainable growth and development. This is in credence to a popular maxim that, "a health nation is a wealth nation". This assertion becomes more imperative within the context of locality and community development. To this extent, Primary Health Care is therefore medical service delivery at the community area.

The term, Primary Health Care (PHC) was officially launched in 1978 at a World Health Organization (WHO)/UNICEF Conference in Alma-Ata in the former Soviet Union at which some 150 governments were represented (Robson and Brown, 2016:1). In other words, the etymology of “Primary Health Care” can be traced to the global Conference at Alma-Ata where critical issues of national, regional and world health challenges were examined.

Subsequently, the Alma-Ata declaration (World Health Organization, 1978) defined Primary Health Care as follows:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and the country afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system of which it is central function and main focus and of the overall social and economic development of the community.

Also, Primary Health Care is the first level of contact of the individuals, the family and the community with national health system bring health care close to where people live and work and constitute the first element of a continuing health care processes (Amason 2010) it implied that primary health care is medical services provided for individual and community survival and development. It is easily accessed and made available to the community and families by relevant institutions and government.

The Basic Elements of Primary Health Care

The basic elements of primary health care delivery as declared by Alma-Ata conference in 1978 are:

1. Health Education
2. Identifying and controlling prevailing health problems
3. Food supply and proper nutrition
4. Provision of safe water and basic sanitation
5. Maternal and child health care including family planning
6. Immunization
7. Prevention and control of endemic disease

8. Appropriate treatment of common disease and injured
9. Promotion of mental health
10. Provision of essential drugs

Accordingly, Merriam and Joyce (2007) established the roles of primary health care as identified by the World Health Organization, WHO

1. To provide continuous and comprehensive care.
2. To refer to specialist and/or hospital service.
3. To coordinate health service for patient.
4. To guide the patient within the network of social welfare and public health services.
5. To provide best possible health and social services in the light of economic consideration.

Primary Health Care in Nigeria Local Government System

Accordingly, Fajiobi (2010) remarked (as earlier indicated) that local governments are responsible for primary health care delivery. They are to budget, implement, manage, monitor and evaluate primary health care within the local government areas. In Nigeria local government system, the primary health care delivery is premised on eight components which are:

- i) Health Education
- (ii) Maternal and child health including family planning
- ii) Immunization
- iii) Prevention and control of disease
- iv) Adequate water supply and sanitation
- v) Food supply and nutrition
- vi) Provision of essential drugs
- vii) Treatment of minor ailments

These components and structures stem from the country's health care system.

A Health care system comprises all medical care services involved in prevention, diagnosis, treatment and rehabilitation service as provided by the government, public and private institutions (Tandon, et al 2013). Again, health care system comprises of four-model: The individual, patient, the care, complex system of interacting approaches of human health that has an ecological base that is economically and socially viable indefinitely. In Nigeria, health care is funded by a combination of tax revenue, donor

funding, user fees and health insurance, social and community (Anyika, 2014).

The Nigerian government is committed to quality and accessible public health services through provision of health care at the community areas as well as provision of preventive and curative service (Nigeria Constitution, 1999). Primary Health Care (PHC) is provided by local government authority through health centers and health posts and they are staffed by nurses, midwives, community health officers, health technicians, community health extension workers and by physicians (doctors) especially in the southern part of the country.

The service provided at these PHCs include:

- (a) Prevention and treatment of communicable disease
- (b) Immunization, maternal and child health service
- (c) Family planning, public health education, environmental health and collection of statistical data on health and health related events.

The health care delivery at LGA is headed politically by a supervisory councilor and technically and administratively by a PHC coordinator and assisted by a deputy coordinator. The PHC coordinator reports to the LGA Chairman (Adeyemo, 2005, Federal Ministry of Health, 2004). The different components of the LGA PHC are led by personnel of different diverse specialty. The LGA is running her primary health care service delivery in compliance with the framework principles of the National Health Policy (Nigerian National Health Bill, 1987).

