Assessment of Management Approach and the Effectiveness of Primary Health Care Systems in FCT Abuja, Nigeria

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Abstract
Failure of Primary Health Care Systems in meeting previously set Millennium development goals and other health targets in Nigeria has necessitated a critical look at its Primary Health Care systems to decipher challenges and requirements necessary for its effectiveness in achieving Immunization Coverage. The purpose of this study was to analyse management approaches within the context of the primary health care system in the Federal Capital Territory, Abuja, Nigeria for effectiveness in achieving immunization coverage. A descriptive survey approach was used and entailed the collection of data from 184 Primary Health Care Management Board members in the Federal Capital Territory, using a researcher- developed instrument titled a "Primary Health Care Manager Instrument (PHCMI).
Data obtained from the questionnaire was analysed using IBM SPSS version 21. T-test and Regression analysis were used to answer the research questions and test the hypotheses respectively. The findings revealed that classical and neoclassical approaches were employed in promoting the effectiveness of Primary Health Care systems for achieving Immunization Coverage in the Federal Capital Territory, though strategies meant to promote immunization Coverage in Primary Health care systems were not well implemented. The test of hypothesis revealed that both Classical and Neoclassical Management Approaches have positive and significant effect on DTP3 Coverage in FCT at the conventional level. In reference to the findings and conclusion from the study, non-adaptation, low adaption, low engagement and poor implementation are factors that have mitigated the effectiveness of primary health care systems in the FCT. The management of the Federal Capital Territory Primary Health Care systems should be reoriented and incentivised to focus on core value delivery.

Key words: Assessment, Management, Approach, Effectiveness

1.1 Background to the study

Management is central to the survival of any human activity; whether personal, group, association, organization, societal or country. Management of Primary health care systems is important to governments especially in the achievement of the sustainable development goals. Anyakora (2022) described Primary Health Care systems as health systems having the capacity to provide the needed framework for organizing and delivering care based on a patient-centred, efficient, fair and cost-effective approach to healthcare. Generally from available literature, there are four principal management approaches that can be adopted by health managers of public Primary Health Care systems to achieve Immunization Coverage these includes; a classical approach, where a hierarchical organizational structure focused on efficient job actualization at the detriment of worker's welfare is adopted, a neoclassical approach, where the human aspect of management is emphasized that takes into consideration the welfare of individuals and where group perspectives influence organizational

performance, a systems approach where the totality of an organization's structure is cognizance to efficiently realize its goals or a contingency approach, where the management of health care systems is subject to changing circumstances in the Federal Capital Territory, the current management system adopted cannot be classified with all level of certainty and hence the reason for this research, which is analysing management approaches within the context of the primary health care system in the Federal Capital Territory, Abuja, Nigeria for performance on Immunization coverage.

The global focus of Primary Health Care systems is to achieve health equity in line with the 2030 Agenda of Sustainable Development. Notable amongst its Health Care strategies for promoting the wellbeing of populations is the employment of the expanded program on immunization (EPI) against major infectious disease (NPHCDA, 2021). Mantel & Cherian (2019) reported that "the Expanded Program on Immunization (EPI) was initiated in 1974 with the goal of providing universal immunization with essential vaccines. Among the initially targeted six vaccine-preventable diseases (VPDs), diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis, a substantial reduction in the burden of preventable childhood illnesses and deaths was achieved in its initial years. Esezobor (2013) reported that the ultimate goal of immunization programmes is to reduce the incidence of vaccine preventable diseases (VPDs) by attaining high levels of routine immunization coverage with potent vaccines administered at the appropriate ages, and at the right intervals. In Nigeria, the Expanded Programme on Immunization (EPI) was initiated in 1979 to ensure that all children had access to routinely recommended vaccines, and re-launched in 1984. This programme led to significant progress in the delivery of immunization services with 8I.5% coverage for all antigens recorded during the Universal Childhood Immunizations (UCI) days between 1986-1990s. However, this achievement was not sustained as periods of fluctuation in EPI performances and a significant decline in immunization coverage were noted in the 1990s. EPI was then restructured and renamed as National Programme on Immunization (NPI) in 1997, in an effort to enhance the effectiveness of the routine immunization programme and to meet the global challenges of immunization. It was subsequently taken over by the National Primary Health Care Development Agency (NPHCDA) in May 2007 for better management, organization and improved logistics up to the ward /PHC level.(NPHCDA 2017)

