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Local Government and Health Care Delivery in Nigeria: A Case Study

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ABSTRACT This paper seeks to highlight the recent activities of local government in health care delivery. The literature review reveals the interconnectedness between local government and the sustenance of primary health care in Nigeria. The study traced the historical antecedent of health service delivery from the colonial era to the present day. It identifies the major contradictions in the management of primary health care implementation, using a local government as case study. They include shortage of qualified personnel and finance, inadequate transportation, inaccessibility to communities, lack of maintenance culture, political instability, high degree of leadership turn-over. For the sustainability of health care service delivery at the grassroots, the study recommends increase financial allocation, community mobilization, improved health education, policy consistency and provision of qualified health workers.

I. INTRODUCTION

The purpose of this paper is to evaluate the performance of primary health care delivery in Ife-East Local Government of Nigeria. The paper tries to highlight the management of PHC and also to draw lessons for other actors in the health sector. The paper is specifically divided into six parts. The first part is the methodology, while the second made a review of the theories of Local Government and Primary Health Care. The third section is a review of the history of Primary Health Care in Nigeria, the fourth identifies the management of PHC in Ife-East Local Government as a case study. While the fifth and sixth highlights the problems and drew conclusions. This exercise is a product of a micro research work conducted as a Lecturer in Community Health Services.

II. METHODS OF STUDY

The research work is approached through empirical, descriptive and survey methods. However, because of the peculiar nature of the Nigerian Local Government system, the research method is restricted to empirical descriptive research, through personal inspection and observation. A tour of health facilities and operation centres within the Ife East Local Government with the support of the Primary Health Care operators in the LGA were made. Similarly, personal interviews were conducted with other health officers in the LGA. Secondary data were obtained through library study, articles, records and files relating to primary health care services delivery including LGA reports, etc. Personal interview were conducted among the beneficiaries of the LGA health services.

The data collected were subjected to descriptive analysis. This was used to describe data collected in normal and ordinal scale, thus tables and percentages were used to analyze some of the data collected.

III. THE THEORY OF LOCAL GOVERNMENT

According to Adeyemo (1997) there are a number of approaches to definitions of what a theory is. Some of these refer to theory as: list of factors, approaches and models. However, a more concise definition is that suggested by Kerhingin, as a set of generations containing concepts with which we are directed, acquainted and those which are operationally defined.

Theory is the explanation of the general principles of an art of science, reasoned supposition put forward to explain facts or events or ideas. The efficacy of theory is quite invaluable in social sciences under which Local Government falls. It is important in order to explain facts, events and ideas underlying the discipline. Though, Mackensie (1964) opined that 'there is no theory at Local Government' and that 'there is no normative general theory from which we can devise testable hypothesis about what it is'. In addition, C. S. Whitaker, (1970) observed that no obstacle to analysis would arise were there are universally acceptable functions and purposes

of modern democratic Local Government but of course, there are none. Nevertheless, a review of relevant literature, shows that many scholars are of the opinion that there are separate theory of Local Government apart from the general perspectives of government.

Authors such as Wilkman (1970) Mill and Machenzie (1964) wrote extensively on theory of Local Government. One could deduce from their arguments that what they do agree upon is that there is no universally accepted theory of Local Government.

Akindele and Adeyemo (1997) while trying to arrive at a definite theory of Local Government examined some theoretical efforts already documented within the parameters of Local Government studies as relates to the functional and institutional relevance of Local Governments in the politics of the world especially in Nigeria. They reviewed the works of such scholars like Professors Ola (1984) and Gboyega (1987) and noted that the first class attempts to justify the existence or need for Local Government on the basis of its being essential to a democratic regime or for practical administrative purposes like responsiveness, accountability and control. The other class of theories is contrapuntal to the first class of theories. This is in the sense that it argues that an effective Local Government system contradicts the purposes of a democratic regime.

Conclusively, all the positions summed to three schools of thought viz:

(a) Democratic – participatory school
(b) The efficiency – service school
(c) The developmental school.

One could see that none of the three schools of thought is irrelevant to the success or failure of National Health Services delivery. Essentially, Primary Health Care Services Delivery aimed at enhancing of democratic mass participation of all and sundry at the grassroots level. Efficiency – Services School fits in the health services of the people while effort is aimed at the over all development of every individual since Health is wealth. Theoretically speaking therefore, Local Government is expected to enhance achievement of democratic ideals, political participation, protective services and infrastructural services like provision and maintenance of health facilities and institutions.