Similarly, primary health system in Nigeria inspite of its strides and remarkable achievement over the years is still constrained with challenges that stem from the governance and leadership, service delivery and funding. In this vein, Eyitayo (2015) remarked that inadequate political commitment to primary health care development, the limited resources and failure of effectively managing the PHC, lack of logistic facilities to facilitate taking service to remote areas, quality of service are generally poor, low priority accorded to health at all levels especially at local government, under staffing of many of the PHC facilities, poor management of health workers etc. These problems identified are undoubtedly the

unpleasant situations in Nigeria rural areas as revealed below:

Challenges of Primary Health Care in Nigeria Rural Areas

The essence of health care to the local government is to make the management of PHC services more effective and closer to the grassroots. However, in view of the level of health awareness, one begins to question the extent to which health care has been taken to the doorstep of the rural people (Abdulsalam, etal 2012). One of the hindrances to the development of health especially in Nigeria has to do with insufficient number of medical personnel as well as their even distribution. The Third Development Plan (1975 to 1980) for Nigeria was the first to draw attention on the inequality in the distribution of medical facilities and manpower/ personnel. Despite the desire by the government to ensure a more equitable distribution of resources, glaring disparities are still evident. The determination in government facilities, low salaries and poor working condition had resulted in a mass exodus of health professionals (Iyun, 1998).

Subsequently, another significant problem in the management of the PHC is transportation. It has been reported in LGA, PHCs that there are not enough vehicles for workers to perform their task especially to the rural areas. Immunization outreach services are inadequately conducted. The maintenance culture of the existing vehicle is poor while PHC vehicles were used for other purposes other than health related activities. To put succinctly, many of the PHC vehicles donated by UNICEF in the 1980's is totally non-functional (Wicasch, & Olowu, 2016).

Access to many parts of the communities is a function of national topographical and weather conditions ([http://Hen.wikipedia.org/wiki/Geography of Nigeria](http://Hen.wikipedia.org/wiki/Geography_of_Nigeria)); inadequate finance, over dependence of the LGA on federal state and international agencies for support and the internally generated revenue of the LGA is meager (Adeyemo, 2005), have level of community involvement (Omoleke, 2005), general misuse abuse of the scare resources by some political and high leadership turnover at LGA (Adegawo, 2005).

Succinctly, there are obvious challenges bedeviling the tertiary and secondary health delivery systems in

Nigeria. As Abdusalam et al (2012) remarked that people living in remote areas show an adaptability that allows them to adjust to the adverse conditions. Critical observation of since groups of nomads for example the Fulanis and fisherman from the core northern states, the migrant, the farmers from Benue State, reveals satisfaction, physical health and increasing resistance to disease or illness but they are not without health problems. The health and health-related problems of nomads, migrant farmers and rural people include:

- (i) Poverty associated with poor housing, unsatisfactory environmental sanitation, polluted water and food which predispose to malnutrition and infectious disease.
- (ii) Uneven distribution of health services, and shortage of physicians, nurses and trained health personnel in rural areas.
- (iii) High mortality and low average life expectancy due to lack of access to health services. It is unfortunate that systematically collected data are lacking about levels of morbidity in rural communities. Despite the availability of PHC services, some rural dwellers in Nigeria tend to underuse the services due to perception of poor quality and inadequacy of available services. Furthermore, Sule et al (2008) indicates that various reasons can be adduced for the underuse of the services provided.
 - (a) difficulties associated with transportation and communication.
 - (b) high rate of illiteracy among rural people.
 - (c) traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which increase the patronage of the services of traditional healers.
 - (d) Lack of understanding of Primary health care practice among health professionals and decision makers resulting poor quality services.
 - (e) A tendency to press older children into adult responsibilities early, resulting in psychological problems due to role conflict.
 - (f) Endemic disease prevalence such as malaria and trachoma.

- (g) Zoonotic diseases as a result of their close contact from the work place.

Basically, these challenges prevailed in most local government areas across the country including Keffi. As earlier remarked primary health care is facilitated by decentralized health system alternatively known as the District Health System. It is therefore important to examine the nature and structures of Keffi District Health System to further provide insight on the structures and dynamics of primary health care system in the state.