In May 2012, Nigeria commenced expansion of existing children initiatives, with emphasis on polio eradication and strengthening of routine immunization with the replacement of Diphtheria, Pertussis and Tetanus (DPT) vaccine with pentavalent vaccine which contains more antigens(Hepatitis B and Haemophilus type B).(NPC and ICF 2014) There was introduction of pneumococcal conjugate vaccine (PCV) in 2014, introduction of single dose of inactivated polio vaccine (IPV) in 2015 and switch from trivalent (tOPV) to bivalent OPV (bOPV) in April 2016 in the routine immunization program (WHO 2016). All these were aimed at strengthening the existing initiatives directed at the eradication of vaccine preventable childhood killer diseases.

National Programme on Immunization (NPI) prescribes five visits to the health facility to receive one dose of BacilleCalmette Guerin (BCG) and Hepatitis B at birth, three doses of Oral Polio Vaccine(including one IPV), and three doses of Pentavalent vaccine, at six,ten and fourteen weeks and one dose of measles vaccine and yellow fever given at nine months of age.9,10It is recommended that a child should receive all immunization at the appropriate ages and intervals in order to ensure maximal protection from vaccine preventable diseases.11,12The percentage of children who have receive the requisite number of vaccine

doses irrespective of the age at receipt of the vaccine is used to determine vaccination coverage13and the third dose of pentavalent vaccine is the key indicator to measure immunization programme coverage.14

Over the past decades, national immunization programmes (NIPs) have become substantially more complex, with vaccines now available to protect against more than 20 infectious diseases, while

health, societal, and political changes created additional volatility and ambiguity in often more uncertain environments (e.g., with the occurrence of conflicts, epidemics, or increasing vaccine hesitancy). Gavi, the Vaccine Alliance, was established in 2000 primarily to allow new vaccines to reach children in the poorest countries. The World Health Organization introduced a Global Vaccine Action Plan in 2012 with the aim to prevent deaths due to diseases that could be prevented by vaccination. Under this plan, the organization hoped to increase access to vaccinations thereby increasing the percentage of immunization coverage. The important focus on equitable immunization uptake and coverage was also reflected in the 2016–2020 Gavi strategy, the subsequent Gavi strategy leading up to 2025 and in the new Immunization Agenda 2030 (IA2030).This immunization strategy is a step toward the health and wellbeing of humanity as confirmed by Bhatti's 2017 report that, "Immunization averts an expected 2-3 million deaths arising from diphtheria, tetanus, pertussis (whooping cough) and measles every year and an additional 1.5 million deaths could be avoided if vaccination coverage was improved worldwide. It saves millions of lives by preventing diseases". Childhood diseases, morbidity and mortality that were commonplace a few generations ago have become rare because of immunization of children (PAN, 2021). Major successes have been accomplished since the introduction of immunization programs. The mortality rate among children under 5 years of age has been driven down from $^1/_{19}$ to $^1/_{26}$ children in only 7 years between 2010 and 2017. More children than ever (116.3 million) are receiving three doses of DTP before their first birthday, 4.9 million more than in 2010. By 2018, 129 countries had reached at least 90% coverage of the third dose of DTP vaccine. Country decision-making capabilities were strengthened, and many life-saving vaccines were introduced primarily in the poorest countries. Regional Vaccine Action Plans were designed, a global immunization monitoring and evaluation framework was established, and efforts were made to shape vaccine markets and to improve vaccine price transparency. Overall, the GVAP helped to build political will and kept immunization visible on the global agenda (Loharikar A et al (2016), WHO (2018) and WHO (2019)

Nevertheless, vaccine coverage in many lower and middle-income countries (LMIC) still falls short of the World Health Organization's (WHO) target of 90 % national coverage with three doses of diphtheria-tetanus-pertussis containing vaccines (DTP3). Among these are 'zero-dose children, which refers to children who do not receive a single dose of any vaccine in the routine national immunization schedule, and 'missed dose' children who do not receive the complete schedule (Chard and World Health Organization 2019). Unvaccinated children remain vulnerable to vaccine-preventable diseases and are often already disadvantaged due to poverty, conflict, and lack of access to basic health services. Globally, 22.7 million children are estimated to be zero- or missed-dose, and of these, 3.1 million (~14 %) reside in Nigeria *(Vaccine Action Plan (GVAP),2016)*

