AN ASSESSMENT OF THE IMPLEMENTATION OF PRIMARY HEALTHCARE PROGRAMMES IN LOKOJA LOCAL GOVERNMENT AREA OF KOGI STATE 2016 –2021

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Abstract

This paper is an assessment of the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State. It is a fact that no society can develop without the government providing proper healthcare system for its populace who in turn are expected to contribute to the sustainable political and socio-economic development of the nation. This study therefore considered the minimum standards for Primary Healthcare in Nigeria as outlined in the Guidelines Manual prepared by the National Primary Healthcare Development Agency and thereafter, examined the actual implementation of Primary Healthcare Programmes especially in the study area during the period under review. The study is theoretically guided by the David Easton's System theory to interrogate the intervening variables that shapes the implementation of the policy within the study area. The study relies on secondary sources of data. The findings revealed that the implementation of the policy is shrewded with mixed feelings. Hence, there is a variation from what the minimum standard says and the actual implementation in Lokoja Local Government Area. It is among other things recommended that government at all levels should provide adequate funds and logistics for optimal primary healthcare services at both the urban and rural areas as prescribed by the National Primary Healthcare Development Agency.

Key words: Health, healthcare, primary, policy, local, government, and implementation

1.0 Introduction

It is uncertain whether the implementation of Primary Health Care Development Policy has endangered effective delivery of primary healthcare services in Lokoja Government Area. Healthcare service is a fundamental human right to be enjoyed by the people. Governments at every level have the responsibility to provide healthcare services to its citizenry (World Health Organization, 2016). Primary healthcare is the most efficient and effective way to achieve health for all and it is about how best to provide healthcare services to everyone. Primary healthcare forms an integral part of the country's health system because it focus on the health of individuals, families and communities at large. It is imperative

because is also concerned with addressing the overall social and economic development of communities, thereby, targeting the social determinants of health. It embodies a spirit of self-reliance and self-determination (Vukic & Keddy, 2002).

Primary Healthcare is the lowest level and the entry point to healthcare services, which comprise the Health Posts, Primary Health Clinics and Primary Health Centres. Primary Healthcare Centre provides basic primary care services which includes promotive, preventive, curative and rehabilitative services. Its services are based on local technology and can be easily managed by the local people and community. Primary health care is cheaper and affordable to the people of community (Akinseye, 2020).

The Primary Healthcare initiative, which formally began in 1983 in Nigeria following a military intervention instigated by the deteriorating state of health services, when federal government set up a committee to develop a new health system for the country (Scott-Emuakpor, 2010). The committee recommended five strategies for its implementation which include (i) the promotion of community participation. (ii)the involvement of health-related sectors in the planning and management of the services; (iii)strengthening of functional integration at all levels of the health system; (iv)strengthening of the managerial process for health development; and (v)the policy then identified a functionally integrated three- tier structure for the nation's health service.

In August 1987, the Federal Government launched its Primary Health Care (PHC) plan, which President Ibrahim Babangida announced as the cornerstone of health policy in Nigeria. Intended to affect the entire national population, its main stated objectives included accelerated healthcare personnel development; improved collection and monitoring of health data; ensured availability of essential drugs in all areas of the country; implementation of an Expanded Programme on Immunization (EPI); improved nutrition throughout the country; promotion of health awareness; development of a national family health program; and widespread promotion of oral re-hydration therapy for treatment of diarrhea disease in infants and children. Implementation of these programs was intended to take place mainly through collaboration between the Ministry of Health and participating Local Government Councils, which received direct grants from the Federal Government.

