Constraints faced by Farmers in receiving Primary Healthcare Service in the North-Eastern Zone of Benue State, Nigeria

[1*]Ama, I. I., [2]Okeme, S., and [3]Chia, J. I.

[1]Department of Agricultural Economics, University of Agriculture,
Makurdi, P.M.B. 2373, Makurdi, Benue State, Nigeria
[2]National Cereals Research Institute Acha sub-station, Riyon Jos, Plateau State Nigeria
[3]Department of Agricultural Extension and Communication University of Agriculture Makurdi, Benue State Nigeria

ABSTRACT
The paper identified the constraints of farmers from receiving primary health care services in the North-Eastern Zone of Benue State, Nigeria. Data were collected from 240 sampled respondents using purposive and simple random techniques. Both secondary and primary data were used for this study. Factor analysis was employed to extract core constraints that farmers face from the many constraints that were mentioned. The study revealed that farmer's constraints in receiving healthcare service can be summarized under four principal factors. The first and most important of this is the factor which described the idea that most health facilities in the study area is not up to standard with a factor score of 0.835. Other principal constraints include the constraint associated with traditional customs and beliefs of the area (0.710); the constraints that doctors and nurses are not well trained (0.718); and the constraint that cost of medical services is high (0.743). It was recommended that community health education authorities should improve on ways of educating there indigenes on health issues to disabuse their minds from traditional practices that discourage them from standard health services.

Keywords: Healthcare services, Farmers, Benue State, Nigeria

INTRODUCTION

In Nigeria over 70% of her inhabitants live in rural communities yet the area has not attracted sufficient health facilities/projects that would substantially improve the health need of the rural dwellers. The healthcare system in Nigeria and the health status of Nigerians are in a deplorable state (Olayiwola, 1990). Apart from this, most of the health infrastructural facilities are concentrated in urban areas to the neglect of rural areas, and the few health facilities located in the rural areas are not functioning effectively (Ajilowo and Olujimi, 2007).

In Benue State, the health centres/institutions are located in the rural and semi-urban environments or mixed population, while general hospitals are located in State capital, Local Government headquarters and a few other big towns. Tertiary health institutions are controlled and funded by the Federal Government which is often located in urban areas, where large population exists. Even when some doctors, laboratory technologist and nurses are posted to the health centres in the rural areas, they either influence/refuse posting or resume and put up nonchalant attitude to work, because of poor health infrastructural development in these areas. Due to the low level of available healthcare facilities/infrastructures in the rural areas; most of the rural inhabitants travel long distant and spend a lot of time to patronise health facilities located in the surrounding urban area where better facilities

---

*Corresponding author: (ama.innocent@yahoo.com) 08060207894

could be sought. Also in most of the health establishments visited, there is the underdevelopment of the system of collating, collecting basic health data on births, deaths, the occurrence of major diseases, and other health indicators and as such retrieval of health information and data for research and other health planning issues from health establishment in Nigeria becomes difficult (Russel, 2004). There are also series of complaints by patients of far distant, inadequate doctors to meet their health demand on daily basis and drugs availability, and the health officials often complain of inadequate infrastructural facilities for them to carry out their duties effectively. It is on this premise that this study is aimed at examining the problems that hinder effective healthcare services in the North Eastern Zone of Benue State in particular.

METHODOLOGY
The study area
Benue State is one of the 36 States of Nigeria located in the North-Central part of Nigeria. Its geographic coordinates are longitudes 7° $47`$ and $10^O$ $0`$ East and Latitudes 6° $25`$and $8^O$ $8`$ North. Benue State has a population of 4,780,389 (National Population Census. NPC, 2006) and occupies a landmass of 35,518km^2, comprising 23 Local Government Areas (LGAs) which are divided into agricultural zones A, B and C. The climate is tropical, manifesting two distinct seasons. The rainy season is from April to October and the dry season is from November to March. Annual average rainfall varies from 1750mm in the Southern part to 1250mm in the North. Benue State is the Food Basket of Nigeria because of the abundance of its agricultural resources, with 80% of the population deriving their livelihood from agriculture. Crops produced are cassava, yams, rice, beniseed and maize. Others include sweet potato, millet, soya beans, sugar cane, oil palm, mango, citrus and bananas. Furthermore, primary healthcare system in these areas employs the concept of village health committees usually composed of local residents chosen without regard to political affiliations, sex, age or religion. These committees are expected to actively participate in planning, organizing and managing the primary healthcare system in the villages.

Sampling technique
The population of the study was 22,082 respondents from five (5) different villages in Vandeikya and Kwande LGA of Benue State. Sample sizes of 240 respondents were selected using purposive and simple random sampling techniques. Sampled respondents in Vandeikya and Kwande L.G.As were selected by means of simple random sampling, using Benue State Primary Healthcare Programme list of communities that have benefited from primary healthcare programmes, and the National Population Commission list of households as sample frame. In the first stage, two (2) LGAs (Vandeikya and Kwande) were purposively selected. The two LGAs were selected because they have excelled in primary health care programmes when compared to other local government areas in the zone (Federal Ministry of Health, 2007).

The second stage involved a random selection of five council wards from each of the two LGAs. Furthermore, five (5) different villages were randomly selected from all the five council wards in the third stage. The fourth and final stage involved sampling of 1.1% of the total household population in all the selected villages using simple random sampling technique to give a sample size of 240 households.

Data collection
Both secondary and primary data were used for this study. Secondary data were sourced from research reports, official statistics from Benue State ministry of health, publications in the internet, library materials such as text books and journals. Primary data were obtained using questionnaire administered to sampled beneficiary and non-beneficiary respondents of the two LGAs with the aid of enumerators.