Nigeria has had a complex history of immunization dating from the 1970s/1980s, where active supporters of immunization made up of bilateral and multilateral aid agencies, made efforts during that time, funding the program. Funding was however compromised during a period of political turbulence that led donors to cut funding in the country, a case that was however reversed during the civilian rule in 1999 though not without some recorded setbacks in immunization coverage stride. When the National Program on Immunization (NPI) was established, it was absorbed into the National Primary Health Care Development Agency (NPHCDA) in 2007 promoting a conducive platform for international donors to reenter the arena, but for many years routine immunization (RI) coverage performance has fluctuated uncertainly. As reported by NPHCDA (2018) "in the last decade however, there have been gradual improvements in national coverage for vaccines such as *bacille Calmette-Guérin* (BCG) for tuberculosis, the third dose of diphtheria-tetanus-pertussis (DTP3), polio, and hepatitis B,. Strengths in Nigeria's current Routine Immunization (RI) system are most apparent at higher government levels. Strong support for RI is evident from NPHCDA and the Federal Ministry of Health (FMoH), and funds for vaccine procurement have been consistently included in the federal budget". In addition Mahachi & Kessels (2022) reported that "after several years of challenges,

Nigeria has succeeded with interrupting polio transmission, and in October 2015 the country was certified polio free after 1 year of no polio cases. Overall, great achievements have been made in reducing mortality rates among children under 5, from 201 per 1,000 live births in 2003 to 114 per 1000 in 2020"

According to the Nigeria Strategy for Immunization and Primary Health Care System Strengthening 2018 – 2028 (NSIPSS, 2018), Nigeria has the highest number of unimmunized children in the world, estimated at 4.3 million children in 2018. In recent years, the coverage of DPT3/Penta 3, a key indicator of a country's performance of Routine Immunization, has fallen from 52% in 2014 to 33% in 2016.In response to the declaration of State of Public Health Concern on Routine Immunization Programs on the 17th of June 2017 by the MICS/NICS report of 2016/2017 survey, the National Emergency Routine Immunization Coordination Centre (NERICC) was established and inaugurated on the 4th of July 2017. NERICC has been mandated to work in an emergency mode to rapidly improve routine immunization (RI) performance in the eighteen lowest performing states over eighteen to twenty-four months, while maintaining targeted support to the other medium to high performing states to improve their current performance. As a matter of urgency, the eighteen poorest performing States are also expected to ensure the establishment of the State Emergency Routine Immunization Coordination Centre (SERICC) and Local Government Emergency Routine Immunization Coordination Centre (LERICC).

The NSIPSS 2018 highlights leadership, management and coordination (LMC) as core pillars underpinning the immunization program in Nigeria and by extension posing significant challenges in the achievement of its goals. "As a nation made up of federating states, leadership is devolved to each of the federating units at State, and LGA levels. Within the immunization program, the complexity of this devolution impacts on how the program is managed and results achieved. While the NPHCDA drives policy and central coordination, the subnational levels are tasked with implementation, with significant levels of autonomy, which leads to varying program performance. Other factors such as weak accountability and coordination, poor program and financial management also have negative effects on the immunization program. In addition, feedback mechanisms and linkages between the different levels is also a challenge. In most instances, national and state teams have limited visibility to the implementation of activities at the primary health care level and are thus poorly responsive to emerging challenges or course corrections that should be promptly implemented. Improving the management of the program both at the national and sub-national levels is at the heart of this strategy. It has been widely recognized that a transformation in coordination and accountability is imperative in Nigeria and that no part of the program can succeed without significantly improved transparency on progress and accountability for results"

To improve leadership, management and coordination, NSIPSS proposed; strengthening PHC management through Primary Health Care Under One Roof (PHCUOR) (which calls for consolidating all PHC management and implementation under the SPHCDA), improving coordination at national and sub-national levels (between Inter-Agency Coordination Committee (ICC), The Core Group, chaired by the ED / CEO of NPHCDA, National Emergency Routine Immunization Coordinating Centre(NERICC) and the National Technical Advisory Group on Immunization (NITAG)), instituting an accountability framework for routine immunization and improving organizational capacity to manage the immunization program(including better defining departments and roles, and shifting staff to more productive posts (from the current 60:40 ratio of administrative to programmatic staff to a healthier 40:60).

