Challenges of Local Government in the Provision of Primary Health Care Services in Ebonyi State. Nigeria

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Abstract

Rural areas in Nigeria including Ebonyi State, suffer from development challenges. One of these challenges is inadequate provision of primary healthcare services to the people. This ugly condition has worsened the case of infant and maternal mortalities in Nigeria and Ebonyi State in particular and this demands urgent attention of the local governments as well as other key development partners in order to address the challenge and improve the standard of living of people at the grassroots. It is based on this that this study investigated the challenges of local government in the provision of primary healthcare services in Ebonyi State. Data were sourced from text books, journals, and internet and library materials. As a qualitative study, content and narrative techniques were adopted to analyze the study. The study revealed that minimum standards set for provision of primary healthcare service delivery have not been met in Ebonyi State; hence, local governments in the study area have not optimally contributed to reduction of infant and maternal mortalities due to certain factors which include: poor healthcare financing, dilapidated primary healthcare infrastructure, shortage of qualified healthcare personnel, corruption in the healthcare sector, and lack of broad-based data bank for beneficiaries of primary healthcare services in the area. The paper therefore recommended proper funding of primary healthcare centres in

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Ebonyi State in line with the international and national benchmarks. This can be achieved through increased budgetary allocations by granting financial autonomy to local governments; more hospitals and clinics should be provided to increase access to health care facilities; there is also urgent need for massive recruitment of qualified healthcare personnel in the study area to among other things improve the quality of healthcare services available to the people in the localities.	

1. Introduction

Provision of primary healthcare services is one of the major responsibilities of local governments in Nigeria. Part of the Fourth Schedule of the 1999 Constitution of the Federal Republic of Nigeria as amended, substantially indicates that local governments are saddled with the provision and maintenance of primary healthcare services. These services which cut across infant and maternal health, individual, family and community health care needs are expected to satisfy the health care needs of the people. As the first point of call for the people at the grassroots, the importance of primary health care units cannot be over emphasized. These services are to be performed in conjunction with the state governments. According to USAID (2020), Ebonyi State Government has the responsibility for secondary health care in its jurisdiction. It shares this responsibility with the local governments- through the Ebonyi State Primary Health Care Development Agency (EBSPHCDA) - for primary health care centres and health posts. The importance of primary health care service delivery cannot be overemphasized as it provides the first point of call in the structure of healthcare system of any nation or state. The aim of primary healthcare is among others, to provide adequate supply of water, and basic sanitation, maternal and child care including family planning and immunization against infectious diseases.

Universally, primary healthcare integrates preventive, promotive, curative and palliative health care services. This has become imperative in view of the fact that access to basic healthcare facilities is limited especially at the grassroots of developing countries including Nigeria and Ebonyi State in particular.

Historically, the concept of primary healthcare could be traced to the WHO –UNICEF conference held in 1978. Prior to this conference, existing healthcare system in most countries were in comatose conditions and needed surgical operation and total overhauling. Different strategies and approaches had earlier been deployed over the years before this conference across nations aimed at improving health care provision but these efforts yielded little result. In view of this, the conference advocated for a revolutionary approach to improving healthcare across nations. There were also during this period a noticeable gap between the quality of healthcare services provided in the developed and developing countries and the need to bridge the gap by maintaining universal health care standards. It is to be noted that the outcome of the Alma-Ata Conference metamorphosed into the WHO goal of "Health for All" in the year 2000. It was the above development that gave birth to the concept of primary health. In contemporary time, primary healthcare constitutes one of the most researched areas of global healthcare architecture.

Over the years, local governments in Nigeria including Ebonyi State, seem to have failed to fill the expected grassroots developmental gaps. Rural dwellers suffer neglect and are disconnected from the dividends of democracy. Local government officials have failed to fulfill their promises of providing basic social amenities to the people. This ugly state of affairs have called for a research intervention of this nature in order to determine the challenges of local government in providing primary healthcare services in Ebonyi State.

Ebonyi State is one of the 36 states in Nigeria located in the South Eastern part of the country with 13 local government areas. Since the creation of the state in 1996, successive administrations have made frantic efforts to develop the poor state in all ramifications including the healthcare system.

