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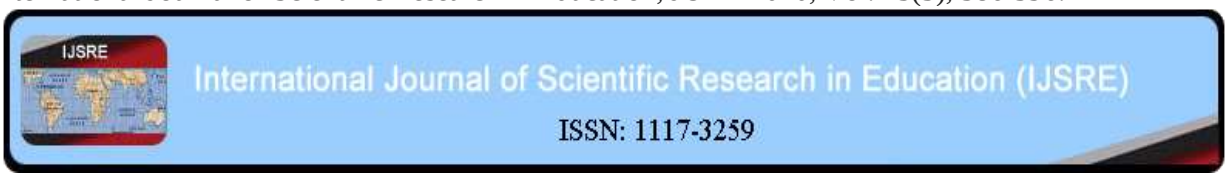

Primary Health Care Delivery among the Igalas in the North Central Nigeria

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Abstract

The study Appraise Primary Healthcare Delivery among the Igalas of Kogi State. The main purpose of the study is to assess primary healthcare delivery system among the tribals and proffer solutions to identified confronting the full implementation of this rural centred health programme. Survey research design was used for the study. The study population was men and women that were randomly selected in Dekina Local Government Area. The sample size was 290. Systematic sampling was used for the study. Descriptive statistics used in the analysis of the data, while chi-square was used for the test of hypothesis. The findings revealed from the study shows that a varying degree of domicile and mother's occupation are significant factors influencing routine immunization. Nursing mother who live quite relatively fare from health facilities patronized less of immunization services. The author advocates adult education and advocacy campaign in primary health care, child immunization, provisions of drugs and medical personnel for clinics and hospitals.

Keywords: Primary Health Care, Routine Immunization, Nursing Mother.

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BACKGROUND OF THE STUDY

One of the greatest challenges to the third world countries, especially Nigeria, is the problem of health care delivery looking at the development of healthcare delivery system in Nigeria since independence; we discovered steady failure of health care delivery to individuals and groups. This poor situation in the delivery of health care in Nigeria is much more glaring in the rural areas than in the urban areas; and as a result, there is a wide gap that exists between them.

Development policies in Nigeria have not always produced the anticipated results. Lack of basic amenities; such as good roads, health centers, electricity and good drinking water are common features especially in our rural areas, where more than 75% of Nigerian population live.

One of the strategies to combat these predicaments especially that of healthcare was the introduction of primary healthcare in 1976. According to the 1976 local government reform as well as the 1979 local government edict which transformed the local government into a third tier of government, the local government was then expected to serve as the agent of effective transformation of the rural communities. The national guideline for local government reforms established a framework for decentralization of some healthcare functions and delegating such functions to local governments.

World health organization (WHO) annual bulleting (2004), noted that a striking feature of public delivery of primary health care services in Nigeria is that service appear not to be reaching their destination. There is evidence of large scale leakage in public resources in many states; away from original budget allocation. Whose analysis shows that there are frequent cases of non-payment of staff salaries. The bulleting also stressed that, the greater the extent of non – payment of salaries, the higher the likelihood that facility staff start rendering their services as private providers, with more services provided outside the facilities through home visits and with essential drugs being privately provided either funded by staff own resources or expropriated from facility stocks.

National health care policy (1999) clearly lays out the roles and functions of each of the tier of government in health care delivery system in Nigeria. While the federal government is assigned the responsibility of overall policy formulation, co-ordination and adherence to internationally recognized standards, the state government with the active participation of local government is responsible for actual delivery of health care services in Nigeria especially primary healthcare. However, neither the national health policy nor 1999 constitution makes clear descriptions about delineation of responsibilities and authorities between states and local governments. Instead, the official language seems to suggest that state government have the ultimate responsibility for delivering primary health care, while the role of local government can vary within a state and across the states depending on particular state polices and local economic conditions. The policy equally noted the role of the community particular participation in the delivery of primary health services. It indicates that local government shall mobilize communities to participate in the provision and maintenance of health care services, eliciting the support of various formal and informal community leaders.