To this end, one can ask what is Local Government? There are avalanche of definitions given by various schools of thought about the concept. The Nigerian 1976 Local Government Reforms as enshrined in the 1979, 1989 and 1999 constitutions of the Federal Republic of Nigeria defined Local Government as:

"Government as the Local level … established by law to exercise specific powers within defined areas (and) to initiate and direct provision of services and to determine and implement projects so as to complements the activities of the state and federal government in their area (Local Government Reforms, 1976).

The United Nations Organization defines Local Governments "As a political sub-division of a Nation or in a federal system, a state which is constituted by law and has substantial control over the unit or local affairs including the power to impose taxes or to extract labour for prescribed purposes".

In addition the International Encyclopedia of social sciences (1976), defines Local Government as "A political sub-division of National or Regional Government which performs functions which nearly in all cases receive its legal power from the National or regional government but possess some degree of discretion on the making of decisions and which normally has some taxing powers.

In Nigeria however, the functions and responsibilities of Local Government is contained in Fourth schedule of the 1999 constitutions of the Federal Republic of Nigeria and some of these functions that are of relevance to health services are as thus. Section 7 (1) C specified the establishment and maintenance of cemeteries burial ground and homes for the destitutes or infirm.

- Establishment, maintenance and regulation of slaughter houses, slaughter slabs, markets, motor parks and public conveniences;
- Provision and maintenance of public conveniences, sewage and refuse disposal
- Registration of all births, deaths
- Control and regulation of movement and keeping of pets of all description, restaurants, bakeries and other places of sale of food to the public.

The above functions supposed to be the sole responsibilities of Local Governments' Primary Health Care.

IV. THEORY OF PRIMARY HEALTH CARE

The concept of PHC was formulated by the 134 countries that met at the Alma Ata conference in Russia on 12th September 1978, organized under the auspices of the World Health Organization (WHO) and the United Nations Childrens Fund (UNICEF).

According to W.H.O. Primary Health Care means essential health 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 which the country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. Primary Health Care form an integral part of the Nigerian social and economic development. It is the first level contact of the individual and community in the national health system, thus bringing health care as close as possible to where people live and work and contributes the first element of a continuing health care process (Akinsola, 1993: 100).

In the same vein, W.H.O. 1987 specified the aims and objectives of Primary Health Care as follows:

1. To make health services accessible and available to everyone wherever they live or work.
2. To tackle the health problems causing the highest mortality and morbidity at a cost that the community can afford.
3. To ensure that whatever technology is used must be within the ability of the community to use effectively and maintained.
4. To ensure that in implementing health programme. The community must be fully involved in planning the delivery and evaluation of the services in the spirit of self-reliance.

In sum PHC is essentially aimed

(i) To promote health
(ii) To prevent disease
(iii) To cure disease
(iv) To rehabilitate i.e. help people live full; normal lives after an illness or disability.

In the 1999 Constitution of the Federal Republic of Nigeria, health is on the concurrent legislative list, by implication the three tiers of government are vested with the responsibilities to promote health. According to the constitution, federal, state and Local Governments shall support in co-ordinated manner, a three-tier system of health care viz.:

(a) Primary Health Care Local Governments
(b) Secondary Health Care State Governments
(c) Tertiary Health Care Federal Governments

Therefore Primary Health Care shall provide general health services of preventive, promotive, curative and rehabilitative nature to the population as the entry point of the health care system. It implies therefore that the provision of health care at this level is largely the responsibility of Local Governments with the support of State Ministries of Health and within the pivot of national health policy.

Components of Primary Health Care

There are 10 components of Primary Health Care. They include:

i. Education concerning prevailing health problems and the methods of preventing and controlling them;
ii. Promotion of food supply and proper nutrition;
iii. Adequate supply of safe water and basic sanitation;
iv. Material and child health care including family planning;
v. Immunization against the major infections diseases;
vi. Prevention and control of locally endemic diseases;
vii. Appropriate treatment of common diseases and inquiries;
viii. Provision of essential drugs;
ix. Community mental health care; and
x. Dental Health.

It is worthwhile to note that mental and dental health care are not presently available in Nigeria due to shortage of personnel.

It is also pertinent to mention here that the principle upon which the Primary Health Care is founded is that health is a fundamental human right to be enjoyed by the people, in all walks of life, in all communities. The fact is that health is more than just the delivery of medical services. Primary Health Care system attempts to address peoples, “health needs” through an integrated approach utilizing other sectors such as agriculture, education, housing, social and medical

services. The integrated approach supposed to encourage active horizontal relationships between people and their local services as opposed to the traditional vertical relationships.