The District Health System in Nasarawa State

Nigeria is a federation of decentralized structures of governance and institutions. Health care delivery is also decentralized to meet the health needs of the citizens at the levels of state and local governance. The District Health System (DHS) is a decentralized health care structure and service, As Uzochukwu et al (2014), embellished,

The District Health System (DHS) is a form of decentralized provision of health care where health facilities, health care workers' management and administrative structures are organized to serve a specific geographic region or population.

The Nasarawa State District Health System delivers health care service to a defined population with a geographical area (varying in size from 16,000 – 60,000) and through various categories of health facilities. The policy is delivered under a structured management system (the district health management team) which integrates the primary and secondary level of health care. This structure was intended to eliminate the duplications/parable service provision and inefficiencies of the old stratified health care system through ensuring a functional referral system between the three levels of care, thereby increasing efficiency and equity in health care provision utilization (SMOTH, 2004) enhanced community involvement in planning and implementation in the DHS leading to a level of community accountability in the implementation. (Uzochukwu, 2015).

The District Health Service comprises of health care facilities under District Health Authority (DHA), health post, health clinic, community health centers, in

Nasarawa State, the District Health Service comprises the following categories of health care facilities under each District Health Authority (DHA): they are;

- (a) health post
- (b) health clinic
- (c) community health centers
- (d) cottage hospitals
- (e) district hospital with a tertiary hospital as an apex referral center for the state.

In this existing structure, the apex state tertiary health facility is the Nasarawa State Dalhatu Araf Specialist Hospital at Lafia. The district hospital is linked to and controls all the primary health care centers and cottage hospitals within the district so as to ensure that each health facility is founded in health service appropriate to their resources, capacity and role. The district hospital also serves as the focus of its secondary care and as referral center. As a minimum standard, the district hospital should contain six departments which are:

- (i) medicine
- (ii) surgery
- (iii) obstetrics and gynecology
- (iv) paediatrics
- (v) laboratory and
- (vi) pharmacy (Ikenna et al, 2009:9)

To ensure effective coordination control and accountability four layers of authority were established:

- (a) The Policy Development and Planning Directorate (PDPD)
- (b) The State Health Board (SHB)
- (c) The Health Authority (HA)

These layers have their respective members and peculiar functions.

The schematic representation of the functional links of the component levels of the DHS and the referral mechanisms of the facilities within the DHS.

From the above analysis, it can be deduced that local Health Authority illuminates the strategic importance of primary health care. In this regard, primary health care is one of the pillars or components of the Nasarawa State Health District System.

3. Methodology

3.1 Research Design

The research design of this study is a survey design. The study adopted a cross-sectional survey design. Hence, Ezech (2004) remarked that cross-sectional survey design takes a photographic situation report of issues and phenomenon and events. It is appropriate and suitable for this study particularly with reference to the plights, values and ideas with regards to the challenges of Primary Health Center in Keffi and the appropriate roles of the local government in this regard.

3.2 Area of the Study

Keffi Local Government Area is one of the thirteen local government areas in Nasarawa State. It has an area of 383 km² and a population of 279,089 with reference to 2006 census and its headquarter is Keffi town (NBS, 2024).

In reference to health care facilities, the Keffi Local Government Area has the following Health Centers and Cottage Hospitals.

Table 1: Health Centers in Keffi Local Government Area

S/N	Types of Facilities	Community
1	Keffi Health Centre	Angwan Lambu
2	Keffi Health Centre	Korofi
3	Keffi Health Centre	Kofar-Pada
4	Keffi Health Centre	Dadin-Kowa
5	Keffi Health Centre	Sabon-Gari
6	Keffi Health Centre	Angwan Nimzo
7	Keffi Health Centre	Old Barrack
8	Keffi Health Centre	Makwala
9	Keffi Health Centre	Tutun Amama

10	Keffi Health Centre	Jigwada
11	Keffi Health Centre	Angwan NEPA
12	Keffi Health Centre	Pyanku
13	Keffi Health Centre	Kofar Hausa
Total		13 communities

Source: Office of the Head, Personnel and Administration, Keffi Local Government Area, 2024.

It is important to note that these health centers were built by the local government and have reasonably number of qualified health personnel. Indigenes and non-indigenes in the local government area visit the Health Centers. And, services provided by the Health Centers include, child delivery, HIV/AIDS counseling, immunization, treatment of sickness etc.