The National health policy (2004) stated that the goal of the policy is to bring about a comprehensive health care system, based on primary health care which is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social wellbeing and enjoyment of living. The policy also emphasized that the health services, based on primary health care shall include among other things.

Education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, maternal and child health care, including family planning, immunization against the major infectious diseases, prevention and control of local endemic and epidemic diseases as well as; provision of essential drugs and supplies. The policy noted that there is three tier of health care delivery system in Nigeria, namely, primary health care, secondary health care and tertiary health care. Despite all the promises embedded in the 2004 national health policy, Nigeria still ranked third in terms of

infant mortality rate in the world as published in a report by the United Nation children fund, UNICEF in 2017.

According to the report released by UNICEF, the World Health Organization, the World Bank and the population division of UNDESA, which make up the Inter – Agency Group for Child Mortality Estimation (IGCME), at current trends, 60 million children will die before their fifth birthday between 2017 and 2030, half of them new-borns. Every single day, Nigeria losses about 2,300 under-five years old and 145 women of child bearing age, making the country the largest contributor to under-five and maternal mortality rate in the world.

In order to stem down this ugly trend, the current National Health Policy (2017) was approved. This was revealed by the Minister of Health, Isaac Adewole. The title of the policy is 'promoting the health of Nigerians to accelerate social economic development." In order to achieve a significant success in terms of infant and maternal health, the policy lays emphasis on primary health care has the bed rock of the national health system and additionally it also provide for financial risk protection to all Nigerians particularly the poor and vulnerable population. Only time will tell if it will deliver on its premise. The level of implementation and achievement of set goal within the policy is solely dependent on improving the health seeking behaviour of the tribals, in this case the Igalas in Kogi State, North Central Nigeria.

LITERATURE REVIEW AND CONCEPTUALFRAMEWORK

Concept of Primacy Healthcare

In recent years, the concept of primary health care has gained wide spread popularity among communities and community health care providers. The concept of primary health, in the context it is presently known, Erinosho (1992), was popularized during an international conference on health in Alma Ata 1987 in former USSR. The conference examined avenues of bridging health care gaps between the developing and developed countries, the urban and rural communities, the privileged and the disadvantaged sections of every population. The conference concluded that the adoption of primary health care (PHC) was the needed strategy for ensuring fair and equitable health care delivery to every segment of a population across the globe. He noted that social targets of governments, international organizations and the whole world community should attain health for all by the year 2000. The conference approved primary health care as the vehicle for the achievement of this target.

According of Erinosho, primary health care was defined at the conference (on health Alma-Ata 1978 in former USSR) as essential health based on practical, scientifically, sound and socially acceptable methods and technologically made universally accessible to individuals and families in the community and country can afford to maintain at every stage of their development in the spirit of self-determination and self-reliance. He noted that primary health care forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as much as possible to where people live and work and constitutes that first element of community health process.

Primary Health Care Delivery in Nigeria

According to Nigeria table of contents on health (2005), in August 1987, the Federal government of Nigeria launched Primary Health Care plan (PHC), which President Ibrahim Babangida announced as the corner stone of health policy. The policy is intended to affect the entire national population, its main stated objectives included accelerated health care, personnel development, improved collection and monitoring of health data; ensure the availability of essential drugs in all areas of the country, implementation of expanded programme on immunization (EPI), improved nutrition throughout the country, promotion of oral rehydration therapy for the treatment of diarrhea disease in infants and children. Implementation of these programmes was intended to take place through the collaboration between the ministry of health and local government councils which receive direct allocation or grants from the federal government.

The publication further stressed that the governments' population programme also came under primary health care (PHC). This official policy was strong to encourage women to have not more than four children. Though, no official sanctions are attached to the government's population policy; but birth control information and contraceptive supplies were available in many health facilities. The federal government also sought to improve the availability of pharmaceutical drug imports, so the government attempted to encourage local drug manufacture, because raw materials for local manufacture had to be imported, however, costs were reduced particularly for Nigeria to limit its foreign expenditure and simultaneously to improve massive expansion of primary health care, and foreign assistance would probably be needed. This document disclosed that, despite advance against major diseases, Nigeria's population continued to be subjected to several major diseases, some of which resulted in acute outbreaks causing large-scale infection and debilitation.