In addition, fundamental to the Primary Health Care System is the realization that the major killer diseases in rural communities in the Third World are preventable, and that the majority of victims of these diseases are children under the age of five. Therefore PHC system encourages countries to shift their national Health Care strategy from urban to rural areas/location, such childhood killer diseases most severely affect children living in rural areas or locations. To this effect Community Health Workers are being made use of as key factors in the delivery of Preventive Health Care.

The Primary Health Care system also gives recognition to local people in its little or no formal education who could be trained to perform some basic health services. Thus the use of traditional healers or traditional birth Attendants or mid-wives in the villages. They perform the basic functions such as:

(i) Delivery of high-quality basic first aid
(ii) Recognition of signs and symptoms of more serious conditions
(iii) Delivery of babies under more hygienic conditions
(iv) Educating their fellow villages in understanding the disease process in their community.

Complimentarily, the P.H.C. system 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 Health Care System in the villages.

V. HISTORY OF PRIMARY HEALTH CARE IN NIGERIA

The National Primary Health Care was launched by the Military Administration of President Babangida in 1988, the scheme as emphasized above was to be a collaborative effort of the three tiers of government which should be more adapted to Nigeria's socio-economic and cultural context. It should be people-oriented in that it strives to develop local capabilities, initiatives and to promote self-reliance. This in a way was for the realization of sustainable improvement in the health of the people.

Health services delivery in Nigeria had its historical antecedents. It had evolved through a series of developments including a succession of policies and plan, which had been introduced by previous administrations. Previous administration here refers to the unorganized administration of the colonial and post-colonial administration in Nigeria.

Oyewo (1991) traced the historical epoch of Nigerian health sector beyond the organized colonial period and asserted that maternal and child care of pre-colonial period through primitive, compared to the orthodox medical care, served the people with precise efficiency which was proportional to their level of development. Oyewo further identified the beginning of a meaningful health service policy with the first Ten year National plan (1946 - 1956) wherein health was put on the concurrent legislative list with both Federal and Regional government exercising defined powers within their areas of direct administrative control.

Similarly, many published and unpublished works remarked that Public Health Services in Nigerian and other West African Protectorates originated from the British Army Medical Services. When the army became integrated with the colonial government, medical care was extended to the local civil servants and their relatives and eventually to the local population, especially those living close to government station. At the same time various religious bodies especially Christian Missionaries and private agencies made spirited efforts to established hospitals, dispensaries and maternity centres in different parts of the country, particularly in the South and the Middle Belt.

The first Ten-year National plan (1946 – 1956) whose proponents were mainly expatriate officials had a number of deficiencies, especially in the health services. The health policy at the Second National Development Plan (1970–1974) focused in part at correcting some of the deficiencies in the health delivery services. There was a deliberate attempt to draw up a comprehensive national health policy dealing with such issues as health man-power development, provision of comprehensive health care based on basic health care service scheme, disease control, efficient utilization of health resources, medical research and health planning

and management.

The Third National Development Plan of 1975 – 1980 was aimed at increasing the proportion of the population receiving health care from 25% to 60%. The Basic Health service scheme policy which was incorporated into the Development Plan had the following objectives

(a) To initiate the provision of adequate and effective health facilities and care for the entire population;
(b) To correct the imbalance between preventive and curative care;
(c) To provide the infrastructures for all preventive health programmes such as control of communicable diseases, family health, environmental health, nutrition and others;
(d) To establish a health care system best adapted to the local conditions and to the level of health technology in the country.

According to Sani (1990: 3 - 4) the Fourth National Development Plan too made the Basic Health Services Scheme the core of its orientation in the health sector. The problem with BHSS was its total neglect. The Federal Government in particular focused much more attention on the establishment of teaching and specialist Hospitals. This was reflected in the budgetary allocations for Health capital projects and programmes as they were contained in the Fourth National Development Plan. Specifically, a total of ₦862.40 million (71.8%) was allocated to the Teaching and Specialist Hospitals, while only ₦101.00 million was allocated to Basic Health Service Scheme and other related health programmes.

The administration of General Babangida and the appointment of Prof. Olukoye Ransome-Kuti brought about the encouragement of Primary Health Care Directorate in the Federal Ministry of Health. It was charged with the responsibility for formulating, developing and implementing the National Primary Health Care System in line with the recommendation of the 1988 International Conference on Primary Health Care.