It is important to note that the National Primary Health Care plan was launched by the military administration which brought about the appointment of late Professor Olukoye Ransome Kuti between 1986 and 1992(Aregbeshola & Khan, 2017). Subsequently, Primary Health Care Directorate in the Federal Ministry of Health was established and charged with the responsibility of formulating, developing and implementing the National Primary Health Care system in line with the recommendation of the 1988 international conference on primary healthcare. This period was characterized by the development of model primary healthcare centres in fifty-two (52) pilot Local Government Areas, all of which were implementing all the components of primary healthcare. The scheme was to be collaborative efforts of the three tiers of government, which should be more adapted to Nigeria's socio-economic and cultural context. It was meant to be people-oriented with the aim of developing local capabilities, initiatives, and promoting self-reliance thereby paving

way for the realization of sustainable improvement in the health of the people (Akinseye, 2020). Since inception of the Primary Healthcare in Nigeria, government had come up with different programmes aimed at providing basic health care, priority health interventions and health related interventions such as National Programmes on Immunization or Expanded Programmes on Immunization for measles, diarrhoea, polio meningitis, malaria, yellow fever, corona virus, etc.

Considering the above background regarding the evolution of Primary Healthcare Services in Nigeria, scholars have divergent views about its functionality and efficiency. On their part, Gofin (2005) and Olise (2012), Primary Healthcare is a grass root approach meant to address the main health problems in the community by providing preventive, curative and rehabilitative services. Alenoghena, Aigbiremolen, Abejegah and Eboreime (2014) carried out a research on the Primary Healthcare in Nigeria with focus on the strategic trends and constraints in the implementation of Primary Healthcare in Nigeria since the WHO declaration on Primary Healthcare in 1978. Babatimehin, Ayanlade, Babatimehin and Yusuf (2011) also conducted a research on geo-political patterns of Healthcare facilities with concentration on Kogi State. These studies focused on the distribution of healthcare facilities in Kogi State within the context of the geography and politics of the state. Their studies analyses the spatial patterns of healthcare facilities among the three senatorial districts (which corresponds to the division along major ethnic lines) in the state. Also, the ownership structure of facilities and the relationship between population and distribution of healthcare facilities in the state were analyzed.

Furthermore, Omachi (2021) focus on patient's satisfaction and customer care in healthcare delivery system in the era of global challenges in Nigeria and did not assess the level of implementation of Primary Healthcare programmes in Lokoja Local Government Area of Kogi State. In addition, Akinseye (2020) researched on the Administration of Primary Healthcare programme in Local Government in Nigeria but did not capture the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State. None of the works of the invested pyramid of literature specifically interrogated the implementation of Primary Healthcare Programmes in Lokoja Local Government Area. Even the studies of Babatimehin, et al (2011), and Omachi (2021) that focused on Kogi State did not look at the general implementation of the Primary Health Care Development Policy so as to ascertain whether the implementation of the programmes are in line with the national benchmark or not. It is the gap in literature above that the thrust of this study is to assess the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State particularly between 2016 and 2021.

1.1 Statement of the Problem

The problematic of this research lies on the premise that in as much as everyone has the right to healthcare services, most rural communities in Nigeria have the challenges of collapsing healthcare system, and thereby leading to inaccessibility which is antithetical to the tenets of the national primary healthcare development policy. Due to this problem, the current state of Primary Healthcare system in Nigeria is appalling as less than 20% of health facilities across Nigeria are working (Aregbeshola & Khan, 2017).

The Article 25 of the Universal Declaration of Human Rights succinctly states that a well-functioning healthcare requires a financing mechanism, a well-trained and adequately paid workforce, reliable information on which to base decisions and policies, and well-maintained health facilities to deliver quality medicines and technologies (WHO, 2012). Sequel to the above, Kogi State Primary Health Care Development Agency synergized with both national and international partners to ensure full implementation of its Primary Healthcare Programmes by inaugurating for instance, the State Emergency Routine Immunization Coordination Center (SERICC) in the State and at the LGA level, Local Emergency Routine Immunization Coordination Center (LERICC). In addition, the Agency conducted Baseline Survey of its Primary Healthcare Facilities and also the Executive Governor of the State signed the Amendment Bill into law that incorporates Primary Health Care in the State under the national overarching Primary Health Care Under One Roof (PHCUOR) policy as well as the commencement and operationalization of the Basic Health Care Provision Fund (BHCPF) in Kogi State with the approval of One Hundred Million Naira (N100,000,000) counter-part fund and effective pre-implementation plans for BHCPF, amongst others (KSPHCDA, 2017).