Some of these policies and programmes designed to improve the quality of healthcare service delivery include the National Health Act (2014), National Human Resources for Health Policy (2015), National Health Policy (2016), Second National Strategic Health Development Plan (2018 – 2022), Ward Minimum Health Care Package (2007), National Primary Health Care Development Agency [Cap N69] (2004) and the Ebonyi State Primary Health Care Development Agency (ESPHCDA).
However, it is to be noted that these efforts are yet to yield satisfactory results. The state is one of the poorest states in the federation with low health indicators among other development indices. Health service delivery in Ebonyi State is structured into three tiers, with primary healthcare at the base, supported by secondary and tertiary healthcare services. According to USAID (2020) there are 604 healthcare facilities (491 public and 113 private). The report recoded that 548 are primary healthcare facilities, 54 are secondary, and two are tertiary. Reproductive, maternal, newborn, child, and adolescent health services, as well as nutrition and other services are provided by these facilities. A variety of preventive and treatment services for malaria, tuberculosis, and HIV/AIDS is provided at all the primary health facilities in the state, depending on the classification of the health facility. Preventive education services for non-communicable diseases such as diabetes and hypertension are generally provided in all health facilities. Mental health services are available in the Ivo LGA of the state.

The rate of child labour and out of school children in the area is alarming. For instance Onwe and Nwakamma (2015) citing Chukwu (2012) revealed that in Ebonyi State, physical infrastructure (such as roads, portable water and electricity) and social services (such as education, health, recreation and security) are not adequately provided. Mortality rate is still high, women still engage in hard labour to fend for their children and complement family income in the face of low income per capita. Lack of infrastructure facilities and the degrading condition of life in most rural communities have resulted to increasing migration (inflow of people into the Abakaliki Capital City thus leading to congestion and attendant urban problems like unemployment, increase in house rents and general cost of living, amidst low level of income. The Nation Bureau of Statistics (NBS) rated Ebonyi State as the fourth poorest state in Nigeria and first in the South-East, with regards to economic development (Okah, 2020). These ugly socio-economic conditions contribute in lowering the standard of living of people in the study area hence, this study has become imperative to interrogate the challenges of local governments in the provision of primary healthcare services in Ebonyi State.

1.1 Statement of the Problem

Government exists mainly for the welfare of the people. This welfare reflects various dimensions of government's services to the people ranging from healthcare, provision of pipe-borne water, rural roads, education, job creation, poverty reduction, etc. Despite the importance

attached to primary health care delivery, its provision has been poor in Ebonyi State. Ozo (2022) regretted that "primary healthcare battles crippling shortages in Ebonyi State". Primary healthcare units are in dilapidated conditions with severe lack of basic drugs and other healthcare consumables. This ugly trend in the healthcare system of the state in general and the local governments in particular, largely contributes to poor healthcare indicators in the study area. HealthCare Financing (2020) a report by USAID, on the current health status in Ebonyi State, revealed that indices of improved health care standards are poor relative to estimates from lower-middle income countries (LMCCs) in Sub-Saharan Africa. Coupled with the above is food insecurity which still constitutes the major problem of the poor in the study area. Cases of water born diseases such as cholera, diarrhea among others frequently occur in the study area. Ajah, Onu, Ogbuanya, Ajah , Ozumba, Agbata, Onoh and Ekwedigwe (2019:1) in their study titled "Choice of Birth Place among Antenatal Clinic Attendees in Rural Mission Hospitals in Ebonyi State South-East Nigeria", found that in Ebonyi State

> Approximately 43.8% of the respondents were delivered by the skilled birth attendants. Also 61.7% of the respondents chose to deliver in public health facilities due to favourable reasons but this could be hampered by the rudeness of some healthcare providers at such facilities. A significant proportion of private health facilities had unskilled manpower and shortage of drugs. A greater proportion of women will prefer to deliver in health facilities. However there are barriers to utilization of these facilities hence the need for reversal of this ugly trend.

The above state of affairs required urgent attention, hence the need for this study.