Methodology

3.1 Research Design

The research design adopted for this study is a cross sectional descriptive survey design, which involved the collection of data from a representative sample and the compares' this data with secondary data obtained from DTP3 immunization coverage and dropout rate between 2017 to 2021.

3.2 Population, sample size and sampling technique

The overall population of this study comprised of three hundred and forty-one (341) Primary Health Care managers from the Federal Capital Territory Primary Health Care Management Board. A sample size was obtained using Taro Yamane's formula for calculating sample size which states that for a 95% confidence level and p=0.05, size of the sample should be

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

Where N is the population and e is the level of precision , N=341 with 5% precision assuming 95% confidence level and p=0.05 we get the sample size as

$$n = \frac{341}{1 + 341(0.05^2)}$$

n=184

The data for the study were collected using a researcher-developed instrument titled Primary Health Care Management Instrument (PHCMI). The study compose of two sections; Section A and Section B. Section A covers the demographic information of the respondents while Section B was based on the research variables of management approaches and their impact on the effectiveness of the Primary Health Care System service coverage in the Federal Capital Territory, FCT, Abuja, Nigeria. The responses and corresponding weights of the instrument were: SA – strongly agree (5 points), A – Agree (4 Points), UND – Undecided (3 points), D – Disagree (2 Points) and SD – Strongly Disagree (1 Point). The researcher and two research assistants participated in the administration of the instrument on sampled respondents. The researcher personally ensured that the research assistants were briefed on how to conduct the exercise in order to achieve a high retrieval rate in terms of returned questionnaires. The research assistants who participated in the study were Masters Students of the University of Abuja from the Department of Psychology and Counselling and Statistics respectively. They were selected as a result of their previous experiences in the administration of questionnaires while handling departmental based research. A retrieved rate of 100% was obtained, thereby indicating the successful nature of the administration of the research instruments on the respondents. The face and content validity of the research instrument were determined by the project supervisor and an official from the National Primary Health Care Development Agency (NPHCDA). Thus suggestions, corrections and modifications were taken into consideration while preparing the final draft of the questionnaire. The need for the validity test was a basic feature of ensuring the reliable nature of the research instrument in gathering data required. The reliability of the research instrument was confirmed through a pilot test involving 48 Primary Health managers excluded from the study. Cronbach's Alpha test was used to compute the reliability coefficient of 0.722. We are 72% sure that there is strong correlation between all factors considered to affect UHC and PHC in FCT.

3.3 Method of Data Analysis

Data obtained from the questionnaire was analysed using IBM SPSS Version 21. Descriptive and inferential statistical tools were used for the data analysis. The descriptive statistical tools of percentages and frequency counts were used to analyse demographic data of respondents. Means scores and standard deviation were employed in answering the research questions of the study. Inferential statistical tools of Pearson Product Moment Correlation Coefficient and Linear Regression were used to test the null hypothesis at 0.05 level of significance. The decision rule for research

questions was based on 2.50 Mean score benchmark. Therefore, mean scores below 2.50 were rejected as negative responses, while mean scores from 2.50 and above were accepted as positive responses. For the test of hypothesis, the decision rule was; accept null hypothesis when P value is greater than 0.05 level of significance and reject null hypothesis when P value is less than 0.05 level of significance

Results

Answer to research question 1 on the extent managers of the Federal Capital Territory Primary Health Care adopt the classical management approach to promoting immunization Coverage in FCT is shown in table 4.1 below

Table 4.1: t-test distribution of the Responses from the respondents on the Federal Capital Territory Primary Health Care adopted the classical management approach to promoting immunization Coverage in FCT

S/N	Items	Average*	t**	df	P-Value	**Remarks**
1	PHC systems have several units each with specific and clear goals	4.0489	55.601	183	0.000	Reject
2	Procedures for ensuring immunization coverage (IMC) involve formal rules that must be dully followed	3.4511	44.606	183	0.000	Reject
3	Decisions made toward IMC are exclusively taken by the leadership and directives are given to the managers to follow	3.7880	44.252	183	0.000	Reject
4	Actions taken toward the implementation of IMC must pass through all necessary processes before its implementation	3.1848	38.391	183	0.000	Reject
5	There are several hierarchical structures in the PHC system that delay processes promoting IMC	3.0054	39.494	183	0.000	Reject
	Grand Mean	3.49564				