Analytical techniques

Factor analysis was employed to extract core constraints that farmers face from the many constraints that were mentioned. It is expressed as:

$Z_a = \underline{x_{a-}\mu_a}\, S_a$

Where

a   = indexed a variable in the factor analysis (i.e ''a'' represents all the components and factors of the constraints that have hindered farmers from receiving primary healthcare services.

Z_a = the standard score of variable ''a''

x_a = value taken by variable ''a'' (''x'' represents constraints affecting farmers)

μ_a = mean of variable ''a'' (Is what you get after computing the constraints, mean and standard error i.e $\underline{x_{a-}\mu_a}$) S_a

S_a = standard error of variable ''a''

Therefore the factor analysis model for a sample is then

$Z_i = L_1\, x_1 + L_2\, x_2 \ + \ L_3\, x_3 + L_4\, x_4 \ldots\ldots\ldots\varepsilon_t$

Where

Z = principal component factors (the are the four (4) major factors/constraints in the study area)

i   = indexes respondents (i is a subscript attached to L_i and X_i i.e $\{L_2$ and $x_2\}$, $\{L_1$ and $x_1\}$)

L_i = is the vector of factor loading for variable X_i {meaning the degree to which each of the variables (X_i) correlates with each of the factors (L_i)}

X_i = vector of constraints faced by respondents

Therefore:

L_1 is the vector of factor loading for variable x_1

L_2 is the vector of factor loading for variable x_2

L_3 is the vector of factor loading for variable x_3

L_4 is the vector of factor loading for variable x_4

ε_t = error term

RESULTS AND DISCUSSION

Table 1 summarized the result of factor analysis employed to extract core constraints that farmers face from the many constraints that were mentioned. The table revealed that farmer's constraints in receiving healthcare services can be summarized under four principal factors namely: (i) that health facility in the study area is not up to the standard. (ii) Constraints associated with traditional customs and beliefs of the area; (iii) the constraints that doctors and nurses are not well trained; and (iv) the constraint that cost of medical services is high.

Contributing factors to the first major constraint is the shortage of drugs in primary healthcare centres/hospitals, which is closely followed by inadequate doctors, nurses, community health workers in primary health care centres and hospitals. Contributing factors to the second constraint is the factor of poor educational background, and is closely followed by the long distance of primary healthcare centre/hospital to the respondents' homes. Contributing to the third constraint is the factors of inadequate doctors, nurses and community healthcare workers in primary healthcare centres and hospitals, and is closely followed by poor educational background of some respondents. The fourth constraint is contributed to by the factors of high transportation cost to primary healthcare centres, and is followed by the far distance of primary healthcare centre and hospital to the farmers' houses. The implication of the result is that primary healthcare facilities in the study area need continual improvement to adequately serve the farmers. This agrees with the work of Rusell (2004) that primary healthcare centres are designed to improve health of citizens mostly in the rural areas and to make health facilities accessible to individuals and the society at large.

Table 1:   **Summary statistics of rotated component matrix on constraints farmers face in receiving primary healthcare services**

Constraints	Components			
	1	2	3	4
Cost of healthcare services in primary healthcare centre is high	-0.248	0.055	0.117	0.743
Long distance travelled by respondents to primary healthcare centres.	0.207	0.153	-0.265	0.614
Road conditions are in deplorable state.	0.570	-0.011	-0.395	-0.117
Health facilities in primary healthcare centre are not up to standard.	0.835	0.013	0.034	0.087
Shortage of drugs	0.772	0.103	0.145	0.182
Few doctors, nurses and community healthcare workers are available in primary healthcare centre	0.669	0.089	0.437	-0.016
Doctors, nurses and other community healthcare workers are not well trained	0.372	0.087	0.718	-0.061
Poor educational background	-0.019	0.673	0.331	0.139
There is no primary healthcare centre in the communities.	0.035	0.082	-0.686	0.215
Cost of transportation to primary healthcare centre is very high	0.241	0.092	-0.183	0.702
Traditional customs and beliefs of most farmers	0.039	0.710	-0.127	0.142

Source: Field Survey, 2014

CONCLUSION AND RECOMMENDATIONS

Given the significant influence of four important constraints of lack of standard in health facilities, inappropriate training of doctors, nurses and community healthcare workers, high cost of medical services, as well as traditional belief of the people, it is needful that primary healthcare centres in the study area need continual improvement in terms of personal and facility standard. Additionally, community health education authorities must improve on ways of educating the community on health issues to disabuse their minds from traditional practices that discourage them from standard health services.

REFERENCES

Ajilowo, J. and Olujimi B. (2007). Accessibility of the Rural Dwellers to Healthcare Facilities in Nigeria: The Owo experience. Pakistan *J. Social Sci*. 4(1): 44-55.

Federal Ministry of Health (2007). Integrated Maternal, Newborn and Child Health Strategy. Abuja: FMOH. 50:63-70.

National Population Census, NPC. (2006) Federal republic of Nigeria Official Gazzete, Lagos, Nigeria. 94(4):10-12.

Olayiwola, L. M., (1990). A study of the adequacy of infrastructural facilities in rural area of Oranmiyan Local Government Area of Oyo State. *Unpublished Ph.D Thesis*, Obafemi Awolowo University, Ile-Ife 12:23-25.

Russell S (2004). The economic burden of illness for household in developing countries: A review of studies focusing on malaria, tuberculosis, and human immunodeficiency virus/acquired immunodeficiency syndrome. *American Journal of Tropical Mediterranean* 71(2): 147-155.