

GOVERNANCE CONSTRAINTS AND HEALTH CARE DELIVERY IN NIGERIA: THE CASE OF PRIMARY HEALTH CARE SERVICES IN AKWA IBOM STATE.

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INTRODUCTION

This paper examines the extent to which constraints related to funding and supply of health workers affect provision of primary or basic health care services at the local government level in Nigeria. It is motivated by concern with limitations in services and attendant adverse consequences, and the need to offer suggestions and policy insights that might address the situation. Limitations in availability and access to such basic services as immunization for pregnant women and infants, ante- and post-natal maternal and child care, etc., is often associated with poor health outcomes. Among the outcomes are high maternal and infant mortality rates, and overall low life expectancy.¹ While there is ample discussion of the causes and consequences of poor health services in Nigeria in local and international work (HERFON 2006, Iyayi 2009, Oloriegbe 2009, FMOH-NPHCDA 2004, UNICEF-WHO 2009, etc), the constraints of funding and human resources on health service provision at the local level have scarcely been explored.

I interrogate the question of whether it is scarcity of public funds or corruption in the allocation and utilization of funds that account for limited provision of health services by local governments. Secondly, I investigate how inadequacies in the number and training of health workers impact service delivery in local health facilities. I focus on health care delivery in two local government areas (LGAs),

Uruan and Etinan, in Akwa Ibom State in southeastern Nigeria.

I assess the responses to a survey undertaken in the two areas in the spring (January-March) of 2007 with a view to providing a snapshot of the state of health care in Nigeria and measures that could be taken to improve it. Before presentation of the research and discussion it is necessary to clarify the key concepts, governance and primary health care delivery, and the context in which they are used.

CONCEPTUAL CLARIFICATION

Governance: The constraints of funding and human resources on health care delivery are discussed within the context of governance because decisions on how much public funds to allocate for health services vis-à-vis other competing needs are authoritative decisions by political leaders in government. As well, the numbers of health workers, their training and distribution in public health facilities have implications for governance in the sense that government has a role in training health workers, providing good working conditions, and equipping public health facilities.

The premise is that a proactive and accountable government would prioritize health care of the people and this would reflect in how it deploys resources for service delivery including building requisite human resource capacity. However, accountable political leadership and good governance have been in short supply in Africa; especially so in the case of Nigeria, and bad governance is thought to have adverse implications for public sector service delivery.

According to Hyden (1990:246), the generally low levels of socio-economic development in African countries “can best be understood by a critical examination of the

conditions of governance in Africa.” Multilateral development agencies such as the World Bank, International Monetary Fund (IMF) the United Nations Development Program (UNDP), etc, emphasized leadership accountability, transparency, and democratic participation in their views of governance.

The World Bank (2000) perceived governance as entailing the building of capacity of government for effective policy-making and implementation, strengthening regulatory mechanisms, and ensuring transparency and accountability in the conduct of government business and service delivery. In the view of the UNDP (1997) governance was the exercise of economic, political and administrative authority to manage a country’s affairs at all levels.

On its part, the United States Agency for International Development (USAID) saw governance as “the ability of government to develop an efficient, effective, and accountable public management process that is open to citizen participation and that strengthens rather than weakens a democratic system of government.”² It emphasized not only effectiveness of the public administrative system but also the need to strengthen popular participation in government as a way of ensuring accountability in service delivery.

In the case of Nigeria even though there has been much progress in democratization in the last decade, the trend of poor service delivery and lack of transparency and accountability of political leaders to the people have persisted. This is noticed at all levels of government (Elaigwu 2005, Bratton 2007) and is the frame of reference for this exploration of funding and human resource constraints on primary health care delivery.

Primary health care: Primary health care delivery refers to provision of such preventive services as immunization, maternal and child health care, and control

of locally endemic diseases including malaria, tuberculosis, polio, and prevention of HIV/AIDS infection. The focus is on the local government level because Nigeria's National Health Policy assigns responsibility for primary health care delivery to local governments with coordination and assistance of state governments (FMOH 2005:11, 13).

Immunization services (immunization shots for pregnant women and infants against such killer diseases as measles, tuberculosis, polio, diphtheria, etc) and maternal and child health services (including regular clinic attendance for antenatal and postnatal care of mothers and children), are about the two most important aspects of primary health care because of the potential for improved health outcomes; for example, substantial reductions in infant and maternal mortality rates if services are available in local health facilities and are provided at minimum cost for women and children.