Despite the efforts by the Government, many rural communities in Kogi State still lack access to good healthcare facilities. Presently, most of the Primary Healthcare facilities in the Local Government Areas lacks the capacity to provide essential healthcare services in addition to having issues such as poor staffing, inadequate and poor condition of infrastructure, poor distribution of health workers, poor quality of healthcare services, low communities participation, lack of essential drugs, poor maintenance culture of the existing vehicles, etc (Aregbeshola & Khan, 2017). For instance, according to the statistics of Federal Ministry of Health (2000), Lokoja Local Government Area has about 35 health facilities (i.e. 30 Primary Healthcare Centres and 5 Secondary Healthcare facilities which are grossly inadequate). Besides the issues of inadequacy of healthcare facilities, the problem of bad roads and high cost of transportation makes accessibility to available healthcare facilities in the Local Government Area and the referral services available outside highly difficult.

1.2 Objectives of the Study

The general objective of this study on the assessment of the implementation of primary healthcare programmes in Lokoja Local Government Area is to ascertain the level of compliance with the prescribed standards. The specific objectives of this study include the following:

i. To assess the degree of community participation in the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State.
ii. To ascertain the challenges affecting the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State.
iii. To highlight the strategies that can effectively assist in the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State.

2.0 Methodology and the Study Area

This paper used qualitative data mainly from secondary sources. Publications from the National Primary Healthcare Development Agency (NPHCDA), World Health Organization (WHO) and other relevant literature from the sources of information needed for this paper. The reason for this method is based on the fact that the thrust of the study is to assess the implementation of the Primary Healthcare programmes in Lokoja Local Government Area of Kogi State. And as such, the essence of using this method is to ascertain the extent of the implementation of the policy in the Local Government whether it is in accordance with the prescribed standards.

For the study area, Lokoja is one of the ancient towns in Nigeria now a fast growing city. The town assumed metropolitan status from pre-independence days, harboring many Nigeria ethnic groups. It is both the administrative and commercial Capital of Kogi State, the most centrally located state in the Country. It lies at the confluence of the Niger and Benue rivers. Projected to be the third fastest growing African continent city between 2020 and 2025, with a 5.93% growth. The population of Lokoja stands at 741,482 (NPC, 2020). Lokoja Local Government Area has ten (10) Council Wards.

The original settlers of Lokoja were the Bassa-Nge arriving in 1831 and followed by the Oworos in 1970 (Akamisoko, 2002). Since then, different ethnic groups have peopled the town. The present Lokoja comprises of, in addition to the Bassa-Nges and Oworos, the Egbirra-Koton, Hausa and several Nupe language groups, Kakanda, Kupa and Egan. Other Nigerian ethnic groups found in Lokoja include Yoruba, Igbo, Tiv and Igala as well as, many slave aborigines of Sierra Leone origin, being a former slave depot (Alaci, 2009). Lokoja is therefore cosmopolitan in nature.

Formerly the Capital of Kabba Province, it was later a Divisional and Local Government Headquarter in Kwara State. Lokoja remained part of Kwara State up to 1991. By the 27th of August, 1991, the status of Lokoja was boosted when new states were created and Lokoja became the Capital of the new Kogi State. Consequently, Lokoja Local Government Area has 37 Primary Healthcare Clinics and 7 Primary Healthcare Centres.

S/NO	COUNCIL WARD	Number of PHC
1	Eggan	1
2	Kakanda	1
3	Kupa North East	1
4	Kupa South West	1
5	Lokoja A	1
6	Lokoja B	1
7	Lokoja C	Nil
8	Lokoja D	Nil
9	Lokoja E	Nil
10	Oworo	1

Source: Field Survey, 2021

3.0 Literature Review and Theoretical Framework

This section examines the related literature and the theoretical framework for clarification and interrogation of the intervening variables in this study.

3.1 Review of Literature

This section discusses the scholarly works related to the demand of the topic. The essence is to interrogate the invested pyramid of literature that are related to the thrust of the study with the view to understand the nature and character of the argument of previous studies and the gap therein.