To this end, it is imperative to examine the management and evaluation of performance of Primary Health Care System in Ife East Local Government. It is believed that through this study a comparative lessons can be drawn by researchers and health practitioners.

VI. MANAGEMENT OF P.H.C. IN IFE EAST LOCAL GOVERNMENT: A CASE STUDY

The Ife East Local Government was created in December 1996 out of the Ife Central L.G.A. with its Headquarter at Oke-Ogbo. It is about 3,600 square Kilometers landmass with a population of 375,370. It is the largest LGA in Osun State of Nigeria. It consists of more than 60 villages and some part of Ile-Ife township.

The health care delivery at the LGA is headed by a Supervisor of Health, while PHC is headed by a PHC Co-ordinator and Assisted by a Deputy Co-ordinator. The PHC co-ordinator reports to the Supervisor who in turn reports to the LGA Secretary. The different components of the LGA PHC are manned by personnel of diverse specialty. There are three levels of operation of PHC in LGA. These include:

(1) Village level
(2) District level
(3) Local Government level.

The organogram shown below is a typical LGA – PHC organizational structure in Nigerian Local Government. It shows the various levels of responsibility.

The Nigerian PHC system status with respect of PHC targets for 2000 AD was placed as shown in table 1.

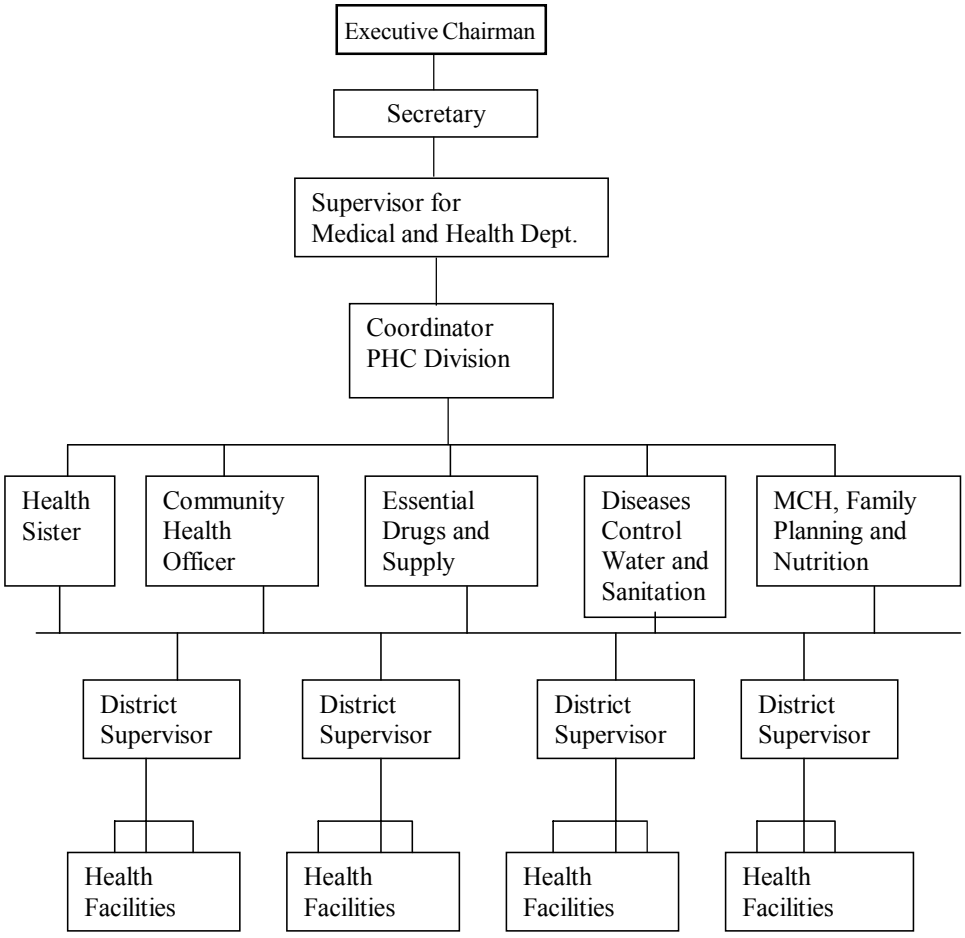
As indicated above, there is no doubt that LGA – PHC are bedevilled with amalgam of problems. This peradventure accounted for the non-attainment of Health for all in the year 2000.