1.2 Objectives of the Study

The broad objective of the study was to explore the contributions towards provision of primary healthcare services in Ebonyi State. The specific objectives are;

1. To determine the extent to which local governments have improved access to primary healthcare services in Ebonyi State.
2. To ascertain the contributions of the local government in reducing infant and maternal mortality rates in the study area.
3. Investigate the extent to which the local government has contributed in construction of clinics and hospitals for people in the area.
4. To identify and recommend solutions to challenges the hindering provision of quality and efficient primary healthcare services in Ebonyi State.

2. Conceptual Review

Local Government

Local government is one of the most discussed areas of the field of Public Administration. Scholars, research students, institutions among others have subjected the concept of local government to plethora of definitions. The interest devoted to local government over the years draws from its utility as the government closest to the people at the grassroots where most of the people reside. Hence, local government, according to the International Union of Local Government Authorities (IULA), in Braimah and Onuoha (2022) is defined as a level of government with legally specified powers and responsibilities to control and administer public affairs in the sole interest of the local community. Accordingly, local governments were established in Nigeria as a third-tier administrative structure to decentralize governance, bring

government closer to the people at the grassroots, and make social services vital to national development. Local government is a means as well as the instrument of accommodating diverse interests that require governments' intervention without undermining or truncating the collective will of the people at the grassroots. It acts as a channel of dispersing and localizing political tension, and in that way neutralizing its impact. This assertion was also captured by Onwe (2004) argued that there are problems which the central and state governments cannot fully comprehend; local government best handles such problems. Examples of such matters are local markets, sanitation, refuse disposal, local roads, educational needs and maternity homes. These functions are targeted at grass roots development which constitutes the major reason for the creation of local governments. Local government is created to provide the centre stage for the people to be openly involved in government affairs at the grassroots level. In associating with the government, people are more diverse and do not have parochial citizenship within the state. Globally, local governments exist as the key instrument of grassroots development. Studies have shown that majority of the world's population reside in the rural areas which are often referred to as the grassroots. As the government closest to the grassroots, citizens expect the local governments to provide basic infrastructure facilities such as quality road networks, clinics, hospitals, pipe-borne water, electricity, as well as guarantee human-oriented development such as education, skill acquisition, and job creation, among others. Local governments efforts in these areas culminate in grassroots development aimed at reducing poverty and improving the standard of living of the people.

One major function of the local governments that directly impacts the live of the people at the grassroots is provision of primary healthcare services. Local Governments are expected to bridge the development gap at the grassroots and improve the standard of living of the people.

Primary Healthcare

Primary healthcare is recognized as the fulcrum of service delivery in any healthcare system. Primary health centres offer basic medical care for individuals and communities before referring them to more advanced, hospital-based care (Ebonyi State Ministry of Health, 2018). This is why it is designated at the local government level. As the government closer to the people, the local government is expected to feel the healthcare pulse of the people of the area. Inhabitants of a given local government look up to the authority and the healthcare services they provide as their first point of call to access healthcare services. In the study area, majority of the population reside in the rural area and demands are made on governmental authorities to solving their healthcare problems. In view of the foregoing, the primary healthcare is very instrumental to the healthcare system of every given state. In his contribution, Kasum (2020) observed that "Primary Health Care (PHC) is the healthcare that is available to all the people at the first level of healthcare". According to World Health Organization (WHO), 'Primary Health Care is a basic healthcare and is a whole of society approach to healthy well-being, focused on needs and priorities of individuals, families and communities.' Among other things, the objectives of PHC according to Kusum (2020) include:

- To increase the programmes and services that affect the healthy growth and development of children and youths.
- To boost participation of the community with government and community sectors to improve the health of their community.
- To develop community satisfaction with the primary health care system.
- To support and advocate for healthy public policy within all sectors and levels of government.
- To support and encourage the implementation of provincial public health policies and direction.
- To provide reasonable and timely access to primary health care services.

- To apply the standards of accountability in professional practice.
- To establish, within available resources, primary healthcare teams and networks.
- To support the provision of comprehensive, integrated, and evidence-based primary healthcare services.