Gupta and Khemini (2003) stated that the overwhelming majority of local government councils are the principal decision makers for most facility level provision of primary health care services when compared to other two tiers of government. The state and federal government indicate very infrequently as decision makers in the provision of primary health care services in Nigeria. This evidence to health care delivery system according to Gupta and Khemini is a striking contrast to available evidence for health care delivery in Nigeria. They stressed that among government agencies, the local government is the main sources of financing of primary health care service delivery in Nigeria, especially at the facility level, staff salaries, facility building construction and maintenance, supply of drugs, equipment and other medical commodities are all predominantly provided by the local governments. However in some few situations, community based organizations and facility staff are frequently indicated.

According to Gupta and Khemini (2003) community participation in primary health care delivery has been institutionalized in Nigeria through the creation of village development committees and district development committees. They noted that there is striking difference in the sharing of responsibilities between local government and community development committees. In some parts of Nigeria, more than 80% of the facilities level have the local government area as principal decision makers, and in most of the areas service delivery at the facility level, while some parts, 50% of principal decision are made by the L.G.A. The remaining parts have either the community development committees or the facility head or both as principal decision makers. They also indicated that community organization is particularly active in the areas of counting maintenance, and acquiring drugs, medical supplies and equipment for

facilities. There is comparatively little community engagement in setting charges as well envisioned by the Bamako initiated and almost negligible indiscipline staff, which is overwhelmingly indicated as the responsibility of local governments.

The Concept of Immunization

Immunization is a health technology that is central to child health care practices in communities. Immunization continues to be the most cost effective and the cornerstone of strategies aimed at preventing morbidity and mortality among children aged 0-5 years. It is a form of preventive medicine which prepares the body to fight against infections. It aims at preventing individuals and communities from infectious diseases. Immunization is aimed at protecting children against childhood diseases, Even though there are some rural-urban differences in the perception of immunization, it is a popular opinion among public health experts that immunization strengthens the child and prevents diseases.

Studies by Jegede (2010) have shown that immunization coverage is low in Nigeria. The 2003 Nigeria Demographic and Health Survey reports that only 13 percent of Nigerian children aged 12-23 months can be considered fully immunized, the lowest vaccination rate among the African countries in which Demographic and Health Survey (DHS) rates have been concluded since 1998 (National Population Commission, 2004). Nigeria's immunization programme is the most cost expensive but with the worst coverage records in sub-Saharan Africa, (FBA, WHO 2005). Consequently, thousands of children die or are maimed for life from preventable causes. The national programme on immunization (2011) reported that Nigeria recorded 57 new cases of wild polio virus in 2011. The outcome of poor immunization coverage in Nigeria is not only locally reaped but continues to compromise positive efforts in neighbouring countries mostly due to the virulent nature of the disease pathogens.

Infant Immunization is particularly important in Nigeria because the incidence of childhood diseases among the different population groups is very high. These childhood diseases are preventable by immunization. The childhood diseases include measles, tuberculosis and diphtheria others are whooping cough, tetanus and poliomyelitis, about one-third of all deaths in children less than five years of age are attributed to these diseases (UNICEF, 1993, 1994).

In order to prevent these childhood diseases, since 1979, through the Federal Government's Expanded Programme on Immunization (EPI), (National Programme on Immunization (NPI) was charged with the responsibility of effectively controlling, through immunization and provision of vaccines to stop these preventable diseases by 2005.

Study Area

The study area is Dekina Local Government Area, of Kogi State North Central Nigeria. Dekina Local Government Area was created in 1976 with Dekina Town as it headquarter. See figure 1.