Meanwhile, it is essential to evaluate the performance of PHC in our case study. However, this will be reviewed on the basis of availability data in the Local Government.

Table 1: The Nigerian PHC system status with respect of PHC targets for 2000 AD

PHC Component	*% Target Achieved as at December 1992 (this figure declined drastically since then*
E. P. I. Coverage	54.5%
Antenatal Care	48.4%
Nutritional Status/Pregnant Women	34.4%
Attendance at Delivery	52.3%
Contraceptive Prevalence	38.0%
Access to Health Services	43.3%

Source: James Wunsch et.al, USAID Governance Initiative in Nigeria. A strategic assessment of PHC and Local Government (USAID Lagos 1994) P.18.



One Supervisor for each district in LGA.
Fig. 1. A typical LGA – PHC Organogram

There is evidence that the Local Government area gives priority to health sector in the budget as, indicated in table 2 between 1997 – 2000.

From interview conducted, it was observed that most of the funds released during this period were expended on payment of salaries of health workers. Although apart from Education, health ranked second in the approved estimate.

It was observed that the high wage bill experienced between 1999 – 2000 had implication on the accessibility of the people to health services. Similarly it had a far-reaching effect on the State's Government free health programme.

Table 2: Approved Budget of Ife-East Local Government between 1997 – 2000.

Year	*Admin.*	*Treasury*	*Works*	*Soc. Ser. & Health*	*Education*	*Agric.*
1997	3,173,747	5,016,005	2,553,589	3,408,941	13,000,000	203,123
1998	3,389,110	6,086,287	2,607,505	3,277,852	13,500,000	233,123
1999	6,507,080	875,480	3,301,850	6,623,232	6,000,000	440,120
2000	860,060	1,012,450	5,705,920	8,875,115	8,250,000	640,250

Source: Ife East Local Government Estimates 1997-2000

As indicated in table 3 the number of health personnel required fell short of the ones

Table 3: Health personnel requirement, need and gap

Category	*No. available*	*Location*	*No. needed*	*Gap*
Doctor	1	Nil	2	1
CHO	2	HQ	5	3
S/N/M	6	NQ/HF	10	4
S/N	6	HQ/HF	10	4
S/M	6	H/Facility	10	4
CHEW	11	HQ/HF	18	7
EHO	5	HQ/HF	8	3
MRO	2	HQ/HF	4	2
Total	39		67	28

Source: See Oladipo 2000: 40

available, whereas the total No. of personnel needed was put at 67, but 39 was available while the gap stood at 28. In view of the population and ruralized nature of the LGA more health personnel ought to have been provided. To this effect, we observed that some of the targeted beneficiaries of health services were not serviced.

From table 4, it was observed that there was a fair distribution of health workers to the various facilities. This distribution was based on the nature, population and service needs of each location.

The urban nature of part of the LGA where there are other LGA health facilities and private clinics, were responsible for the non-usage of Market Based Agents.

From table 6, the establishment of a Comprehensive Health Centre at Abiri with a population of 2821 was due to its accessibility and strategic nature. Moreover, the CHC was built before the creation of the LGA in 1996.

Collaborating Health Institutions (Private)

1. Alaafia Tayo Clinic, Omi-okun near Ondo Road, Ile-Ife.
2. Iranlowo Edumare Clinic Arubidi, Ile-Ife
3. Ebenco Maternity Home Oroto, Ile-Ife
4. Onile-Ayo Maternity Home Iloro, Ile-Ife
5. Ilera-loro Clinic Opa-Ilesa Road, Ile-Ife.

To a large extent the privately – owned health facilities no doubt complimented the role of government in the provision of health services. From the interview conducted, it was discovered that many people (especially the middle class) prefer to patronize privately – owned health institutions.

Table 5: VHWs / TBAS / Market based agents

Type	*No*	*Functional*	*Location*
VHW	21	21	All the Health District
TBA	-	-	All the Health Districts
MBA	-	-	-

VHW = Voluntary Health Workers
TBA = Traditional Birth Attendant

Table 6: Community access to health facilities

Town/Village	*Population*	*CHC*	*BHC*	*HC*
Abiri	2821	1		
Enuwa	5689		1	1
Aroko	2920		1	
Arubidi	3714		1	
Aye-Oba	2994		1	
Ita-akogun	3989		1	
Toba	2949		1	
Iloro	4998		1	

Table 4: Personnel involved in P.H.C. Activities in Ife-East Local Government Area

