© 2012 Cenresin Publications
www.cenresinpub.org
ISSN 2277-0038

CHALLENGES OF HEALTH DEVELOPMENT AT LOCAL LEVELS: A COMPARATIVE STUDY OF LOCAL GOVERNMENT COUNCIL EXAMPLES IN BRITAIN AND NIGERIA

Abdur-Rahman Olalekan Olayiwola
Department of political science
Lagos State University, Ojo, Lagos, Nigeria

ABSTRACT

Health is wealth. A Healthy Nation is a wealthy Nation. This paper is about a comparative view of health development challenges at the Local Levels in London Britain and Egbeda Oyo State, Nigeria. The paper compares and contrasts health development in the two societies with the objective of identifying the variables which determine whether and to what extent health development in the systems can be implemented. It also specifies the constraints which limit the range of options effectively available to Local Government Councils and health policy – makers at the Local Level in Britain and Nigeria. The paper examines the rhetoric versus reality on Health Development at the local level and concludes that;

(1) Local governments are not alone among the levels of government in their failure to provide comprehensive health development programmes;
(2) The local governments lack a comprehensive policy of health development at the local level in general and particularly on the health hazards caused by many factors including environmental pollution;
(3) There is a total dependence on seeking foreign medical attention and treatment which ensures that Nigeria is unable to properly regulate health development and various hazards on health;
(4) The failure of government has forced ordinary people, the primary victims, to engage in self-help medication and measures in an effort to stop fake health practitioners from the reckless destruction of people's health and life;
(5) There are fragmentations of policies, overlapping and unclarified responsibilities on health development matters at the Local Level

In addition to analysing the major trends on health development at the Local Level, the paper assesses the ramifications of the issues on health services. Because local government as a sub-national system initiates and applies public policies and influences daily life, the paper examines its important role in the functioning of health development programmes, and concludes that local governments need a more coherent policy on health development. The paper takes into account, among other things, the availability of materials and human resources, the traditional attitude to health in various social segments, the opportunities which the ever expanding health programmes and services have created for people such as the National Health Service (NHS) in Britain and the National Health Insurance Scheme (NHIS) in Nigeria. Finally, the paper considers the critical adverse effects on health development of challenges, factors and problems such as inadequacy of funding, population, racism and post-code health care delivery in Britain; unavailability of drugs, training and re-training of health personnel, social security fraud and corruption, environment and hygiene issues in disease control and prevention, the issues of health care services for physically

challenged persons, the mentally ill, the beggars and destitutes, the homosexuals, gays and lesbians and people affected/infected by HIV/AIDS – Acquired Immune Deficiency Syndrome, as well as the ubiquitous and pervasive role of the mass media in Health Development Communication Education and Information Dissemination. The paper makes numerous suggestions, proposals and recommendations for reforms on health development, the delivery and payment of health services at the Local Levels.

INTRODUCTION: STATEMENT OF THE PROBLEM

There has been so much talk on health for all by the year 2000, that is, eleven years ago. The origin of the catch-phrase "health for all by the year 2000" is attributed to Halfdan Mahler, a director-general of the World Health Organisation (WHO), an agency of the United Nations International Organisation (UNO). (Mahler, 1978). To achieve the objective of health for all, Primary Health Care (PHC) was declared the most effective way of achieving health for all citizens of the world. The World Health Organisation, Alma-Ata Declaration, (1978) states: "A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary Health Care is the key to attaining this target as part of development in the spirit of social justice". The World Health Organization itself performs the following functions in relation to health development in the world generally,

(1) It helps in eradicating diseases like small pox, polio, malaria, yaws, leprosy and other deadly diseases;
(2) Assists in training medical personnel throughout the world.
(3) Assists in sending medical personnel to countries that have such needs and request for it.
(4) Improves nutrition, housing, sanitation, recreation and economic conditions of the people of the world
(5) Improves the knowledge and standard of health all over the world
(6) Directs and co-ordinates international health work in the world.
(7) Sets quarantine and inoculation regulations.
(8) Assists in the control of manufacturing and distribution of dangerous drugs (Olayiwola, 2009, 2010).

In spite of all the rhetorics on health development, the reality on ground is that unfortunately not enough has been done and/or achieved in the direction envisaged. In Britain, there have been broken promises and bad intentions which have paved the path of coalition government between the Conservative and the Liberal Democrat Parties on Health Development. The problem nearly toppled the coalition government recently when riots broke out in various London Borough Councils of Hackney, Enfield, Southwark, Lewisham, Greenwhich, and British Cities of Manchester, Liverpool, Birmingham, Bradford, to mention just a few. This marks a repetition of social development problems in Britain (Olayiwola, 2008). Just four months into the ConDem coalition, the list of their cynical promises that have been broken is growing apace. Perhaps the biggest lie was David Cameron's claim that the Tories would "ringfence" the NHS against cuts and ensure a "real terms increase each

year" in NHS spending: it is clear that hospitals and health services face a four-year freeze on spending while demand for health care for Britain's ageing population requires an increase of around 4% every year to stand still.