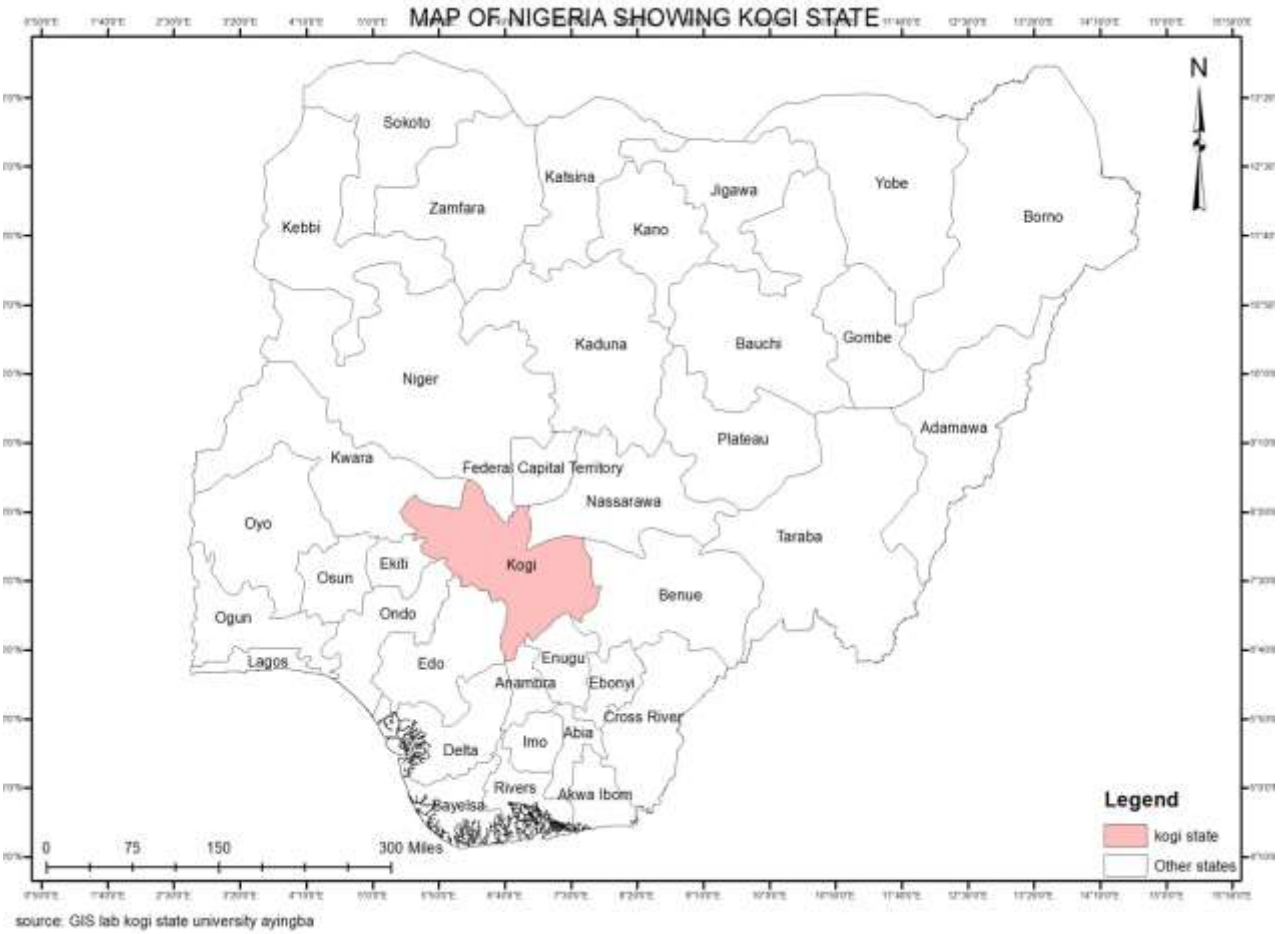

Figure 1: Map of Nigeria showing Kogi State.

Dekina is one of the traditional headquarter of the Igala people and the paramount ruler is the "Eje of Dekina" presently, Dekina Local Government is one of the 21 Local Government Areas of Kogi State.