Minimum Standards of Primary Healthcare Service Delivery in Nigeria

The PHC minimum standards in Nigeria cut across three basic areas which include health infrastructure: This deals with the structure and designs of the buildings, healthcare facilities, furniture and other equipments; Human resources for health: This includes minimum recommended staff number and cadre for each type of health facility; Service provision: minimum requirements for equipments, drugs and other health care consumables. The essence of the standards is to provide quality healthcare at the primary level. The standards can also be viewed as tool through which the performance of PHC system can be measured (see the appendix for the healthcare minimum standards).

Challenges of Local Government in Providing Primary Health Care Services in the Study Area.

Meeting the above standards have been challenging due to certain factors which include the following:

Poor HealthCare Financing:

Nigeria including Ebonyi State is yet to meet the global standards for funding healthcare due failure to address critical issues that hamper healthcare service delivery. Poor healthcare financing is one of the major obstacles to efficient healthcare service delivery in the area. Poor healthcare financing results to inadequate provision of healthcare infrastructure and procurement of equipments as well as shortage in supply of qualified healthcare givers. Available statistics reveal that between 1985 and 1993, per capita investment in health in Nigeria was about $1 per person, compared to the international recommended level of $34 per person. Going forward, a significant improvement was expected to have been made but this appeared not the case because since 2001, Nigeria has consistently committed less than 7% of the total national annual budget to health, leaving a major gap in the financial resources required to drive the health system. The bulk of the state's expenditure across economic indicators is derived from Statutory Allocation from the Federation Account. A report from Ebonyi State HealthCare Financing Landscape indicates that the state performs quite poorly against global health financing targets. The first global measure considered was general government health expenditure per capita, which in 2017 was NGN 809 (US$3), just 3 percent of the globally recommended benchmark in 2017 of $89 (MOB, 2017; Stenberg, et al., 2017). Secondly, global health financing experts recommend that to protect citizens from catastrophic health expenditures, general government health expenditure as a share of gross domestic product exceed 5 percent (McIntyre and Meheus, 2014). However, in 2017, Ebonyi State government health spending as a proportion of state gross domestic product was only 0.6 percent. Finally, state government health spending as a share of total state government spending was just 2 percent in 2017, as compared to the Abuja Declaration target of 15 percent (WHO, 2001). These state budgets reflect what the local governments receive and this affects primary healthcare financing. Poor healthcare financing increases out of pocket expenditure which constitutes the major challenges of healthcare service delivery in the area.

Dilapidated Primary Health Care Infrastructure: Another major challenge to efficient delivery of primary health care in Ebonyi State is inadequate provision of healthcare

infrastructure which include the standard of the health care units, buildings, equipments, among others. The healthcare units are not enough and this results to low access to healthcare service delivery in the area. The available ones are not functioning to full capacity. Dataphyte (2023) revealed that only 20% out of the 34000 PHCs are functional while about 57% of the facilities cannot guarantee 5hours of electricity supply despite the importance attached to primary health globally. This portends great danger to disease prevention and control and the overall health needs of the people. According to Ozor (2023) PHCs in Igbeagu Izzi Local Government Council does not have drug shelves and water, only few beds and one mattress were spotted on the floor of the male wards. On the hand, it was also observed that PHC in Onuebonyi one of the popular areas in Izzi Local Government has no toilet facility, the beds are few and the wards are unconducive. The consequences of poor healthcare infrastructure are quite enormous as the patients will not only be denied access to basic infrastructure but will also not get the right medical treatment.

Shortage of HealthCare Personnel: One major determinant of the healthcare services in every nation is quality and quantity of health care givers. This is why personnel form the minimum standard requirements for PHC globally. Nigeria and Ebonyi State in particular is far from meeting the world standard for Doctors patients' ratio. Due to incessant migration of Doctors from Nigeria to other countries for better conditions of service, records show that Doctors patients' ratio is now 4 to every 10,000 patients against the WHO standard of 1:600. This decline in the number Doctors available for patients' treatment in Nigeria contributes significantly to the poor primary healthcare delivery. As a result, many patients resort to self medication and patronage of quacks which often increase their health problem. The brain drain in the health sector was regretted by Dr. Francis Faduyile, the President of the Nigerian Medical Association cited in Khadijit (2021) who observed that "75,000 Nigeria Doctors were registered with the Nigeria Medical Association (NMA), but over 33,000 have left the country". The Director of Primary Health Care Development Agency (PHCDA), in Izzi local government area, Philomena Ibor , opined that the major challenge in the area is lack of human resource. The nurses/midwives were employed on adhoc basis. This development is quite unfortunate in a nation where shortage of health personnel has proven to be one major obstacle to public healthcare delivery.