3.3 Population of the Study

The population of this study stretch across health personnel (doctors, nurses) local government staff and indigenes. The researcher established or targeted population figure of over 10,000. However, the researcher decided to limit the figure to 2,700 as distributed below.

Table 2: Population of the Study

Categories of population	Number
Doctors	26
Nurses	52
Auxiliary Nurses	130
Community Public Health Personnel	200
Ward Politicians	142
Local government staff	150
indigenes	2000
Total	2,700

Source: Field Survey, 2024.

3.4 Sampling Technique and Sample Size

To determine the sample size, the researcher adopted Taro Yamani sampling technique. The procedure is explicit below:

$$\text{Formula } n = \frac{N}{1 + N(e)^2}$$

When n = sample size

N = population

Σ = margin of error

I = constant

e = 0.05

$$n = \frac{260}{1 + 2,700 (0.05)^2}$$

$$n = \frac{260}{1 + 2,700 (0.025)^2}$$

$$n = \frac{2,700}{1+1} = \frac{2,700}{2} = 1,350$$

Therefore, the sample size is 1,350.

3.5 Instrument for Data Collection

Questionnaire is the instrument used for collection of data. The instrument is divided into two aspects as outlined below:

Section A: The socio-demographic data of the respondents

Section B: The substantive issues

This scheme is organized in a likert five-point scale of strongly agree, agree, disagree and strongly disagree.

Subsequently, the study also explored the importance of secondary source of data collection with reference to Books, journal articles, online etc.

3.6 Validity of Instrument

The instrument was validated by experts in measurement and evaluation from the Faculty of Natural and Applied Sciences of Nasarawa State University of Keffi.

3.7 Method of Data Collection

The questionnaire instrument was distributed and collected through the help of four research assistants. The researcher trained the assistants for three weeks.

3.8 Method of Data Analysis

Data are analyzed using the likert rating scale. Likert rating scale assigned numerical values according to the strength and weakness of the opinion of the respondents. In the following order:

Strongly Agree - 4 Points
Agree - 3 Points

Disagree - 2 Points
Strongly Disagree- 1 Points
Don't know - 0 Nil

The decision for the rejection or acceptance of the questionnaire item is the calculated mean of 2.5 and above, it accepted but when it is less than 2.5 then the questionnaire item is rejected. The researcher equally employed the cumulative grand mean to determine the strength or weakness of the general opinion of the respondents.

4. Results and Discussion

Section A: social-demographic data of respondents

Table 3: Social data of the respondents

S/N	RESPONDENTS	VARIABLES	FREQUENCY	PERCENTAGE
1	Distribution of the respondents by sex.	Male Female Total	627 593 1220	51.3 48.7 100
2	Distribution of the respondents by age	18-28 years 29 -38 years 39-48 years 49-58 years 59 and above	29 150 280 316 445 1220	2.3 12.3 22.9 25.9 36.6 100

Source: Field Survey, 2024.

Table 3 shows the personal data of the respondents. From the above indication, the distribution of the respondents according to gender indicates that 627 (51.3%) were male and 593 (48.7%) were female. Subsequently, the age distribution of the respondents

showed the age bracket of 59 and above represents proportional percentage 36.6% and the age bracket of 18 to 28 constitutes 2.3% of the entire age distribution.

Section B: Substantive Issues

Table 4: Research Question 1: What are the Challenges of Primary Health Care, PHC in Keffi local Government Area?

RESPONSES									
S/N	QUESTIONNAIRE ITEM	SA	A	D	SD	Don't Know	EFX	X	DECISION
1	Shortage of essential drugs and supplies.	201 1005	116 464	514 1542	389 778	-	3,789	3.1	Accepted
2	Inconsistency in the payment of salaries and incentive of health workers.	342 1,710	311 1,244	289 867	222 444	56 56	4,321	3.5	Accepted
3.	Inadequate community nurses and doctors.	421 2,105	318 1,272	271 817	110 220	100 100	4,510	3.6	Accepted
4.	Lack of basic services and infrastructure such as electricity, water, good roads etc.	612 3060	608 2,432	-	-	-	5,492	4.5	Accepted
5	Lack of community participation or involvement in primary health care.	10 50	6 24	641 1923	328 656	235	3,354	2.3	Rejected