3.1.1 Primary Healthcare:

Primary Healthcare is a grass root approach meant to address the main health problems in the community by providing preventive, curative and rehabilitative services (Gofin, 2005; Olise, 2012). It is clear from the above scholars that Primary Healthcare was intended to be a grassroot programmes through which the rural populace can participate by identifying their own health problems and also have access to the health solutions at the Primary Healthcare Centres close to where they live and work before further referral to secondary or tertiary health institutions, if need be. That is why Amason in Udenta (2018) views primary healthcare as the first level of contact of the individuals, the family and the community with national health system bringing healthcare close to where people live and work and constitute the first element of a continuing health care processes. But the main aim of the establishment of primary healthcare system has been defeated since the elites especially the political bourgeoisie in Nigeria care less for the success of the programmes as they do not patronize them because they have the means of travelling outside the country to secure good medical treatments.

As defined in the Alma-Ata Declaration, Primary Healthcare is the "essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self- reliance and self- determination" (WHO, 2012). It forms an integral part of a country's health system of which its central function and main focus are on the overall social and economic development of the community. It is rooted in a commitment to social justice and equity and in the recognition of the fundamental right to the attainable highest standard of health, as echoed in Article 25 of the universal Declaration of Human rights thus: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social services". Nevertheless, many rural dwellers hardly have access to the primary healthcare owing to the fact that the locations where the centres are situated lacks good roads. As stated earlier, primary healthcare is everyone's right but it is the right of the government to provide functional facilities and essential drugs at the centres, absence of which makes life unbearable. How many people or communities can afford the cost of standard medical treatments especially essential drugs. How many communities actually initiate and participate in the implementation of primary healthcare programmes in their localities.

Some basic elements of primary healthcare delivery includes health Education; identifying and controlling prevailing health problems; food supply and proper nutrition; provision of safe water and basic sanitation; maternal and child health care including family planning; immunization; prevention and control of endemic disease; appropriate treatment of common disease and injured; promotion of mental health; provision of essential drugs, etc (WHO, 2012).

Primary Health Care (PHC) is provided by local government authority through health posts, PHC Clinics and PHC Centres and they are manned by nurses, midwives, community health officers, health technicians, community health extension workers and in some places by physicians (doctors). The services 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 (Udenta, 2018). As much as the above statements are true but how many local government has the capacity to ensure the implementation of the healthcare programmes. It is obvious that the essence of healthcare 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 have doubt on the extent to which healthcare has been taken to the doorstep of the rural people (Abdulraheem, et al 2012). One of the hindrances to the development of healthcare 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, there are glaring disparities between the healthcare services at the urban and rural areas. The deterioration in government facilities, low salaries and poor working condition had resulted in a mass exodus of health professionals (Scott-Emuakpor, 2010). These has continued to be on the increase on daily basis and has led to high rate of mortality in the rural areas.

It is note worthy that poor healthcare obstructs prosperity and business profitability (Omachi, 2021). That is why the idea of adopting primary healthcare system in Nigeria was a right step to achieving socio-economic and political development. But the extent to which this has contributed to the political and socio-economic development in Africa is a point in question.

The implementation of PHC is primarily through services carried out at the primary health centres and home visits. The great idea of grassroots healthcare delivery as enclosed in the principles of primary healthcare requires the strong commitment of all stakeholders as earlier mentioned to make it work. Stakeholders are those persons or groups that have vested interest in the delivery of primary health care services and in health care decisions (AHRQ, 2014). The key primary healthcare stakeholders include the people, the government and the health care workers. In reality, stakeholders are only interested in the programmes that is of interest or benefit to them and not the community as claimed.

As practiced in other parts of the world, Nigeria has her own peculiarities characterizing the healthcare system. These peculiarities are related to her cultural, religious and socio-political

diversities. Hence, strategies to implement primary health care must be evolved to meet the challenges associated with these diversities. These strategies include community mobilization and advocacy, service integration, health research, capacity building, and international and nongovernmental collaborations (Olise, 2007). Community mobilization is therefore, the process of arousing the interest of the people and encouraging them to participate actively in finding solutions to their problems. It is the gateway to providing effective health care services to individuals, families and groups within the community concerned. In his view, Magawa (2012) posits that community mobilization engenders community participation and community ownership and ultimately guarantees sustainability of healthcare programmes. In all, it enhances resource mobilization, cost minimization and appropriate utilization of health services.