Location of the Study Area

Dekina Local Government Area is located in the eastern part of Kogi State with a total land area of about 5,091 square kilometers. Dekina Local Government Area has common boundaries with Bassa to the North, Idah to the South, Ankpa to the East, and Ofu to the West. Dekina L.G.A lies

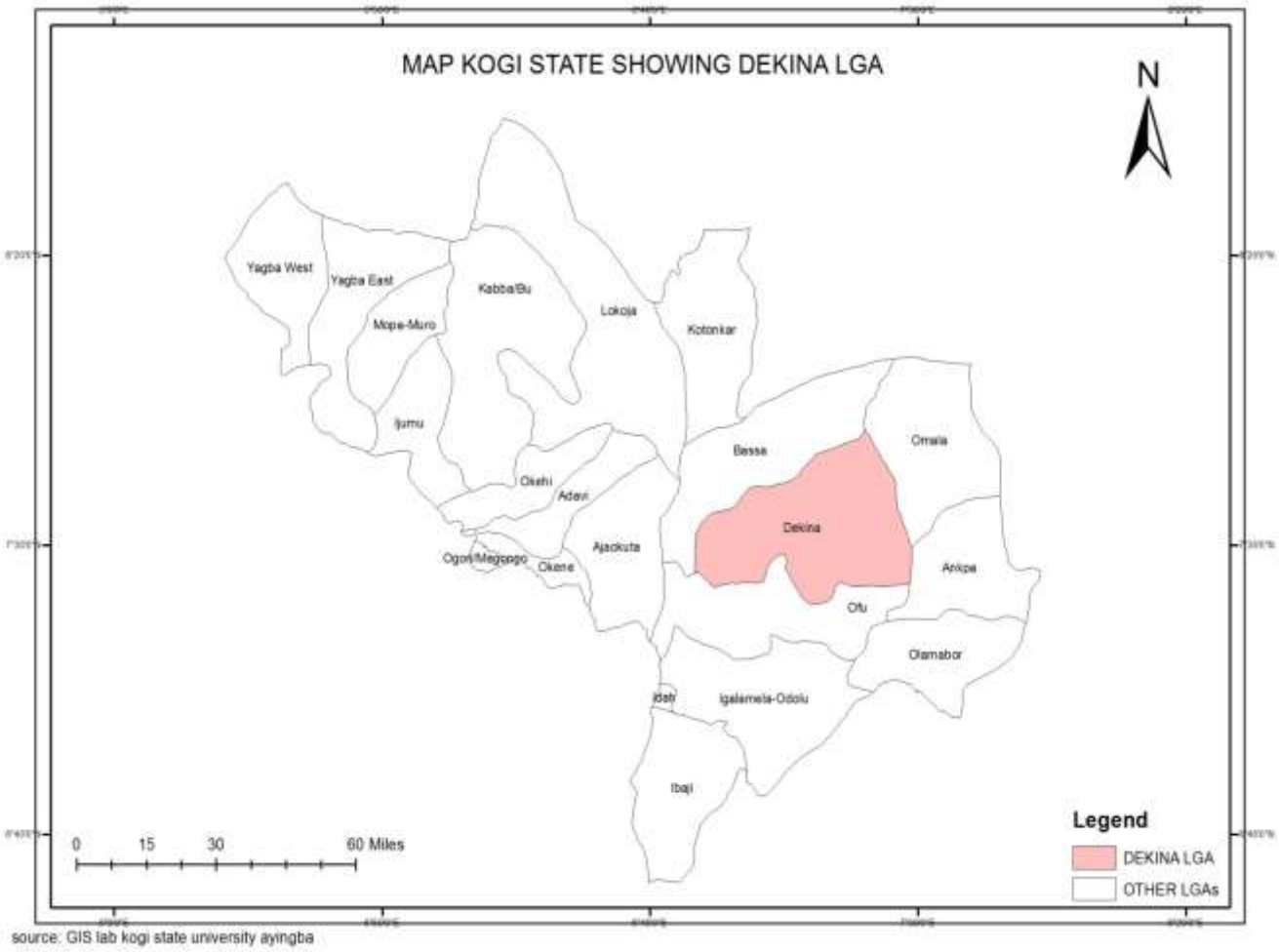

Figure 2: Map of Kogi State Showing Dekina Local Government Area Climate

The area experiences two major climatic conditions which are caused by different trade winds, South-Westerly trade winds which is characterized by harmattan in the dry seasons from December – March.