Health Facilities	*Doctor*	*Nurses*	*CHO's*	*CHEW*	*EHO*	*Technician Or Pharma-cist*	*MRO*	*HATT*
Abiri CHC	1	3	-	3	1	1	1	5
Enuwa HC	-	3	1	3	1	1	1	5
Iloro BHC	-	-	1	1	-	-	-	2
Aroko BHC	-	-	-	-	1	-	-	1
Arubidi BHC	-	-	-	1	1	-	-	1
Aye-Oba BHC	-	-	-	1	-	-	-	1
Toba BHC	-	-	-	-	-	-	-	1
Ita-Akogun BHC	-	-	-	1	-	-	-	1

* CHC – Comprehensive Health Center
* HC – Health Center
* BHC – Basic Health Center

The private health institutions have succeeded in reducing the number of patients who patronized the various LGA – PHC facilities, inspite of the inadequacy of their materials/resources. Yet they form the first point of call to the patients.

Similarly, private-owned institutions still remain health facilities where bureaucratic procedures which have became a thing of paramount importance in the government health centres are not taken so seriously. In most cases, this tendency had further enhanced the patronage of privately - owned health care institutions.

The above table illustrates the pattern of logistic support and equipment required for the sustenance of LGA – PHC. It is an irony to note that most of the equipment used in the LGA are provided by donor agents. This possess a serious delimma of sustainability of the PHC services delivery in the LGA.

Table 8 shows the pattern of distribution of immunization equipment to various health facilities. A cross-section of health officials of the Expanded Programme on Immunization Unit revealed a kind of loopsidedness and inadequacy of the immunization equipment provided by the LGA.

Table 7a: Logistic support, no functioning and location

Types	*No*	*Functionality*	*Location*
Motor Vehicles	Nil	-	-
Motor Cycle	6	4	LG Hq
Bicycle	22	16	LG Hq

Table 7b: Equipment needed and provided

Equipment	*No. needed*	*Provider*
Vehicle	2	UNICEF
Motor Cycle	4	UNICEF Bamako
Deep freezer	4	-
Forcepts/ eatery dissecting	20	UNICEF
Generator	1	UNICEF
Ice-pack	100	UNICEF
Delivery Forcepts	5	UNICEF
Needle Holder	6	UNICEF
Steam Sterilizer	10	UNICEF

Table 8: National programme on immunization equipment

Equipment	*Functionality*	*Location*
Megaphone	3	Headquarter
Deep Freezer	4	Headquarter
Cold Box	61	HF (Health Facility)
Vaccine Carrier	85	HF
Steam Sterilizer	6	HF
Thermometer	15	HF
Ice park	210	HQ
Motorcycle	4	HQ/HF
Motor Vehicle	Nil	-
Bicycle	22	HQ/HF
Kerosene stove	1	HF
Forcepts	4	HF
Generator	Nil	-
Ice-park freezer	-	-

Table 9: Control of diarrhoea disease (CDD) CDD equipment

Equipment	*Number*	*Location*
ORT Management Chart	20	HQ/HF
ORT Corners	6	HQ/HF
Bottles	6	HQ/HF
Cups	24	HQ/HF
Bowls	8	HQ/HF
Measuring spoons	89	HQ/HF
Leveling spoons	-	-
Jugs	6	HF
ORT sachets	Nil	-

Health Services Coverage

To assess the health services coverage, one needs to determine that proportion of individual in the population that has been exposed to primary health care services according to specific disease pattern.

The list of common health problems and their patterns over the 1997 – 1999 is summarized in the table 10.

From the table above, cases of malaria is very high as compared with other Diseases. In attempting to explain the continuing prevalence of malaria in the LGA, it is worthwhile to point out that the problem is partly one of geography of some part of Africa which are highly favourable to dangerous malaria parasites, such as plasmodium falciparum which requires a minimum temperature of 18 degree centigrade – 20 degree centigrade, and the most resilient of the vectors: the Anopheles gambiac, the Anopheles arbabiensis and the anopheles

Table 10: List of common health problems

Diseases	*1997*	*1998*	*1999*
Diarrhoea	292	42	139
Measles	15	17	46
Malaria	757	242	975
Malnutrition	59	5	29
Pneumonia	5	3	-

funestus. This is essentially true of Nigeria where the humidity permits a rapid multicipation of mosquitoes and an easy accomplishment of the sparogenic cycle. To arrest its incidence, it is therefore necessary to prevent malaria fever by improving the environmental factors. Similarly, essential preventive measures should be put in place.