There is limitation or inadequacy in services when services cannot be obtained either because there are no health facilities in local communities or they are unaffordable as is the case in most parts of Nigeria (Aregben 1992, Alubo 1993, Adeyemo 2005, Omoleke 2005, NHC 2009, etc). However, in the absence of hard numbers or official statistics for measuring limitations in service delivery at the local level, a survey was undertaken in order to gauge the thoughts of stakeholders (community residents and health workers) on availability of services.

RESEARCH METHODOLOGY

Assumptions of the research: The research assumed that there were severe limitations in availability of primary health services in Uruan and Etinan areas because there were so few public health facilities serving a large population, and that it did not appear as if the local governments were deploying enough funds for building,

equipping, and staffing health facilities. As well, it was assumed that services were limited because there were so few trained health workers in the health facilities to meet the need of clients.

In this regard, two hypotheses were proposed: (1) that low level of public funding likely resulted in limited health service provision, and that there was likely corruption in the form of diversion of the funds meant for health services, and (2) that small numbers of health professionals in Uruan and Etinan health facilities, and the insufficient training they receive, likely hindered them in delivering adequate and quality health services for clients.

Uruan and Etinan were selected for the survey out the 31 LGAs in Akwa Ibom State because of factors such as size, population, and number of public health facilities. According to *Akwa Ibom State of Nigeria 2002 Diary*, Uruan is one of the largest local areas in terms of geographic size (422,352 square kilometers) with population of 118,300 while Etinan is one of the smallest in size (182,325 square kilometers) but is one of the most densely populated areas with a population of 169,284, based on figures of the 2006 national census.³ Uruan is sparsely populated because its northern section is made up mostly of uninhabitable high hills and valleys; however, Uruan has more primary health centers than Etinan, 9 and 5, respectively.

Both areas are rural with only the headquarters in Idu and Etinan Town, respectively, possessing some urban/modern social amenities such as electric power supply, running water, and at least a primary health center. Besides this information on population, size, number of health facilities, there is no available official data on demographic and socio-economic features such as educational attainment and income levels pertinent to these two LGAs. And there are no specific records on number of

health workers in the health facilities and budget allocations and expenditure for health services.

I was interested in finding out whether residents of Uruan felt they had more access to health services than Etinan residents. I also wanted to highlight any similarities and differences in the local governments' effort to provide basic health services for citizens and what funding and human resource constraints they faced in order to extrapolate and explain the state of health services in Akwa Ibom State and Nigeria as a whole.

Study sample: I tested these hypotheses based on findings from a survey of a sample of the population. I drew a convenience sample of 280 people which represented a small proportion of the about 280,000 people who live in the villages and towns in Uruan and Etinan LGAs. Sampling was purposive in the sense that respondents were required to self-identify as belonging to one of three categories of people who were thought to be knowledgeable about primary health care delivery because they were either pregnant or nursing mothers who need or receive immunization and maternal/child care services (these were denoted as "customers/clients"), or doctors, nurses, and allied health professionals who serve in local public health facilities (denoted as "health workers"), or those who make or implement decisions about primary health care including elected and appointed political officials as well as bureaucrats (denoted as "policy makers").

Another sense in which sampling was purposive was that the survey was administered in select locations, i.e., villages and towns that either had public health facilities or were within the vicinity of health facilities in the two LGAs as follows: 80 health worker questionnaires were randomly distributed among health workers in 5 Uruan facilities and 3 Etinan facilities; 30 policy maker questionnaires were administered among political and

administrative officials including the elected council chairs and councilors, the heads of health department, and coordinators of primary health services in the local government council headquarters at Idu and Etinan Town; and 170 customer/client questionnaires were distributed among a random sample of residents in communities that had facilities and those who live within the vicinity of facilities. The large number of questionnaires for the community survey was informed by the need to tap the widest range of views from customers/clients of the public health facilities.

The survey: Three different sets of questionnaires each with two sections: (a) close-ended questions and (b) open-ended questions, was designed for each of the three categories or clusters of respondents. The close-ended questions required respondents to select from a 5-point Likert scale response menu ranging from „strongly agree“ to „undecided/don’t know“ or „no response“. The open-ended question required respondents to pick any number of items from a suggested list and space was provided for additional comments. The questionnaires are placed in the Appendix.