Source: Field Survey, 2024.

$$\text{Grand Mean } \sum \frac{x}{n} = \frac{3.1+3.5+3.6+4.5+2.3}{5} = 3.4$$

Table 4 shows the views or responses of the respondents on the challenges of primary health care in Keffi local government area. Responses elicited from the respondents were arranged in a cluster of five questionnaire items contained in items of 1, 2, 3, 4, and 5. Analysis of the questionnaire items indicates that item 1, 2, 3 and 4 recorded mean above the 2.5 mean bars which is alternatively the decision rule. However, item 5 in contrary recorded mean bar below 2.5 which further indicates that non-participation of the community people in health care is not necessarily the major challenges of the primary health care

delivery in Keffi local government area. Subsequently, the responses in item 1, 2, 3 and 4 also established the fact that primary health care delivery in Keffi local government area is bedeviled with challenges that stem from staff inadequacy, inadequacy of basic services etc in primary health exercise. The calculated 3.4 grand mean equally lent credence to the cumulative opinion of the respondents.

Research Question 2:

What are the factors responsible for these challenges in primary health care delivery in Keffi local government area?

Table 5: The Factors or Causes of the Challenges of Primary Health Care Delivery in Keffi Local Government Area

RESPONSES									
S/N	QUESTIONNAIRE ITEM	SA	A	D	SD	Don't know	EFX	X	DECISION
1	Lack of political commitment to the development of PHC.	407 2035	389 1,476	211 633	157 314	76 76	4.537	3.7	Accepted
2	Corruption/ fraud/ mismanagement of resources	671 3,355	549 2,196	-		- -	5.551	4.5	Accepted
3	Failed supervision and monitoring by federal and state authorities.	310 1550	297 1188	285 855	215 430	113 113	4.136	3.3	Accepted
4	Lack of clear definition of the local government responsibility in the development of PHC.	16 80	-	642 1926	421 842	114 141	2.989	2.4	Rejected
5	Lack of policy framework	- -	21 84	514 1,542	480 960	205 205	2791	2.2	Rejected

Source: Field survey, 2024.

$$\text{Grand Mean } \sum \frac{x}{n} = \frac{3.7 + 4.5 + 3.3 + 2.4 + 2.2}{5} = 3.2$$

Table 5 shows the opinion of the respondents on the factors responsible for the challenges of primary health care delivery in Keffi local government area. Data gathered showed that the cluster of the five questionnaires expressed in 1,2, and 3 overwhelmingly established the fact that challenges of primary health

care delivery in the Keffi stem the failure of the local government. The responses recorded mean bar above 2.5. In the contrary, item 4 and 5 recorded mean below 2.5 which inextricably indicates that absence of definition and policy framework. The calculated grand mean of 2.5 lent credence to this reality.

Research Question 3: What are the implications of the challenges bedeviling primary health care delivery at Keffi Local Government Area?

Table 6: The Implications of Challenges Bedeviling Primary Health Care Delivery in the Study Area

RESPONSES									
S/N	QUESTIONNAIRE ITEMS	SA	A	D	SD	Don't Know	EFX	X	DECISION
1	It leads to pandemic or outbreak of disease.	418 2090	389 1556	217 651	151 302	45 45	4,644	3.8	Accepted

2	It leads to high infant and maternal mortality	345 1725	307 1228	298 894	264 528	6 6	4.38	3.5	Accepted
3	It intensify rural-urban migration	-	120 480	481 443	479 958	140 140	3021	2.4	Rejected
4	It promotes the use of native medicine.	218 1090	349 1396	318 954	218 438	116 116	3994	3.2	Accepted
5	It creates widespread apathy towards urban and rural governance	310 1550	418 1672	265 795	218 436	9 9	4.462	3.6	Accepted

Source: Field Survey, 2024.

$$\text{Grand Mean } \sum_n^x \frac{3.8 + 3.5 + 2.4 + 3.2 + 3.6}{5} \quad 16.5 \\ /5 = 3.3$$

Table 6 shows the opinion of respondents on effects or challenges of the problems bedeviling primary health care delivery. The researcher elicited information from the respondents in a cluster of five questionnaire items as contained in items 1, 2, 3, 4 and 5. All the questionnaire items recorded means high than the 2.5 mean bar except item 3 which indicates that these

challenges cannot necessarily leads to rural-urban migration. This implies that political violence does not influence good political education. The calculated grand mean of 3.3 is cumulative opinion of the respondents which inextricably indicates that there were adverse effects from the challenges of PHC in Keffi.