A summary of table 11 indicates some satisfactory activity in the LGA in Environmental Health activities.

A survey of immunization coverage of the LGA as contained in table 12 revealed that children under the age of 5 were immunized against various diseases. This was in response to the Federal Government Extended Programme on Immunization.

Investigation revealed that with the co-operation of both Federal, State and Local Governments immunization coverage had been successful. To an extent the LGA and the State Local Government Service Commission had organized workshops and seminars to broaden and strengthen the horizons of health workers. Some of the materials provided free of charge by UNICEF in the Local Department to stimulate immunization coverage among others include:

(a) Vaccines for EPI programmes;
(b) Syringes and Needles;
(c) Logistics supports like motorcycles, bicycles, cold boxes etc.
(d) Teaching aids like pamphlets, posters, handbills etc.

Status of Implementation of Health Services in Ife-East Local Government

The health services as being implemented currently in the Local Government Area have experienced varying degrees of successes vary from 0 – 74%. The analysis is shown in the table 13.

VII. EVALUATION OF PRIMARY HEALTH CARE IN IFE-EAST LOCAL GOVERNMENT

It has been discovered though the available data, personal observation and oral interview of the officers and beneficiaries of the primary health care in the LGA that:

Table 13:Level of implementation of health in Ife-East Local Department

N.P.I.	74%
C D O	62%
Malaria	60%
Malnutrition	59%
Guineaworm	1%
Oncocerciasis	72%
HIV/AIDS	Nil
Baby Friend hospitalInitiative	Nil

Table 11: Report of environmental health activities within Ife-East Local Government between 1997 – 2001

Activities	*1997*	*1998*	*1999*	*2000*	*2001*
House Inspected	3086	4621	5034	6035	8162
Satisfactory	1234	3926	4112	5612	6725
Pit Latrine Inspected	2216	2754	2984	3016	3272
Satisfactory	924	1028	1321	1519	1736
Abatement served notice	1106	2289	2465	2692	2865
Number compiled with	923	2015	2316	2512	2751
Pipe-borne water supply	3211	3746	3989	4125	4331
Satisfactory	3211	3741	3757	3962	4106
Springs inspected	3	4	3	4	3
Satisfactory	-	-	-	-	-

Table 12: Immunization coverage

Health Facilities	*BCG*	*Polio*	*DPT*	*Measles*	*T-Toxoid*
Abiri CHC	419	9925	209	119	110
Enuwa HC	520	9818	102	116	121
Aroko BHC	210	4912	80	96	103
Arubidi BHC	99	3212	81	71	61
Aye-Oba BHC	19	2001	21	14	19
Ita-akogun BHC	29	1209	30	28	39
Toba BHC	21	1131	26	20	41
Iloro BHC	33	2112	31	29	38

(1) The LGA is running her Primary Health Care Services Delivery in compliance with the principles / the framework of the National Health Policy. The LGA is divided into various Health Districts so as to enhance maximum benefit of the principle of decentralization of the health sector. Whereby people are involved, participate, and mobilized in the PHC processes.
(2) Household health registration were made, through house numbering, and home-based health record were placed in order to keep every house-hold informed of health activities within their community.
(3) Within the short life span of the Local Government, and in view of the instability that greeted its creation; yet there are indication of activities and assemblage of essential health information / data.
(4) The available health workers were well trained, and still attends regular workshops and seminars. Comparatively, the LGA – PHC programme in better staffed and equip than some other LGA's in the state.
(5) Traditional birth attendants were also trained to render delivery services at the village level.
(6) The LGA – PHC committees at the various level meets to sensitized the community on health related situations. They exist at LGA level, Health District PHC committee, village committees and other sub-committees.
(7) Health Education and monitoring, Evaluation and Records Units were being moderately financed for proper education, mobilization, monitoring, evaluating, and record-keeping of all activities.
(8) Finance posses a serious threat to the sustainability of PHC programme in the LGA. Most of the available funds are expended on wage bills, therefore the reliance on the LGA on Donor – Agencies for supply of health equipment or counterpart funding of programmes.
(9) Reports of environmental health activities has shown a relative awareness on the community for healthy living. Although it was observed that the habit of the people had not changed considerably. This accounts for the mortality and morbidity rate in the LGA. The rate of mortality is low while morbidity rates are high, due to poverty level and sanitation profiles among other unhealthy aspects of the environment and its people. Although there are no quantitative data about mortality rate but available information in Table 10 call for concern to stem morbidity rate.
(10) The maternal and child health care and family planning units were being run by experts on the fields and through supervision, monitoring, evaluation and proper records were being kept accordingly.
(11) The status of implementation of health services in Ife-East Local Government can be considered fairly good as indicated in Table 14. On the whole Ife-East could be adjudged as one of the Local Governments where in the issue of PHC is given a fairly good attention. Although, there exist some problems, which vary from scarcity and uneven distribution of resources, finance, political instability, manpower and health facilities. These could be cited as sources of many problems, which are cogs in the wheel of progress of the LGA – PHC. Others problems that relates to the people has to do with the level of poverty among the community. This phenomena has far-reaching implication on the health of the people especially the low-income group.