Corruption in the HealthCare Sector. Corruption in the health sector manifests in misappropriation, mismanagement and diversion of public health care funds to other uses. It also rears its ugly head in the award of contracts, diversion of drugs among others. All these constitute challenges of the local government in attending to her primary healthcare mandates. Corruption diverts public resources to private purse and denies many people access to life sustaining amenities. It is the major bane of governments especially in developing countries where institutions for fighting corruption are weak and undermined by political leadership. Sagay (2016:15) described corruption in the following words:

> The consequences of looting the common wealth of the country could be such level of deprivation in our social and economic services that people's lives could be affected like women who may not get ante-natal care, hospitals that are not well staffed and not well-funded, roads that are not well constructed; people could have accident and die. I am wary that an accused person may not have thought of the final consequences it have on people.

The practice of State-Joint Local Government: The Nigerian 1999 Constitution in section 162 provides for the joint account system into which the statutory allocations to the local

governments must first be paid before distribution to the local governments by the state governments. State governments are also mandated to pay 10% of their internally generated revenue into the account. The framers of the constitution believe that this practice will ensure transparency, probity and accountability in the management of local government finances. The joint account system was introduced to ensure effective checks and supervision of local governments spending by the state governments, strengthen inter governmental relations especially state-fiscal relations and make available to the local governments adequate funds to pursue developmental goals. Unfortunately, the operation of joint account is the bane of local government administration in Nigeria as this denies local government access to their funds meant for the development of the council areas. Onwe (2014) in Amaefule (2021) maintained that the joint account may appear logical in a way but has negative consequences on the financial autonomy of the local governments. He argued further that many programmes executed in the states by the governors and their wives are monies deducted compulsorily from the local government state allocation and internally generated revenue. Garuba (2017) observed also that state governments sometimes do hide under local government allocations to perpetuate fraud and this led to the reason why some stakeholders called for the scrapping of state/local government joint account system in order to make the council administration enjoy financial autonomy in Nigeria. The issue of joint account does not make funds readily available for local government's developmental programmes as they rely on what the state governors provide for their projects. This overbearing influence extends to specific projects that should be provided as council chairmen work according to the dictates and the directives from the state government. Often times, this unconventional practice slows down the pace of grassroots development where they exist at all. Wheare (1963:5) in Eze (2022) argued that each level of government should have adequate resources to perform its functions without appealing to the other level of government for financial assistance. He went further to state that:

> If state authorities, for example, find that services allotted to them are too expensive to perform and if they call upon the federal authority for grants and subsidies to assist them, they are no longer coordinate with the federal government but subordinate. Financial subordination makes an end of federalism, no matter how carefully the legal forms may be preserved. It follows therefore that both state and federal authorities in a federation must be given the power in the constitution each to have access to control, its own sufficient financial resources. Each must have power to tax and to borrow for financing of its own services by itself.

So many sundry deductions are made each month from the local government accounts by the state governments in the name of joint account at the end of the day, local governments are left with little or nothing to carry their responsibilities especially with respect to primary healthcare provisions. The practice of joint account has enthroned all manner of corrupt practices towards local government funds leading to poor revenue base of the council areas.

Lack of Broad-Based Data Bank for Target Beneficiaries of Primary Healthcare Services: Inadequate data of those that are in needs of healthcare from time to time distorts planning and constitutes the problem of local government in primary care delivery. Nigeria has not fully imbibed the habit of record keeping and this has been one of the major challenges of policy formulation. In the end, the public resources are not adequately utilized as target beneficiaries are hardly reached. It is worthy of note that however good the intention of government may be for her citizens, it cannot be translated into concrete terms towards improving the socio-economic status of the people if the accurate data of beneficiaries were not known. It is difficult

to determine the accurate number of Nigerians living in abject poverty, the sick, the aged, the handicapped, internally displaced persons in different IDP camps, and the unemployed, those living with HIV/AIDS among others due poor data. Hence, making adequate provision for such persons becomes difficult,(Abah, Edeh and Nwakamma, 2016). Other factors as cited in Onwe & Nwakamma (2015) are:

i. Poor coordination
ii. The absence of a comprehensive policy framework
iii. Excessive political interference
iv. Ineffective targeting of the poor, leading to leakage of benefits to unintended beneficiaries
v. The unwieldy scope of programmes, which caused resources to be thinly spread across too many projects, etc.