Research Question 4: In what ways can these challenges of primary health care delivery be mitigated by Keffi Local Government Area?

Table 7: Measures to improved primary health care delivery in Keffi Local Government Area

RESPONSES									
S/N	QUESTIONNAIRE ITEM	SA	A	D	SD	Don't Know	EFX	X	DECISION
1.	Expressed political commitment	318 1590	398 1592	218 654	275 550	11	4397	3.6	Accepted
2.	Increased budgetary allocation to PHC at the level of federal, state and local governments.	514 2570	599 2396	218 654	107 321	-	5.287	4.3	Accepted
3.	Strengthening the supply chain management at LGA.	618 3090	541 2164	-	-	61	5.315	4.3	Accepted
4.	Intense collaboration with donor development agencies, state and federal government.	458 2290	381 1524	251 753	130 260	-	4.593	4.3	Accepted
5.	Community sensitization and advocacy for participation in PHC.	706 3530	514 2056	-	-	-	5.586	3.7	Accepted

Source: Field Survey, 2024

$$\text{Grand Mean } \sum_n^x \frac{3.6 + 4.3 + 4.3 + 3.7 + 4.5}{5} \quad 20.4 \\ /5 = 4.0$$

Table 7 shows the opinion of the respondents on the solutions to the challenges of primary health care delivery. Information was elicited from the respondents in a cluster of five questionnaire items as contained in items 1, 2, 3, 4 and 5. All the solutions

raised were accepted by the respondents as all were above the 2.5 mean bar.

4.1 Discussion of Findings

The study ostensibly revealed the issues and limitations freighting primary health delivery system in Keffi Local Government Area of Nasarawa State. The first research question is on the challenges of

primary health care in Keffi showed that over whelming responses on staff, basic services and facilities inadequacies and reluctance of indigenes to participate in PHC exercise or programs as reflected in 3.1, 3.5, 3.6 and 4.5. However, the challenge of involvement recorded mean bar below 2.5.

Another finding of this study ostensibly showed that most of these challenges emanates from the failure of the government. In this regard, failure of political commitment to the development of primary health care, fraud and finance inadequacy are factors stridently stressed as obvious in 3.7, 4.5, and 3.3. These conditions identified were also canvassed by scholars (Ndibuagu 2015 etal, 2005, Anyika 2014 and Eyitayo, 2015).

The study equally found out that these challenges identified undoubtedly leads to adverse and unpleasant situations as seen in spread of disease, infant and maternal mortality, reliance on traditional medicine for treatment and alienation from governance as reflected in 3.8, 3.5, 2.4 and 3.6 mean bar. On the other hand, proportional percentage of the respondents however stressed that these failures cannot necessarily leads to rural-urban migration for medical treatment rather they may employ the service of native physicians or tradition health practitioners as seen in 2.4 mean bar.

Finally, the study identified certain measures imperative to mitigate against these challenges. Political commitment, increased budgetary, strengthening the supply chain, collaboration and advocacy for involvement elicited positive responses from the respondents. These responses reflect proportionally in 3.6, 4.3, 4.3, 3.7 and 4.5.

5. Conclusion and Recommendations

Based on the findings, the study concludes that the challenges of primary health care in Keffi stem from the failure of the local government. These findings provide insight on the challenges bedeviling primary health care in Nasarawa State and Nigeria at large. This unpleasant situation therefore calls for spirited

efforts and commitment from the relevant stakeholders in government, health industry and the populace. This is because health is a very sensitive issue especially when its accessibility and affordability for the treatment of our aged persons, pregnant women and immunization of our children. To this end, the following recommendations (beyond the identified measures) are pertinent in this regard.