For health workers, some of the pertinent closed-ended questions included: (i) Insufficient number of available health workers means more work for me and I am not able to serve all clients all the time; (ii) Inadequate training of health staff is responsible for the low quality of basic health services provided in this health facility. The key open-ended question was: What do you think is the foremost reason for inadequate provision of basic health services in this health facility? (Suggested options: poor funding, or inefficient use and/or misappropriation of available funds; or non-availability of required number of health workers; or poor salary and conditions of service of health workers; or irregular/non-payment of salaries, etc); additional comments, if any.

For the community survey, close-ended question included (i) I am not able to get service at local government health facilities because I cannot afford the cost of service. (ii) The local government is not making enough effort to provide affordable and good quality primary health care services for this community. The key open-ended question was: What do you think is the foremost reason for inadequate provision of basic health services in this local government? (Suggested options: poor funding, or inefficient use and/or misappropriation of available funds; or non-availability of required number of health workers; or poor salary and conditions of service of health workers; or irregular/non-payment of salaries, etc); additional comments, if any.

From the 280 questionnaires administered, 209 completed questionnaires were retrieved indicating an overall response rate of 74.64%; and they were sorted out according to selfidentifying categories as follows: 85.30% response rate was recorded for the client/customer group [from 170 questionnaires administered, 145 completed questionnaires were returned]. For health workers, the response rate was 75% [from 80 questionnaires, 60 were completed], and for the policy maker group the rate was 13.30% [from 30 questionnaires, only 4 officials returned completed questionnaires]. Testing of hypotheses and analysis was based on responses from the health worker group and the community survey; there is no analysis for the policy maker group because of the very low response rate.

Data presentation and tests of hypotheses: The Statistical Package for the Social Sciences (SPSS) software was used for entering the survey data and obtaining frequency distribution of responses. The distribution indicated number of respondents and percentage of responses to the different questions, on which the test of hypotheses was based.

1. On the relationship between public funding and limitations on service provision, the response of health workers in the two areas to the question of what they thought was the foremost reason for inadequate provision of services in the health facilities was collated as follows: 26 out of 60 health workers (43.3%) chose the option that poor funding was the foremost reason for inadequate provision of health services [10% of respondents chose inefficient use of funds; 31% chose insufficient numbers of health workers; another 10% affirmed that poor conditions of services was responsible for limited services; while 5% of respondents had no response]. The response from the community survey to the question of what was the foremost reason for limited health services was as follows: 61 out of 145 respondents (42.1%) chose the option that poor funding was responsible for limitations in health service delivery [35.9% of respondents chose inefficient use of funds. The remaining 22% of respondents chose different other reasons].

The results indicate that the two categories of respondents were divided in their opinion of the foremost factor that accounted for limited services. There were no clear majorities in responses that would validate the hypothesis that poor funding was likely the cause of inadequate service delivery, even though about half (26 out of 60) of the health worker respondents thought that poor public funding accounted for limited health service provision. The point is that the survey result did not provide conclusive evidence of connection between poor funding and limitation in service delivery in Uruan and Etinan, especially given the fact respondents did not have concrete information about public funding.

On the assumption that corruption in the local governments in form of diversion of funds allocated for health services likely resulted in limited health service provision, 52 out of 145 respondents from the community

survey (35.9%) thought that corruption existed; 6 out of 60 respondents in the health worker category (10%) thought the same way. It was not possible to test and validate that hypothesis because it was not the majority opinion; and even the opinion of the 52 respondents was not based on knowledge of the intricacies and politics of allocation and utilization of public funds in local government.

In other words, that opinion can at best be regarded as the *perception* of the respondents. A close reading of respondents' optional additional comments in the open-ended section of the questionnaire pointed to a strong perception among respondents that there is diversion of public funds meant for health service in the councils, even though no concrete evidence or instances were provided. A respondent to the community survey, after selecting the option that inefficient use of funds is the foremost reason for inadequate health care services, added this comment: "Because most time (sic) fund send (sic) to the local govt. is often misappropriated by council officials."⁴

It is the case in Nigeria that members of the public, for the most part, have no clue about how much money is allocated at the different levels of government for health services and how and for what purpose such funds are used. It is hard to provide factual evidence on actual budgeted amounts, disbursements and utilization of funds. This is because not only is it difficult to obtain accurate information on how much money local government councils receive as their share from the central federation account pool but it is also impossible to know how much funds local governments allocate in their budgets for health care services. In the case of Uruan and Etinan councils, I could not obtain any information on the councils' health budgets and how funds were applied because local officials were unwilling to release any financial information.