3.2 Minimum Standards/Requirements for Primary Health Care in Nigeria

National Primary Healthcare Development Agency (NPHCDA) was established under the decree no. 29 of 1992, to provide support to states and local governments in matters relating to implementation of primary health care (PHC). In this regard the NPHCDA has designed minimum standard requirements of PHC structure, system, staffing and equipment for PHC service delivery at local government level (NPHCDA, 2013).These are discussed as follows:

3.2.1 PHC Infrastructure: Facilities and Equipment

Health facilities are static or mobile structures where different types of health services are provided by various categories of health workers. These health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered and by ownership. Many terminologies have been used over the years including dispensaries, health clinics, health centres, primary health centres, maternities, health posts and comprehensive health centres. However, based on the Ward Health System, the three recognised facility types are:

(1) Health Post

(2) Primary Health Clinic and

(3) Primary Health Care Centres.

Appropriately, the standard infrastructure in terms of physical building, space and equipment was addressed in the manual as shown in the table below:

S/N	HEALTH FACILITY	LEVELS OF MANAGEMENT	EXPECTED NUMBERS
1	Teaching/Tertiary Hospitals	Federal government	1 per State Therefore, in 36 states and FCT making 37
2	General Hospitals	State government	1 per Local Government Area i.e. minimum of 774 in

			Nigeria
3	Primary Health Centres	Local Government	1 per ward With an average of 10 wards per LGA, a total of 7,740 will be expected
4	Primary Health Clinics	LG and Ward Development Committee (WDC)	1 per group of villages/neighbourhood with about 2000 - 5000 persons.
5	Health Posts	Village Development Committee (VDC) and Community Development Committee (CDC)	1 per village or neighbourhood of about 500 persons. There can be as many as the number of villages.

Source: NPHCDA Guidelines Manual, 2012

In Nigeria, these facilities are either owned by the government, the private for-profit and the private not-for-profit organizations. Private health facilities are classified according to their structure and the services they provide and the private healthcare providers in Nigeria are broadly clinics, maternity homes and hospitals while the ownership includes individual professionals, faith-based and other civil society organizations.

3.2.2 Human Resources for PHC

The failure of primary health care in Nigeria can be partly attributed to the inadequate number and proportion of the various cadres of healthcare workers necessary to provide services in the health facilities.

The NPHCDA manual proposes the minimum number, mix and skill sets required in each facility type. The cadres of staffs are Community Health Officer (CHO), Nurse/Midwife, Community Health Extension Worker CHEW), and Junior Community Health Extension Worker (JCHEW). The manual recommends that the cadres are matched to services based on their competencies.

I. Health Post

- This is for an estimated 500 persons or neighbourhood with at least 2 rooms facility, functional toilets, motorized borehole, power supply, clearly signposted, fenced, generator house, staff accommodation, bicycle, motorcycle, mobile phone, etc.

- The Health Post should be headed by at least a JCHEW, who supervises *Community Resource Persons (CORPs) working within the community.

II. Primary Health Clinic

- This is for an estimated 2000 - 5000 persons or neighbourhood with at least 5 rooms facility, functional toilets, motorized borehole, power supply, clearly signposted, fenced, generator house, staff accommodation, bicycle, motorcycle, mobile phone, etc.

- the Personnel includes:

Midwife or Nurse Midwife - 2

CHEW (must work with standing order) - 2

JCHEW - 4

Support staff Health attendant/Assistant - 2

Security personnel - 2

In a Primary Health Clinic, the minimum requirements of health workers include 2 midwives, 2 Community Health Extension workers, 4 Junior Community Health Extension Workers, 2 Health Attendants and 2 Security personnel for effective service delivery.

III. Primary Health Care Centre

This is for an estimated 10,000 - 20,000 persons or neighbourhood in a political ward with 13 rooms facility, consulting rooms, functional toilets, motorized borehole, power supply, clearly signposted, fenced, generator house, staff accommodation, bicycle, motorcycle, mobile phone, ambulance, etc.