VIII. PROBLEM AREAS IN IMPLEMENTATION

The essence of transferring Primary Health Care to the Local Government are to make the management of PHC services more effective and closer to the grassroots. However, in view of the level of health awareness, one begin to question the extent to which health care has been taken to the doorstep of the rural / urban dwellers.

One of the hindrances to the development of health especially in Nigeria and our case study in particular has to do with insufficient number of medical personnel as well as their uneven distribution. There has been too much concentration of medical personnel at the urban to the neglect of the rural areas.

Another significant problem in the management of PHC is transportation. It was observed during this study that there are no enough vehicles for workers to perform their task especially to the rural areas. The maintenance culture of the existing vehicles was poor while

PHC vehicles were used for other purposes other than health related activities.

The irregular accessibility to many parts of the communities owing to natural topographical condition such as excessive flooding during rainy season, hilly and mountainous terrain of the landscape. One other problem has to do with inadequate finance. This manifest itself in increase in wage bills, over dependence of the LGA on Federal, State and International Agencies. The internally – generated revenue of the LGA is merger and not anything one can to write home about.

The level of community involvement in PHC management is another matter of concern. There are evidences of low community participation. It is a truism that the cornerstone of PHC is community involvement but to a large extent this has becoming crisis ridden problem throughout Nigerian Local Government.

Another problem is the general misuse and abuse of the scarce resources, human, material and financial by some political and administrative leadership.

Similarly, lack of continuity of LGA leadership posses another problem. There are high degree of leadership turn-over as well lack of continuity in Local Government leadership in between 1996 – 2001, there are five Administrators either appointed or elected in the LGA. This accounted for inconsistencies in health policy decisions. Undoubtedly, the problems facing LGA – PHC are legion and inexhaustive.

IX. RECOMMENDATIONS FOR FUTURE IMPROVEMENT

Having identified the litany of problems against effective and efficient implementation and achievement of the goals and objectives of Primary Health Care Services Delivery at the Local Government, the following recommendations are suggested as a way forward.

There is the dearth need for the Local Government as well as all the other tiers of government to increase their allocation to the health sector. Local Governments on the other hand should be more inward-looking and aggressive in the area of internally-generated revenue. This is to reduce the dependence on the federation account in financing health programmes.

Priority should be given to improved living condition of the people beyond the present poverty level, so as to enhance better healthy living. To this end, intensive and effective health education of the public must of necessity be reinforced, in other to eliminate such diseases as malaria, typhoid and other infectious diseases. There is the need for maintenance of minimum health standard, improved housing condition, water, environment, sanitation and food supply for the sustenance of good health condition.

Poor leadership and political instability have been the basis for unsuccessful implementation of most government policies and programmes on health care delivery. Therefore good leadership and political stability is desirable to provide enabling environment for the implementation of the PHC programmes. This will invariably reduce the problem of abandoned projects in the health sector.

There is the need to put a stop to unnecessary responsibilities being given to LGA's by the state governments. It is a common occurrence for federal and state governments to shift part of their responsibilities to LGA, such as purchase of useless books, Calendars/Almanac and imposition of sponsored programmes. All these are drains on the lean purse of the Local Governments with its attendant effects on health services delivery.

Adequate supervision, monitoring and evaluation of programmes should be pursued with vigor and required manpower provided.

The Nigerian health policy makers should give priority to the training of more rural health workers. This is to prevent the drift of rural health workers from the rural communities to the urban centres. More financial and other incentives should be provided to prevent the high staff turn-over of health workers.

In conclusion, Primary Health Care in Nigeria and especially Ife-East Local Government have come a long way and certainly still require more effort so as to achieve the goal of health for all now and beyond.

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