So while NHS spending is not being cut in absolute terms, the gap between resources and required funding is a staggering £20 billion by 2014. As desperate health bosses look for ways of generating "efficiency savings" (aka cuts) on this unprecedented scale, they are already slashing jobs, services and departments, with much worse to come. This means that another cynical Tory pledge – of a "moratorium" on the closure of Accident and Emergency (A & E) and maternity units – has been swiftly ditched. Even Chase Farm Hospital in North London, the hospital where Health Secretary Andrew Lansley announced the moratorium, is now slated for closure as health bosses dust off plans only briefly interrupted. Accident and Emergency A & E and other hospital services are closing in Bexley in South East London (using the age-old excuse of "staff shortages", at a hospital that has been on management's death row for several years) as well as King George's Hospital in Ilford, Rochdale and Hartlepool, among others. Maternity units are facing the axe in High Wycombe and Maidstone – where paediatrics will close, despite protests by local GPs; a children's ward is closing in Burnley, a ward is closing in Portsmouth and even a hospice is facing cutbacks in Sheffield.

Mental health services are facing cutbacks in many parts of London, Staffordshire, Preston and Oxfordshire. On the job cuts, Oxfordshire so far is the most draconian, with plans to axe the NHS pay bill by £100 million – equivalent to more than 4,000 of the 14,000 staff – over the next three years. Along the Thames Valley Reading's Royal Berkshire Hospital is planning to axe 60 jobs, and the Heatherwood and Wexham Park Trust based in Slough wants to cut 470. In Essex, Southend Hospital is axing two wards and 400 jobs. But all this is only a taster of the cuts to come. Lansley's White Paper proposals for reorganisation mean that the NHS faces the ultimate double whammy of massive cuts, coupled with near-total privatisation of services. Laughingly entitled "Liberating the NHS", Lansley's bombshell proposals for the NHS in England include:

- Implementation of the £20 billion "efficiency savings" by 2014;
- Abolition of all ten Strategic Health Authorities and all 150 Primary Care Trusts, (PCT) with the loss of up to 60,000 jobs;
- Handing the responsibility for "commissioning" services and control of budgets totaling £80 billion to 500-600 local consortiums of GPs. With an average 3-4 GP consortiums per PCT area, a further fragmentation of the NHS and the outbreak of a new "postcode lottery" on access to care, and widening inequalities seem an absolute certainty, while any apparent savings in management costs from scrapping the PCTs seem likely to be undermined by the costs of GPs hiring in the expertise and staff needed to carry out their commissioning role – possibly from costly management consultants.
- Forcing all NHS Trusts either to become Foundation Trusts, or to be taken over by Foundation Trusts by 2013. Foundations in turn are to be shifted out of the NHS framework and become 'social enterprises': they will also be encouraged to raise much more of their funding through private medicine. This means that, with NHS funding

frozen, many Foundations will focus on attracting wealthy fee-paying private patients from home and abroad, rather than treating NHS patients. Already FTs are drawing up plans to scrap the automatic pay rises which NHS staff get under the Agenda for Change agreement, making it clear that many will also take the first opportunity to ditch other NHS terms and conditions such as pensions, sick leave and training.

- The changes would wind up all of the public bodies which currently meet in public and publish the bulk of their proceedings and papers, and replace them with a series of furtive bodies meeting behind closed doors and unaccountable to anyone at local level.
- To make matters worse, all NHS services would be opened up to bids from "any willing provider", encouraging private-for-profit companies as well as so-called "social enterprises" to step in: the National Health Service would become a National Health Market, with an increasing number of private and unaccountable providers effectively sponsored by taxpayers' money from the NHS budget.
- Almost all of the present I million staff working for the NHS in England would cease to be NHS employees, either losing their jobs altogether, or being forcibly transferred to non-NHS employers.

Reaction to these plans, which were announced in July at the start of the holiday season and have only just begun to be discussed seriously, has been slow, but is now building. In September the Trade Union Congress TUC voted unanimously to reject the White Paper and UNISON branded it as 'the end of the NHS', producing a useful booklet-length response, and winning the right to a judicial review of the lack of any proper consultation on the White Paper proposals. Unite has set up a campaign committee. One early weakness was from the British Medical Association (BMA) and the Royal College of GPs, which both assumed that many GPs would be attracted by the prospect of taking over responsibility for commissioning: the BMA Council voted overwhelmingly in favour of "critical engagement" with the consultation on the White Paper. But every indication since then has been that GPs are alarmed and concerned at the implications of the proposals: polls show upwards of 60% of GPs opposed, with only one in five respondents in one poll believing it could improve the NHS.