- The personnel includes:

Medical officer if available - 1

CHO (must work with standing order) - 1

Nurse/midwife - 4

CHEW (must work with standing order) - 3

Pharmacy technician - 1

JCHEW (must work with standing order) - 6

Environmental Officer - 1

Medical records officer - 1

Laboratory technician - 1

Support staff Health Attendant/Assistant - 2

Security personnel - 2

General maintenance staff - 1

From the list above, it is clear that the minimum requirements for health workers in a Primary Health Centre include 1 Medical Officer, 1 Community Health Officer, 4 Nurses/midwives, 3 Community Health Extension Workers, 1 Pharmacy Technician, 6 Junior Community Health Extension Workers, 1 Environmental Officer, 1 Medical Records Officer, 1 Laboratory Technician, 2 Health Attendants, 2 Security personnel and 1 General Maintenance Staff.

3.2.3 Provision of PHC Services

For primary health care to be effective the various activity levels for each component and level of care delivery must be known and standards set for its accomplishment. In defining these activity levels, there would be a need to take into cognizance the three broad operational categories of basic health care, priority health interventions and health related interventions. Each service is matched with the type of facility and the competencies of the staff.

3.2.4 Managerial System for PHC at LGA Level

The manual also provides the Minimum Standards for the LGA PHC department in order for it to effectively perform its statutory function. The LGA PHC department through its PHC Technical Committee is to manage the PHC delivery system in the LGA alongside the LGA PHC Management Committee. While the LGA PHC Management Committee will provide overall direction and enabling environment for integrated PHC service delivery, planning and management of services, manpower development, resource mobilization and provision of an operational guideline.

4.0 Discussion of Findings

The followings are the findings from the study conducted in respect to the assessment of the implementation of Primary Healthcare Programmes in Lokoja Local Government Area (LLGA) of Kogi State. From the records of the Primary Healthcare Department of Lokoja Local Government Area (2021), the category and distribution of Primary Healthcare facilities reveals as follows:

Health Posts	-	Nil
Primary Healthcare Clinic	-	37
Primary Healthcare Centres	-	7

It was observed that no new health facilities were constructed in LLGA between 2016 and 2021, only four (4) were renovated. Not all the health facilities are fenced, just about seven (7) facilities are fenced. It was further discovered that not all the health facilities are in good conditions.

In terms of distribution of health workers according to the category of Primary Healthcare, the records of the Primary Healthcare Department of Lokoja Local Government Area (2021) reveals as follows:

Health Posts	-	Nil
Primary Healthcare Clinic	-	37

Primary Healthcare Centres - 23

Based on this statistics, the finding suggests that the available health workers in the Primary Healthcare Clinics and PHC Centres are grossly inadequate as it is below the national benchmark which is in line with global best practices because the policy says that each Primary Healthcare Clinics and PHC Centres should have a minimum number of health workers of twelve (12) and Twenty Four (24) respectively. This finding is obviously different from the submissions of previous studies on healthcare services in Lokoja. Particularly, the work of Babatimehin, Ayanlade , Babatimehin and Yusuf (2011) which focuses on geo-political patterns of healthcare facilities in Kogi State, Nigeria but not on the implementation of Primary Healthcare Programmes in Lokoja Local Government Area. This is the area in which the findings of this study is different from other studies.

Within the period under review, the Primary Healthcare Programmes embarked upon includes sensitization and administration of family planning, Anti-natal care, Immunization, promotion of proper nutrition and food education, HIV/AIDS Counselling, Malaria treatment, Tuberculosis treatment, Polio menigitis treatment, corona virus vaccination and other curative cares(from the records of the Primary Healthcare Department of Lokoja Local Government Area, 2021). However, it was noted that essential drugs are not provided to the Primary Healthcare Centres as at and when due which is below the minimum standard as prescribed by the NPHCDA..