3. Conclusion

Attempt has been made in this study to determine the challenges of Local governments towards provision of primary healthcare services for people in Ebonyi State. We observed that primary healthcare provision in Nigeria is poor and this reflects poor provision of primary healthcare at the state and local government levels. The minimum standards set for provision of quality primary health in the study area are yet to be met. Access to quality health care provision in the study area is limited by a number of factors which include poor funding, shortage of qualified personnel, dilapidated healthcare infrastructure, corruption, etc. These factors combine to hinder the local government's genuine efforts at providing basic healthcare services in the area. Hence, access to primary healthcare services is still limited. It was also observed that infant and maternal mortality rates in the study area is still high when compared to other places; the local government has not significantly contributed to construction of clinics and hospitals for people in the area; and this is largely as a result of poor healthcare financing.

3.1 Recommendations

Based on the identified challenges and the conclusion drawn from the study, the following recommendations are put forward to improve the capacity of local governments towards provision of primary healthcare services in the study area.

1. There is urgent need for proper funding of PHCs in Ebonyi State in line with the international and national benchmarks. This can be achieved through increased budgetary allocations to the local governments. The local governments can also explore her internal sources of revenue to augment the statutory allocations. The budgetary allocations for healthcare at both federal and state levels of government is still very poor and below the acceptable standard benchmark and this has ripple effects on the healthcare finances of local governments in the area which can be improved to make more funds available for healthcare responsibilities of the local governments.

2. More hospitals and clinics should be provided to increase access to healthcare facilities in Ebonyi State. It was observed that only few PHCs are functional in Nigeria and Ebonyi State in particular. A total overhaul of the dilapidated healthcare infrastructure is therefore recommended as a means of responding to the primary healthcare demands of the people. It should be added that the local governments should increase drug supply and other healthcare consumables across the PHCs in the place in order to improve the quality of health conditions of the people. This will on the long run drastically reduced out of pocket expenditure. Provision of modern standard medical laboratory equipments will also help in accurate, reliable and timely diagnosis of ailments and improve quality of medical treatments.

3. More qualified health care personnel should be recruited and deployed to PHCs in the area. Nigeria including Ebonyi State, currently battles skyrocketed rate of brain drain in the health sector. Two approaches should be taken to address this ugly trend. This includes better condition of service for the health workers- increased pay, fringe benefits as this will serve as a motivation for them to be committed to their assigned duties and also reduce the exodus to other countries for greener pasture. Improvement in the welfare of the health workers is long overdue and this has been the major contributing factor to their migration to other countries mostly United States of America and United Kingdom, Canada among others. Conducive working environment will also help to forestall frequent brain drain of Doctors in Nigeria Secondly, regular training is recommended in order to make sure that services are rendered in line with the international best practices.

4. Those found to have diverted funds meant for the development of the heath care system in study area should be decisively dealt with according to the law. There should not be sacred cows in dealing with corrupt practices as this will serve as deterrence to others. A special committee should be set up to monitor and supervise disbursement and implementation of healthcare programmes especially programmes sponsored by the international donor agencies. Huge amount of money is donated by the WHO and other UN's agencies to developing countries including Nigeria, for primary health care needs of the people but all these have not been properly accounted for due to corruption. The funds are often mismanaged, misappropriated and looted leaving the poor to continue to suffer. International donor agencies should beam search lights on their assistance to the needy countries to make sure financial assistance to these countries get to the target population. There should be a review of financial assistance to Nigeria and Ebonyi Sate in particular to make sure that what was provided to assist healthcare financing was judiciously utilized. Otherwise, those found should face the weight of the law.