2. On the hypothesis that there was insufficient number of health workers and that it likely accounted for

limited service provision, the percentage distribution of responses from health worker category was as follows: 19 out of 60 respondents (31.7%) chose the option that low numbers of health workers was the foremost reason for limited service provision. The assumption of connection between training of health workers and adequacy of health service provision was evaluated by collating responses to the relevant close-ended question in the health workers' questionnaire: "Inadequate training of health staff is responsible for the limited and low quality of health services provided in this health facility." Twenty-one (21) out of 60 respondents representing 35% checked „Agree“ and 14 respondents representing 23.3% checked „Strongly agree“ amounting to 58.3% of positive responses; the remaining 41.7% of respondents checked „Disagree“, „Strongly disagree“, and „Undecided/No opinion“ options.

On the basis of this result, the hypothesis of insufficient number of health workers and its relationship with limited service delivery cannot be validated because only less than half of respondents thought there were not enough health workers. However, the assumption of inadequate training of health workers and connection with limited and low quality service provision can be upheld on the basis of the survey data.

DISCUSSION

Taken together, there did not appear to be much difference between the Uruan and Etinan areas in terms of perceptions of respondents on the efforts of the local governments in health service provision, funding of health services, availability of services, and adequacy in number and training of health workers. The survey results did not appear to confirm the initial assumptions upon which this research was based with respect to identifying in concrete terms funding levels for health services in the Uruan and

Etinan and the presence of corruption in allocation and utilization of funds. On the question of whether there was corruption in handling of funds, the assertion of some respondents reflected more their perception on the issue than statements of facts. In addition, the researcher encountered considerable difficulty in obtaining official data on funding.

It was not possible to establish a connection between the number of health workers in the local health facilities, their level of training, and the range and quality of service provided for customers. This was because respondents either did not have substantive information on these issues or they were unsure about whatever information they had.

But these findings do not detract from the larger issues and concerns underlying the survey and this paper. These include the anemic state of health services, the high incidence of disease infection and morbidity, and associated poor health status of a large number of Nigerians, high rates of maternal and infant mortality, and low life expectancy rates, etc. These are very pertinent issues even articulated in official documents, backed with some form of nation- and state-wide statistical data, which apply to and provide a fair picture of the situation at the local level.

For example, an article on the Akwa Ibom State government website that reviewed the health care situation indicated problems including “inadequate health workers, equipment and shortage of drugs [i.e., medicines].”⁵ It added that the state had “high infant mortality rate of 67/1000 live births and maternal death rate of 800/100,000;” and that “as at 2001, there were 479 medical institutions in Akwa Ibom State with a total bed space of 5,240 beds, with a population of over 3.4 million. This is grossly inadequate; so many general hospitals in the state

were in a state of decayed infrastructure as well as polyclinics and cottage hospitals...”⁶

If data on number of health facilities per population is an indicator of availability of service, and if figures on number of doctors and nurses per population provides any indication of availability of health workers to meet the needs of a teeming population, then it can safely be said that Akwa Ibom State has not fared any better over the years in terms of channeling funds into building more health facilities and hiring and training more health workers. This is because with a population of 3,920,208 people (as of the 2006 national census), the state has only 390 public health facilities and 149 private health facilities (a total of 539).⁷ The public facilities are made up of 344 primary health centers (PHCs), 45 secondary health facilities including general and cottage hospitals, and 1 tertiary health facility. This amounts to 1 health facility for 7,273 people (1:7,273 ratio).

In terms of health manpower, the national statistics bureau reported that as of 2008, Akwa Ibom State had only 112 doctors and only 1,686 nurses giving average doctor/population ratio of 1:35,002 and nurse/population ratio of 1:2,325.⁸ This is far below the expected national Millennium Development Goals (MDGs) benchmark of 1:6,363 doctor/population ratio and 1:1000 nurse/population ratio based on a population of 140 million people. This expected benchmark is calculated from figures in the *Nigerian Health Review* which indicates that for Nigeria to achieve the health MDGs by 2015, the number of doctors in the public health sector needs to increase from about 17,800 as of 2005 to 22,000 in 2010, while the number of nurses needs to increase from 122,800 to more than 140,000. (HERFON 2006:221). At the present moment in 2010, Nigeria (and its constituent state and local government areas) is no way near the attainment of the

benchmark. This is the urgent challenge that faces the three levels of governments in Nigeria.