Rainfall occurs from late March to the end of October with an annual total of 120dm (50-56) metres. The soil are derived from false-bedded sand shore and other upper coal measure sand stone interrupted by winds spreads. The climatic condition has an influence on the vegetation in the area. It is characterized by tall and short growing trees and grasses, with patches of wood land in forest zones which includes marina. The soil type is sandy loam with alluvial clay found in scanty area.

Population

In 2006 census (provisional result) the population of Dekina Local Government Area was estimated at 260, 968. Dekina Local Government represents 9.61 percent of the total population of Kogi state.

The local government has a total number of three districts with sixteen council wards. The ethnic groups in the Local Government area mostly Igalas and a host of other ethnic groups such as the Igbos' Yorubas', Ibiras' Tiv and Idoma; (2006 census). See figure 3.

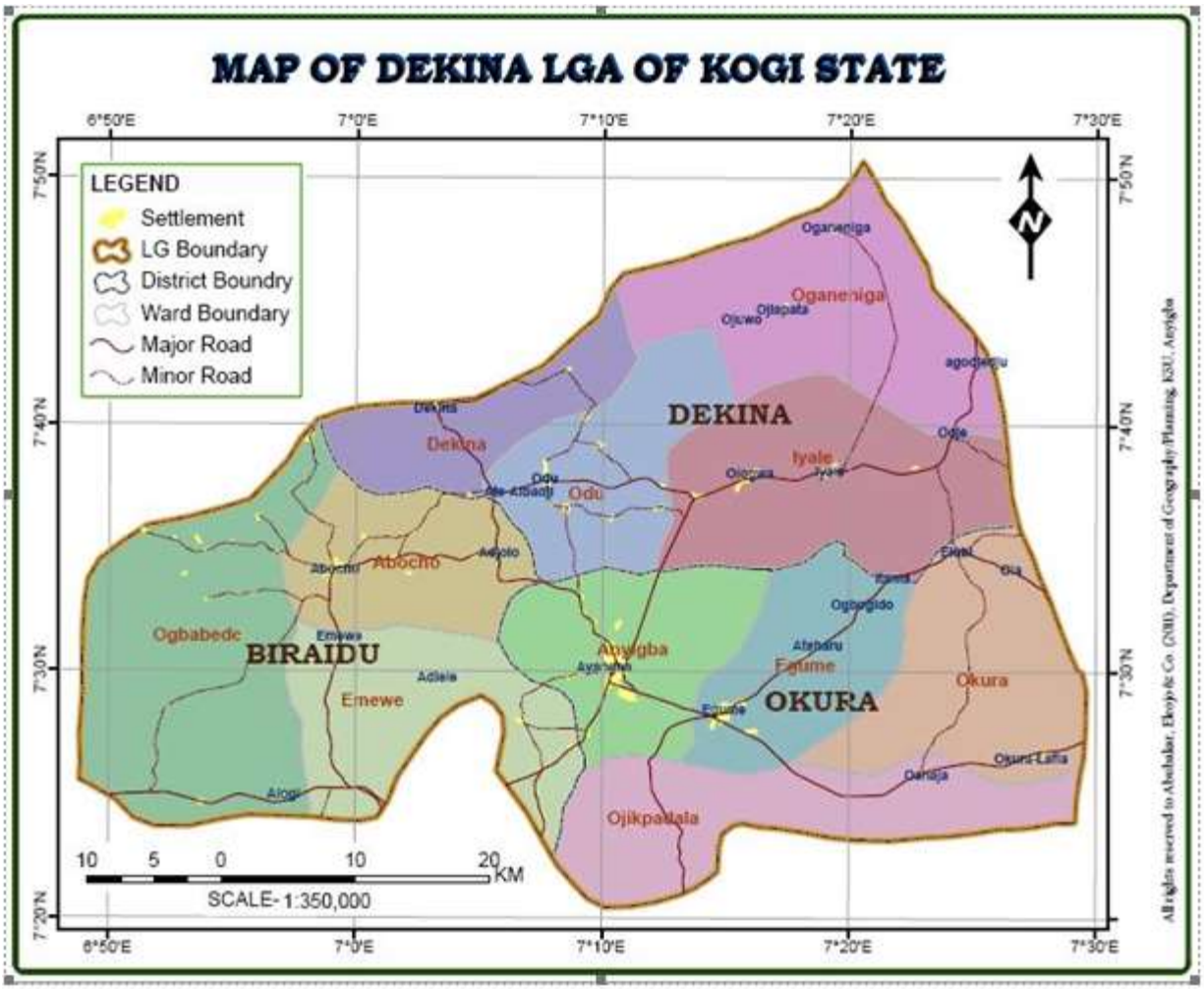

Figure 3: Map of Dekina Local Government Area

METHODOLOGY AND SAMPLING TECHNIQUE

Multi-stage sampling technique was adopted for the study using a sample size of 290 respondents; data were generated from nursing mothers through questionnaire, as they concerned the issues under reference. The reliability of the instrument was achieved through Test-Retest method using 10° 0 of the sample which yielded a correlation coefficient of 0.87 (Pearson's product moment correlation coefficient).

Data Presentation and Analysis

Table 1: Personal Characteristics of Respondent

Level of education	**Frequency**	**Percentage**
No formal education	133	45.9
Primary education	37	12.8
Secondary education	32	11.0
Tertiary education	80	30.3
Domicile		
Unbar	140	48.3
Rural	150	51.7
Occupation		
Government work	90	31.0
Trading	104	35.9
Artisan	8	2.8
Farming	4	1.4
No occupation	84	29.0
Total	290	100

Source: Author's field data, 2020

Table 2: Level of Education and Immunization Coverage

Level of education	Incomplete	Complete%	Total
No formal education	100	33	133
Primary education	22	(95.0)	37
Secondary education	6	15	32
Tertiary education	4	(81.31)	88
		26	
		(40.5)	
		84	
		(24.0)	
Total	**132**	**158**	**290**

Source: Author's field data, 2020