Source: *Researcher's Field Result, 2022*

Table 4.1 contains the results of the t-test distribution of the Responses from the respondents on the Federal Capital Territory Primary Health Care adopted the classical management approach to promoting immunization Coverage in FCT. The results shows that the estimated grand mean (3.49564) , t-value are 55.601, 44.606, 44.252, 38.391 and 39.494 respectively, the degrees of freedom (**df=183**), and the statistical significance (*p*-values=0.000) of the one-sample t-test. Since the grand mean is above the criterion mean of 3.00, therefore, to a high extent managers of the federal capital territory primary health care adopt the classical management approach to promoting immunization Coverage in FCT. However, since probability estimated values of all the items are less than the conventional level of significance (p < 0.05). It can be concluded that the means are statistically significantly different.

Also, answer to research question 2 on the extent managers of the federal capital territory primary health care adopted the neo-classical management approach to promoting immunization Coverage in FCT is shown in table 4.2 below.

Table 4.2: t-test distribution of the responses from the respondents on the extent managers of the Federal Capital Territory Primary Health Care adopted the Neo-classical management approach to promoting immunization Coverage in FCT

S/N	Items	Average*	t**	df	P-Value	**Remark**

6	Immunization goals and objectives are clearly communicated and understood by staff of PHC systems	3.9185	50.619	183	0.000	Reject
7	Individual skills and abilities are valued and promoted in PHC systems	3.3750	45.273	183	0.000	Reject
8	Participation in social associations are encouraged among staff of PHC systems	3.6576	41.831	183	0.000	Reject
9	PHC systems willingly help out staff with work related problems to overcome them	2.9891	35.556	183	0.000	Reject
10	Staff are motivated with incentives to perform better on their jobs	2.7283	30.672	183	0.000	Reject
	Grand Mean	3.3337				

Source: *Researcher's Field Result, 2022*

Table 4.2 shows the results of t-test distribution of the responses from the respondents on the extent managers of the Federal Capital Territory Primary Health Care adopted the Neo-classical management approach to promoting immunization Coverage in FCT. The results shows that the estimated grand mean (3.3337), t-value are 50.619, 45.273, 41.831, 35.556, and 30.672 respectively, the degrees of freedom (**df=183**), and the statistical significance (*p*-values=0.000) of the one-sample t-test. Since the grand mean is above the criterion mean of 3.00, therefore, to a high extent managers of the federal capital territory primary health care adopted the neo-classical management approach to promoting immunization coverage in FCT. However, since probability estimated values of all the items are less than the conventional level of significance (p < 0.05). It can be concluded that the means are statistically significantly different from each other.

Test of Hypothesis

Ho_1: There is no significant effect of Classical Management Approach on the DTP Coverage in FCT.

Table 4.6: Regression Analysis of the effect of Classical Management Approach on the DTP Coverage in FCT.

Goodness of Fit test		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta	T	Sig.	Lower Bound	Upper Bound	Tolerance	
	(Constant)	0.415	0.101		4.107	0.000	.476	.791		
	CMA	0.887	0.030	.909	29.428	0.000	.814	.924	1.000	
R^2	0.732									
$AdjR^2$	0.731									

Source: *Researcher Extract from SPSS Version 26 OUTPUT*

CMA stands for Classical Management Approach See detail in Appendix

Table 4.6 shows the results of regression analysis of the effect of Classical Management Approach on the DTP Coverage in FCT. The results simply show that an increase in the use of classical management approach will increase DTP Coverage in FCT by 88.7%. The coefficient of determination (R^2) is 0.732 which show that 73.2 percent variations in the DTP Coverage in FCT are largely attributed to classical