The study reveals that there is an existing management system adopted for the implementation of Primary Healthcare Programmes in LLGA which includes both the PHC Managerial Committee who provides policy direction and the PHC Technical Committee who ensures implementation of Primary Healthcare programmes. This is in line with the minimum standard.

In LLGA, communities participate actively in the implementation of Primary Healthcare Programmes through community involvement in the primary healthcare activities, formation of health committees, and involvement of traditional leaders, religious leaders, community village volunteers, etc to enhance healthy development of the community which is in accordance with the minimum requirements.

Based on the above findings, the Challenges encountered in the course of implementing Primary Healthcare Programmes in LLGA majorly includes the followings:

a. Lack of logistics to aid effective monitoring and supervision of the implementation of primary healthcare programmes at the rural or remote areas of the Local Government.
b. Inadequate community nurses and Midwives
c. Inconsistency in the payment of salaries and incentives of health workers by the government
d. Shortage of essential drugs and supplies to the Primary Healthcare Centers.
e. Lack of basic services and infrastructure such as good roads, constant electricity, good water, etc.

f. Inadequate funding of Primary Healthcare Programmes by both Federal and State governments.

g. Lack of internally generated revenue and over-dependence on the initiatives of foreign donors on Primary Healthcare programmes.

h. Poor management of information system at the Primary Healthcare Department of the Local Government.

5.0 Conclusion

This study assessed the implementation of Primary Healthcare Programmes in Lokoja Local Government Area of Kogi State where it was noted that communities actively participates in the implementation of primary healthcare programmes through community involvement in the primary healthcare activities, formation of health committees, and involvement of traditional leaders, religious leaders, community village volunteers, etc to enhance healthy development of the community. However, there are challenges bedeviling the effective implementation of PHC programmes in the Local Government which includes among others Lack of logistics to aid effective monitoring and supervision of the implementation of primary healthcare programmes at the rural or remote areas of the Local Government; inadequate community nurses and midwives; inconsistency in the payment of salaries and incentives of health workers by the government; shortage of essential drugs and supplies to the Primary Healthcare Centers; lack of basic services and infrastructure such as good roads, constant electricity, good water, etc and inadequate funding of Primary Healthcare Programmes by both Federal and State governments.

It is apt to conclude that the implementation of Primary Healthcare Programmes in LLGA is hampered, among other challenges as stated above, by shortage of health workers. It is revealed that there are only 37 and 7 health workers in the Primary Health Clinics and Primary Health Centres respectively against the required numbers of health workers as provided for by the minimum standards for Primary Healthcare in Nigeria.

6.0 Recommendations

In view of the above findings, the study makes the following recommendations for effective implementation of PHC programmes especially in Lokoja Local Government Area of Kogi State:

1. Government should provide adequate logistics for optimal Primary Healthcare services at the rural areas such as utility vehicles, communication gadgets, etc to help in regular monitoring and supervision.
2. Both State and Local Governments should collaboratively engage more health workers such as community health officers, nurses/midwives, community health extension workers, junior community health extension workers, community resource persons (CORPS), etc to provide specialized and professional health services in Primary Healthcare Centres to both urban and rural dwellers.

3. The State Government should not short change the health workers through percentage salary payment but should consistently pay them improved salary and incentive packages in order to boost their morale for effective service delivery.

4. Government should provide and sustain consistent supply of medicines for efficient clinical services at the Primary Healthcare Centres in both urban and rural areas. This will strengthen the supply chain management at the Local Government Area.

5. Kogi State government should provide adequate infrastructure and functional facilities to ensure efficient healthcare delivery in the Primary Healthcare Centres in Lokoja and other Local Governments in the State.

6. Government should increase its budgetary allocation particularly for identification and implementation of Primary Healthcare Programmes at federal, state and local government levels.

7. The Local Government in addition to intense collaboration with donor development agencies, State and Federal Government, should be empowered to initiate and also implement some primary healthcare programmes on their own. This will encourage self determination and self reliance.

8. Effective information management system should be put in place to keep tracks of all health problems and remedies provided in the Local Government area.

9. Most importantly, government at every level should embark on mass sensitization and advocacy for continuous community participation in the implementation of Primary Healthcare Programmes.

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