CONCLUSION

The effort was to examine how constraints related to public funding of health services, supply, and training of health care workers, have hindered the provision of health services in two local government jurisdictions, Uruan and Etinan in Akwa Ibom State, Nigeria. Field research involved survey of a convenience sample of people randomly selected from communities in the two areas. On the basis of survey data, it was not possible to validate the assumptions that poor public funding and inadequate number of health workers hindered provision of health services.

There was no clear-cut determination of whether corruption exists in the form of diversion of funds into the private pockets of public officials or the misapplication of funds to uses other than provision of health services. Also, it was not possible to determine the extent to which corruption limited health care delivery. This was because responses to questions related the aforementioned issues reflected more of respondents' perceptions than statements of fact. This also underscored the main limitation of the study: the difficulty in obtaining concrete information on health manpower situation at the local level and on public funding of health services because public officials were unwilling to divulge financial information. It was impossible to learn how much funds were available, how much was allocated for health services, and to determine what financing baseline or level of funding could be considered sufficient for providing all of the health needs of people in the areas.

However, this did not make any less urgent the larger issue of the study: the anemic state of health services

and attendant poor health status and outcomes experienced in Nigeria, and the challenge of harnessing and allocating adequate resources on the part of governments at all levels in Nigeria to build, equip, train, and hire sufficient numbers of health workers for delivery of critical basic health services for a teeming population. This challenge can be confronted within the context of prioritization of access and affordability of basic health services in local and national policy, and fundamental improvements in governance in a manner that emphasizes accountability of the government to the people in resource allocation and utilization and in actual service delivery.

RECOMMENDATIONS

Several suggestions and policy measures have been proposed for addressing the parlous state of health services in Nigeria in the areas of health policy design and implementation, human resources for health including improvements in work environment and conditions for health workers, health financing, monitoring and evaluation, and best practices in health service delivery, among others (Lucas 2005, Chukwuani *et al.* 2006, NHC 2009, Olowu 2009, etc).

Some respondents to the survey also offered a number of quite detailed suggestions in interviews and written comments in the open-ended section of questionnaires, paraphrased thus: “The local government council should give adequate support for health care programme and there should be appropriation of available funds...Staff salaries should be paid regularly to encourage them to work harder...staff should be exposed to modern equipment and techniques to improve their skills.”⁹ Another respondent indicated: “There should be health personnel in the decision making body [local council], policy on health should be implemented seriously and timely.”¹⁰

It is the position of this paper that such practical measures and logistic supports can be implemented with good results in a setting in which political leaders and bureaucrats charged with providing or facilitating access of citizens to health services are transparent and accountable. There is need for a reorientation among Nigerian public officials and a change in the way government business is conducted. This change would occur only with fundamental and transformative changes in the nature of politics and governance in Nigeria. Public officials at all levels of government should internalize and display the spirit of service, and it should be possible to hold them accountable for misdeeds and inefficiencies in public service delivery.

One way this can be accomplished is by establishment, through citizen effort, of an independent monitoring structure or agency composed of nonpartisan community representatives and stakeholders, reputable nongovernmental, nonprofit, civic organizations, as well as representatives of both the ruling party and opposition parties. This home-grown monitoring agency should be empowered to work with the executive and legislative branches of governments to ensure that adequate funds are allocated for health services. It can monitor disbursement of funds for materials, equipment, as well as actual delivery of health services. This agency would obtain citizen feedback on whether or not their needs have been met, liaise with relevant public officials or agencies to address citizen complaints, as well as investigate and expose malfeasance and wrong doings of public officials.