management approach all things being equal. The remaining 26.8 are variations are expounded by other factors not considered in the model. We can see that the VIF value classical management approach is 1.000. Thus, the VIF value of 1.000 is smaller than 10. We can conclude that the VIF value is less than 10, meaning that there is no multicollinearity in the independent variable (classical management approach). Since the overall estimated probability (P-value<0.05), therefore, we can conclude that Classical Management Approach has positive and significant effect on the DTP Coverage in FCT at the conventional level. Figure 4.1 below contains the normal P-P plot of the linear regression establishing the relationship Classical Management Approach and the DTP Coverage in FCT.
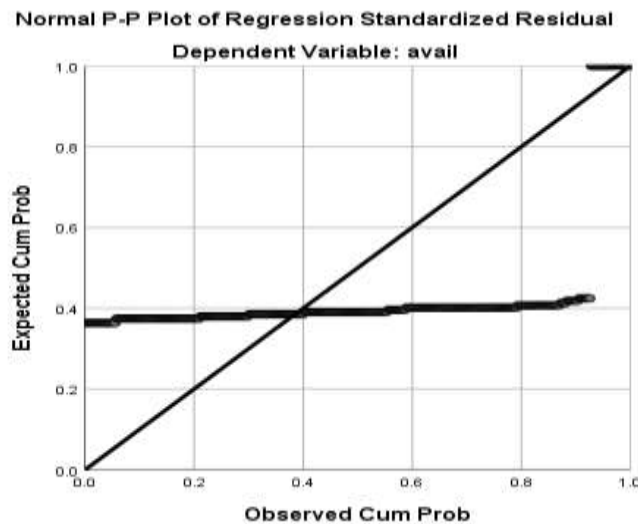

Figure 4.1: Normal P-P plot of the linear regression establishing the relationship Classical Management Approach and the DTP Coverage in FCT.

H$_{02}$: There is no significant effect of Neoclassical Management Approach on DPT Coverage in FCT.

Table 4.7: Regression Analysis of the effect of **Neoclassical Management Approach on DPT Coverage in FCT.**

Goodness of Fit test		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta	T	Sig.	Lower Bound	Upper Bound	Tolerance	F
	(Constant)	1.916	.151		12.66	.000	.158	.532		
	NMA	0.491	.051	.579	9.588	.000	.852	.964	1.000	
R^2	0.336									
AdjR^2	0.332									

Source: *Researcher Extract from SPSS Version 26 OUTPUT*

NMA stands for Neoclassical Management Approach

See detail in Appendix

Table 4.7 shows the results of regression analysis of the effect of neoclassical management approach on DPT coverage in **FCT.** The results simply show that an increase in the use of neoclassical

management approach will increase DTP Coverage in FCT by 49.1%. The coefficient of determination (R^2) is 0.336 which show that 33.6 percent variations in the DTP Coverage in FCT are largely attributed to neoclassical management approach all things being equal. The remaining 66.4 are variations are expounded by other factors not considered in the model. We can see that the VIF value neoclassical management approach is 1.000. Thus, the VIF value of 1.000 is smaller than 10. We can conclude that the VIF value is less than 10, meaning that there is no multicollinearity in the independent variable (neoclassical management approach). Since the overall estimated probability (P-value<0.05), therefore, we can conclude that neo-classical Management Approach has positive and significant effect on the DTP Coverage in FCT at the conventional level. Figure 4.2 below contains the normal P-P plot of the linear regression establishing the relationship neoclassical management approach and the DTP Coverage in FCT.
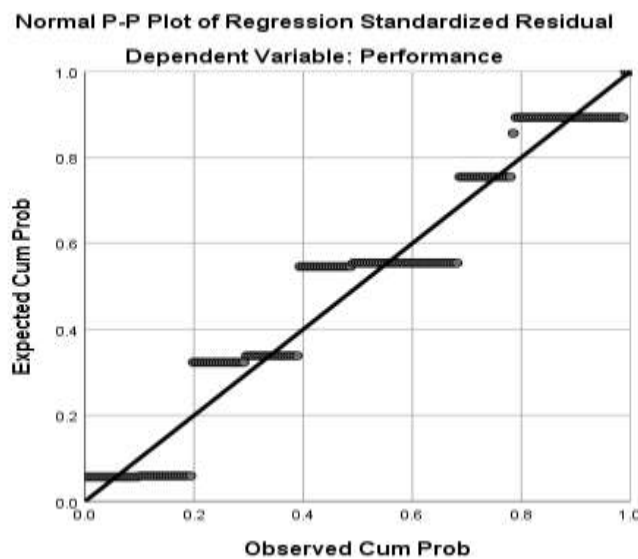

Figure 4.2: Normal P-P plot of the linear regression establishing the relationship neoclassical management approach and DTP Coverage in FCT.