Arising from the findings, the study hereby makes the following recommendations;

1. That Nasarawa State government should ensure adequate primary health personnel in our primary health center with improved salary package and incentives.
2. That Nasarawa State government should provide and sustain consistent supply of medicine for efficient clinical services.
3. That Keffi local government should complement the efforts of the Nasarawa State government on its efforts to tackle the challenges of local healthcare delivery.
4. Adequate and functional facilities should be made available to ensure efficient healthcare delivery in Keffi and other local government councils in the Nasarawa State.
5. Implementation of Primary Health Care Under One Roof (PHCUOR). There is need to develop an organizational framework for the effective implementation of its lofty targets.
6. Government should develop mechanism to strengthen piloting and scaling up- performance based-financing which has the potential of improving primary health care service for the rural communities.
7. Adequate staffing and equipping the Ward primary health care centers with logistics for optimal PHC services at the rural areas.
8. The need for training and retraining of primary health workers on the service and targets of primary health care delivery.
9. Advocacy from the Traditional rulers, the church and mosque in the mobilization of the community's involvement in the primary health care service.

References

- Alma-Ata, A. (1978). *Primary Health Care*. Geneva: World Health Organization.
- Appadoari, A. (1975). *The Substance of Politics*. London: Oxford University Press.
- Awofeso, O. (2003). *Issues in Local Government Administration in Nigeria*. Lagos: Lisjohnson Resources Publishers
- Choudhury, H and Dara Das (1997) *Introduction to Political Sociology*. New Delhi: Vikas Publishing Company.
- Ezeani, E (2003) *Local Government Administration*. Enugu: Ziks-Chuks Publishers.
- Ezeani, E (2012) *Fundamentals of Public Administration*. Enugu: Ziks-Chuks Publishers.
- Fajioji, F. (2010). *X-ray of Local Government Administration in Nigeria*. Ibadan: Cresthill Publishers Ltd.
- Gauba, O. (2003). *An Introduction to Political Theory*, India: Macmillan Ltd.
- Ogunna, A. (1996). *Handbook on Local Government in Nigeria*, Owerri: Versatile Publishers Ltd.
- Udenta, J. (2007). *Local Government: A Comparative Perspective*, Enugu: New Generation Books.
- Ugwu, S.C. (2000). *Issues in Local Government and Urban Administration in Nigeria*, Enugu: Academic Publishing Company.
- Verma, S.P. (1974). *Modern Political Theory*, New Delhi: Vikas Publishing House Art Ltd.
- Abdulraheem, S, Olapipo, R and Awodu, O (2011) Primary Health Care Services in Nigeria: Critical Issues and Strategies for Enhancing the use by the rural communities. *Journal of Public health and Epidemiology* Vol4(1).
- Abiodun, A J (2005) Patient's Satisfaction with the Quality Attributes of Primary Health Care Service in Nigeria. *Journal of Health*.
- Adeymo, D (2005) Local government and health care delivery in Nigeria. *Journal of Humanities*.
- Almata-Ata (1978) *Primary Health Care*. Geneva: World Health Organization.
- Anyika, Emmanuel (2014) Challenges of Implementing Sustainable Health Care Delivery in Nigeria under Environmental Uncertainty. *Journal of Hospital Administration* Vol 3. No 6.
- Berman, P and T, A Bossert (2000) Decade of Health Sector Reform in Developing Countries. *UNAIDS Journal of Reading*.
- Ndibuagu, E O; Nwobi E A, Onoka, C A, Arinze, Onyia S, and Obionu, C N (2015) Knowledge, Attributes and Practices of KeffiState District Health System by Public Primary Health Care Workers. *International Research Journal Of Medical Sciences*.
- Okoli, F C, Nnamani D and Eberinwa, O M (2015) Local Government and Good Governance in KeffiState, Nigeria (2002-2012). *Review of Public Administration and Management*.
- Uzochukwu, Be, O Onwujekwe and Nkoli E, (2014) The District Health System in KeffiState Nigeria. An Analysis of Policy Development and Implementation. *Journal of Health Economics* December, 2014.