ENDNOTES

- 1 On infant mortality, the United Nations Children Fund (UNICEF) and the World Health Organization (WHO), in a recent publication, indicate that as of 2007, Nigeria had infant mortality rate of 97 per 1,000 live births. With regard to under-5 mortality, 189 children per 1,000 live births did not survive beyond their fifth birthday. (UNICEF-WHO 2009). Life expectancy at birth is estimated at 47 years (HERFON 2006).
- 2 Accessed at www.usaid.gov/ourwork/democracyandgovernance/technicalareas/html on 7/27/2007.
- 3 National Bureau of Statistics, "Federal Republic of Nigeria 2006 Population Census." Accessed at <http://www.nigerianstat.gov.ng/connections/pop2006.pdf> on 2/9/2008.
- 4 Direct quote from written response on questionnaire.
- 5 "Health development during Attah's administration and expectations under Akpabio." Accessed at <http://www.akwaibomstategov.com> on 6/22/2007.
- 6 Ibid
- 7 National Bureau of Statistics, "Type of health care facilities and ownership by state." Accessed at <http://www.nigerianstat.gov.ng/> on 2/9/2008.
- 8 National Bureau of Statistics, "Health manpower situation in Nigeria, 2004-2008." Accessed at <http://www.nigerianstat.gov.ng/> on 1/9/2010.
- 9 Direct quote from written response on questionnaire.
- 10 Ibid

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APPENDIX

Questionnaire 1: For health workers (doctors, nurses, allied health workers)

Questionnaire 1(a):

Instruction: Please mark „X“ against the option of your choice for each of the following closeended questions.

Strongly agree	Agree	Disagree	Strongly disagree
	Don“t know		
(5)	(4)	(3)	(2)
(1)			

1. Insufficient number of available health workers means more work for me and I am not able to serve all clients all the time.
2. Inadequate training of health staff is responsible for the low quality of basic health services provided in this health facility.
3. Lack of exposure to modern equipment and techniques is an impediment to improved basic health care provision in this local government area.
4. Irregular payment of salaries is the most significant reason for tardiness (e.g., absenteeism, lateness, etc) among workers in this health facility.
5. Low morale among health staff results in tardiness and poor service delivery.

Questionnaire 1(b):

Instruction: Please fill in your response in the space provided for the following open-ended questions.

1. Are you equipped with the requisite tools/facilities that would enable you to provide service for clients?
2. What do you think is the foremost reason for inadequate provision of basic health services in this health facility?
(Suggested options: poor funding, or inefficient use and/or misappropriation of available funds; or non-availability of required number of health workers; or poor salary and

conditions of service of health workers; or irregular/non-payment of salaries, etc) additional comments, if any.

3. How would you rate the quality of service provided in this health facility (suggested options: fair, good, poor, very good, excellent) additional comments, if any.

4. Do you have any suggestion(s) on what could be done to improve basic health care delivery in this local government area?

Questionnaire 2: Community survey (For client/customers/beneficiaries of primary health services).
Questionnaire 2(a):

1. The service that I receive at local government health facilities is often times of a poor quality.

2. I am not able to get service at local government health facilities because I cannot afford the cost of service?

3. The local government is not making enough effort to provide affordable and good quality primary health care services for this community.

Questionnaire 2(b):

1. What do you think is the foremost reason for inadequate provision of basic health services in this local government? (Suggested options: poor funding, or inefficient use and/or misappropriation of available funds; or non-availability of required number of health workers; or poor salary and conditions of service of health workers; or irregular/non-payment of salaries, etc) additional comments, if any.

2. How would you rate the quality of service provided in this health facility (Suggested options: fair, good, poor, very good, excellent) additional comments, if any.

3. Do you have any suggestion(s) on what could be done to improve the health condition of ordinary citizens in this local government area?

Questionnaire 3: (For administrators/
policymakers/politicians).

Questionnaire 3(a):

1. The provision of primary health services such as maternal health services and immunization of children in the local government health facilities is hampered by insufficient number of trained health workers.
2. Inability to provide training and attractive conditions of service by the local council result in low morale among the health workers.
3. Insufficient allocation of funds limits the ability of this local government council to deliver primary health services for citizens.
4. Misallocation/diversion of funds meant for primary health services limits the ability of this local council to provide needed services for citizens.
5. Financial difficulties encountered by this local council limit its capacity to provide basic health care services for citizens.

Questionnaire 3(b):

1. Given all the inputs that this local council has made in primary health care delivery (finance, personnel, equipment, etc), do you think health services have been provided to citizens at the optimal level?
2. Are service providers in the hospitals, health centers and clinics, and other basic health facilities in this local government area equipped with adequate tools to do their work?
3. Are health workers' salaries paid regularly?
4. Do you have any suggestion(s) on what could be done to improve primary health care delivery in this local government area?