5. The practice of state-joint local government account should be discouraged. The constitutional provisions for the joint account system should be amended to enable local governments have direct access to their statutory allocations in the federation account. The essence of the SJLGA has been defeated as the state Governors hide under the joint account system to mismanage the finances of local governments at the detriment of grassroots development. An independent committee outside the control of the state Governors should be established to review the statutory allocations to the local governments over the years with a view to compare what was allocated to the councils from the federation account and what was finally disbursed to the councils and the implications of the possible discrepancies on healthcare financing of the local government with possible remedial actions.

6. It takes political will to design and implement health care programmes for the welfare of the people. The overbearing influence of the state government on the leadership of local governments in the country has resulted to the failure of the third tier in delivering her mandates to the people. The use of caretaker committee to run the affairs of the local governments should be discouraged to enable the leaders of the councils account to the people. The provision of section7(1) of the 1999 Constitution of the Federal Republic of Nigeria as amended, that empowered state governments to ensure the existence of local governments should be reviewed so that local governments derive their mandates from the people and not through appointments. In this way, they will be accountable to the people and not to the Governors who treat them as stooges.

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Appendix

care.

Table 1: Types of Health Facilities; Management and Expected Coverage

Health Facility Old Nomenclature	Health facility New Nomenclature	Levels of management	Expected numbers
Teaching/Tertiary hospitals	Teaching/Tertiary hospitals	Federal government	1 per State Therefore in 36 States + FCT, 37
General hospitals	General hospitals	State government	1 per LGA, Therefore a minimum of 774 will be expected
Comprehensive Health Centre, Model PHC Center	Primary health centres	Local government	1 per ward With an average of 10 wards per LGA, a total of 7,740 will be expected
Maternity Centre, Basic Health Centre	Primary Health Clinics	Local government and ward development committee (WDC)	1 per group of villages/ neighbourhoods with about 2,000 – 5000 persons
Dispensary	Health Posts	Village Development Committee (VDC)/ Community Development Committee (CDC)	1 per village or neighbourhood of about 500 persons As many as the number of villages

- Dressing forceps - 2
- Fetoscope - 1
- Geo Style Vaccine Carrier (GSVC) - 2
- Ice Packs - 4 per GSVC
- Injection safety box - 1
- Kidney dish - 2
- ORT Demonstration Equipment - 1 set
- (1 set = Cup, jug, wash basin, towel, bucket, standard beer or/and soft drink bottles)

* These are all trained Community Volunteers including, TBA, VHW and other community base service providers that have been duly trained and are recognised by the LGA

**TBAs are not expected to take deliveries.

3.5 Services

Table 2: Type of Service and Providers

S/N	TYPE OF SERVICE	RECOMMENDED PROVIDERS	
		CORPs	JCHEW
	A. HEALTH EDUCATION AND PROMOTION		
1	Informing, educating and communicating necessary behaviour change messages on prevailing health issues and problems; prevention and community based management.	X	X
2	Community Mobilisation for Health	X	X
	B. HEALTH MANAGEMENT INFORMATION SYSTEM		
3	All data collected should be sent to Health facility staff to collate		X
	C. ROUTINE HOME VISITS & COMMUNITY OUTREACH		
4	These services will be conducted in the health post and in the communities	X	X
	D. MATERNAL, NEWBORN AND CHILD CA RE		
5	Identification of pregnant women	X	X
6	Referral of Pregnant women to higher facilities	X	X
7	ANC and Delivery (Based on availability of JCHEW with Modified Life Saving Skills (MLSS) Training)		X
8	Routine post natal care (promotion of healthy p ractices and illness detection)		X
9	Promotion of Exclusive Breast Feeding (counselling and initiation)	X	X
10	Care of the Newborn- clean delivery and cord care.	X	X
11	Growth monitoring	X	X
12	Support for Weaning	X	X