Pearson's Chi Square Table

	Value	**Df**
Pearson chi square	118.928	3
Fisher's exact Test/Linear- Linear equation	116.558	3
No. of valid cases	**290**	

Source: Author's field data, 2020

Table 4: place of domicile and immunization coverage

Domicile	Incomplete	Complete %	Total
Urban	49	91.(65.4)	140
Rural 83	67(44.6)	150	
Total 132	**158**	**290**	

Source: Author's field data, 2020

Chi square table

	Value	**Df**
Pearson chi square	13.073	4
Fisher's exact Test/Linear- Linear equation	12.031	4
valid cases	**290**	

Source: Author's field data, 2020

FINDINGS AND CONCLUSION

Findings from this study generally show that at varying degrees, domicile and mother's occupation are significant factors influencing immunization coverage in the study area. nursing mothers who lived quite relatively father away from health facilities patronized less of immunization services. Those whose occupations took them far away from home also had fewer contact with immunization health workers. Those of them with relatively higher education utilized more immunization services than those with lower education. This study has also revealed that the health behaviour of nursing mothers in most developing countries is largely influenced by socio-economic and environmental factors.

Recommendations

In Igala land, as it is in other state (triber land), the implementation of primary health care is still faced with many challenges. This following recommendation were put forward:

- Government at all level should be charged to re-oreient prospective political office holders on the importance of the health of her citizens, especially pregnant woman and children under the age of five years and the current classification of the state based on its health indices.
- The government also should be encouraged to bring together all the foreign donor agencies and UN agencies to ensure that comprehensive PHC is practiced as against the selective PHC concept with its attendant draw backs.
- Health education should be carried out at all levels by the government for a proper understanding of the real meaning of primary health care and the usefulness of Igala community in particular.

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