Discussion

The extent managers of the federal capital territory primary health care adopted the classical management approach to promoting immunization Coverage in FCT.

Research question one elicits information on the extent of which managers of the federal capital territory primary health care adopted the classical management approach to promoting immunization Coverage in FCT. The results of the analysis revealed that the Classical Management Approach has positive and significant effect on the DTP Coverage in FCT at the conventional level such that an increase in the use of classical management approach will increase DTP Coverage in FCT by 88.7%. The findings of this study were in line with Esene (2015) study on the assessment of Health Management Information System in Primary Health Care Centres in Edo State, Nigeria, where it was found that the utilization of NHMIS practice was important, it was noted that health centres surveyed were capable of operating the NHMIS while most were not and three-quarters of the health centres had focal persons handling data. In terms of overall data accuracy, Pentavalent3 vaccination had major data quality issues, antenatal care had minor data quality issues and institutional birth had major data quality issues.

The extent managers of the federal capital territory primary health care adopted the neo-classical management approach to promoting immunization coverage in FCT.

Research question two elicits information on extent managers of the federal capital territory primary health care adopted the neo-classical management approach to promoting immunization coverage in FCT. However, findings show that to a high extent managers of the federal capital territory primary health care adopted the neo-classical management approach to promoting immunization coverage in

FCT. This simply shows that Immunization goals and objectives were clearly communicated and understood by staff of PHC systems, individual skills and abilities were valued and promoted in PHC systems, participation in social associations are encouraged among staff of PHC systems, PHC systems willingly help out staff with work related problems to overcome them and Staff are motivated with incentives to perform better on their jobs. This was further confirmed as the test of hypothesis revealed neo-classical management approach has positive and significant effect on the DTP Coverage in FCT at the conventional level such that an increase in the use of neo-classical management approach will increase DTP Coverage in FCT by 49.1%. The findings were synonymous to Lamarche, & Maillet (2016), who studied on the performance of primary health care organizations depends on interdependences with the local environment.

Conclusion

Based on the responses of respondents, it is obvious that to a high extent, managers of the federal capital territory primary health care adopted the classical and neo-classical management approaches in promoting immunization Coverage in FCT with both having a positive and significant effect on DTP coverage. The highest distributions of DTP (Penta) Coverage in FCT were done in 2021.

Recommendations

1. There is need for Government to pay close attention to Managers of the Federal Capital Territory Primary Health Care to adopt the classical management approach in promoting immunization Coverage in FCT with emphasis on the physical needs of the patients over job satisfaction or social needs. This could be achieved by timely evaluation of the management system.
2. **Managers of the Federal Capital Territory Primary Health Care should improve in the adoption of the Neo-classical management approach to promoting immunization Coverage in FCT. This is necessary because the neoclassical approach will help them in identifying the importance of physiological and social aspects of workers as well as individual patients in the hospital and their relationships within and among the group of the hospitals in FCT, Abuja.**

References

Anyakora, C. (2022): Addressing Challenges in Primary Health Care as pathway to achieving Universal Health Coverage.

Enyioko, N. (2021). "Classical Management Theories and Organisational Performance in Rivers State, Nigeria. An analysis". Munich: GRIN Verag.

Esene A.H. (2015): Assessment of ealth management system in primary health care centres in Edo State Nigeria. National Postgraduate Medicl College of Nigeria (NPMCN)

FGN (2018). "Second National Strategic Health Development Plan 2018-2022. Ensuring Healthy Lives and Promoting the Wellbeing of Nigerian Populace at all ages. National Health Policy *Promoting the Health of Nigerians to Accelerate Socio-economic Development*

Jaca, A.,Malinga, T Iwu-Jaja, C.J.,Okeibunor J.C.,Wiysonge, C.S. (2022): Strengthening the Health System as a Strategy to Achieving a Universal Health Coverage in Underprivileged Communities in Africa; A Scoping Review". *Int.J. Environ. Res. Public Health*, 19,584.

Lamarche, P and Maillet L.(2016), The performance of primary health care organizations depends on interdependences with the local environment; journal of health organization and management 30 (6) DOI:10.1108/JHOM-09-2015-0150