S/N	TYPE OF SERVICE	RECOMMENDED PROVIDERS	
		CORPs	JCHEW
	E. FAMILY PLANNING		
13	Counselling and motivation for FP	X	X
14	Dispensing of Condoms (Male/Female)	X	X
	F. PROMOTION OF PROPER NUTRITION AND FOOD EDUCATION		
15	Identification of locally available food stuff	X	X
16	Home, School and Communal Gardening	X	X
17	Nutritional Education, including food hygiene, processing and preservation	X	X
18	Screening for nutrition related problems (PEM, Anaemia, Goitre)	X	X
19	Nutrition assessment e.g. mid–upper arm circumference and identification of Malnutrition in children and adults	X	X
20	Food demonstration		X
	G. IMMUNIZATION		
21	Identification of eligible pregnant women and children immunization.	X	X
22	Assist in the provision of routine immunisation (Non-injectable i.e BCG, OPV, DPT, MV, YF..)	X	X
23	Participation in immunisation campaigns	X	X
24	Immunization trend follow up	X	X
25	Assist in the management of Adverse Effect Following Immunization (AEFI)		X
26	Assist in the identification of Acute Flaccid paralysis (AFP)		X
	H. HIV/AIDS		
27	Education on prevention and misconception of HIV/AIDS	X	X
28	Community/home based care and support	X	X
29	Male and female condom distribution.		
	I. TUBERCULOSIS		
30	Contact tracing	X	X
31	Education on prevention and misconception	X	X
	J. MALARIA		
32	ITNs	X	X
33	IPT for pregnant women		X
34	Treatment for children	X	X
	K. CURATIVE CARE		
35	Fever- temperature management	X	X
36	Diarrhoea	X	X
37	Respiratory Infections	X	X
38	Skin diseases	X	X
39	Anaemia (Simple)		X
40	Minor Accidents	X	X
41	Worm Infestation	X	X
42	***All conditions as listed in the Standing Order for the Cadre of Staff***	X	X
	L. ESSENTIAL DRUGS		
43	Replenishment of essential drug stock from designated points		X
44	Use of drugs according to standing orders		X
45	Maintain drug fund system within the community.		X
	M. WATER AND SANITATION		
46	Promotion of personal and community hygiene - hand washing with soap	X	X
47	Advising community on potable water and protection of water source	X	X
48	Advise on pest control	X	X
49	Advice training on safe excreta disposal	X	X
50	Advice training on safe refuse disposal	X	X
51	Advice on care of the mouth and teeth	X	X

S/N	TYPE OF SERVICE	RECOMMENDED PROVIDERS	
		CORPs	JCHEW
	N. ORAL HEALTH		
52	Oral health advice (Dental education on care of mouth and teeth)	X	X
	O. COMMUNITY MENTAL HEALTH		
53	Advice and Counselling on prevention of drugs and substance abuse (promotion of mental health)	X	X
	P. REFERRAL		
54	Counselling and motivation for referral	X	X
55	Effecting referrals for all cases above the level and following up (2 - way referral) for all patients requiring referral.	X	X
56	Mobilising support as required from the community (VDC /WDC) to effect referrals (e.g. logistics)	X	X
	Q. MAINTENANCE OF PHC RECORDS		
57	Participation in house numbering (as appropriate), issuance of child health card and family master card.	X	X
58	Completion of all cards, routine and notifiable disease forms and transmission – Family master card, Child health card, Adult health card, Immunization card, HMIS records and summary forms		X
59	Collection of community based statistics on demography and health events including births and deaths		X
	R. MONITORING		
60	Will be done by health centre staff who should be at least 1 level higher than that at the health post		
	S. SUPERVISION		
61	Will be done by health centre staff who should be at least 1 level higher than that at the health post		
	T. WASTE DISPOSAL		

PRIMARY HEALTH CLINIC

4.0 Nomenclature of health facility: Primary Health Clinic

Service Delivery Area : Group of Settlements/Neighbourhood, Villages or Communities

Estimated Coverage Population : 2,000 to 5,000

4.1 Minimum Infrastructure:

Building and Premises

- Minimum Land Area: 2,475 square metres
- Colour: Blue (see picture below)
- A detached building with at least 5 rooms (see floor plan)
- Walls and roof must be in good condition with functional doors and netted windows
- Functional separate male and female toilet facilities with water supply within the premises
- Availability of a clean water source: at least motorized borehole
- Be connected to the national grid and other regular alternative power source
- Have a sanitary waste collection point
- Have a waste disposal site
- Be clearly signposted – visible from both entry and exit points
- Be fenced with gate and generator houses