It is clear that BMA negotiators seeking to tweak the white Paper have come back largely empty-handed, while of course hospital doctors have everything to lose and nothing to gain from Lansley's proposals. It seems quite possible that the BMA, which is already voicing more criticisms of the White Paper, could be pressed by its members to reject it. But the challenge ahead is to turn the potential into an actual mass campaign that can put the heat on the coalition and defeat these Thatcherite proposals. The ConDems have no mandate whatever for these changes, none of which were put to the electorate in May, and which even break from the list of 47 agreed policies published when the coalition deal was lashed together. In that list the ConDems agreed to democratise PCTs by adding elected members: instead Lansley has simply opted to scrap them altogether, and with it reduce dramatically the limited level of accountability in the NHS. Bizarrely, Lansley's White Paper itself also repeats several times a promise to patient-centred care, by claiming that the principle should be "nothing about me without me". That may sound good as a sound-bite, but the reality is that

the public is the last to be told or consulted about the fundamental changes in the White Paper. Every patient and potential patient faces having their NHS privatised without any actual consultation on whether or not there is any public agreement. The so-called "consultation" is only about how to carry out Lansley's plans, not whether they are acceptable.

In fact many PCTs and other NHS managers are already acting as if the White Paper had already been developed into the necessary legislation and passed by Parliament, which is far from the case. It is vital to make use of the time remaining to step up the fight and unite all of these who reject Lansley's vicious proposals. The government has tried to create the impression that the NHS is somehow separate from the massive package of cuts being driven through with the October 20 Spending Review: but it is clear that the deadly combination of cuts and privatization which is facing local authorities is also threatening the NHS. So it is important that health workers and their organizations are involved wherever possible in wider campaigning against the coalition's onslaught on the public sector in general and welfare state provision in general. That means backing local and national lobbies, marches, meetings and protests of all kinds, and making sure that health workers and the wider public who depend on health services are informed of the threat that is looming, and given the chance to fight the White Paper. It could be one of the issues that helps unravel the Thatcherite ConDem coalition, and speeds the grovelling LibDems towards their well-deserved place in the dustbin of history. (John Lister, 2011).

In Nigeria, there are still acute shortages of drugs and facilities in public hospitals, more emphasis is laid on the curative rather than the preventive aspects of health care development, traditional and orthodox aspects of the country's medicare are not optimally utilized, malaria remains one of the most deadly killer disease in Nigeria, even though, the Millennium Development Goal 6 aims at eradicating HIV/AIDS, malaria and other communicable diseases by 2015. What are the challenges to Health Development in London Britain and Egbeda Oyo State Nigeria. This paper attempts some answers. What institutional arrangements are peculiar to each country – Britain and Nigeria – as independent variables to explain the course of health development policy? This paper attempts some answers. Institutional arrangements are defined as a complex set of variables including:

(1) the states' capacity to intervene;
(2) the role of organized interests;
(3) the way the state and organized interests are linked;
(4) the impact of party structures on policy formulation in relation to health developments
(5) the governance structure of the health sector; and
(6) the level of reflection, that is, the impact of existing policy structures politico-economic and environmental discourse on health development.

As in Britain which introduced the National Health Service (NHS), National Health Insurance Scheme was also introduced in Nigeria (NHIS). It entails a gradual process of putting funds aside, which will take care of the sick when they are ill and calls for contribution from governments, employers of labour, workers and all other prospective beneficiaries. (NHIS, 2001).

EVOLUTION OF NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA

Health insurance scheme as a way of financing health care was first introduced in Germany in 1887, followed by Austria 1897, Norway 1902 and United Kingdom 1910, by 1930, Health Insurance Scheme had been well established and recognized in all European countries (Okezie, 2001). The concept of social health insurance was first introduced to Nigeria in 1962, when Halevi committee passed the proposal through the Lagos health Bill. Unfortunately, it was truncated. In 1984, compelled by the desire to source more fund for health care services, the National Council on Health advised government on the desirability of health insurance scheme in Nigeria and proffered some recommendations. In 1985, the then Minister of Health (Olikoye Ransome Kuti) constituted a committee whose terms of reference included the responsibility of advising on the desirable, viable and acceptable model of health insurance scheme for Nigeria. At the 28th meeting of the National council on Health, another committee was set up on National Health Insurance Scheme in 1989, In 1991, the federal government signed an agreement with the UNDP and the International Labour Organization (ILO) for planning and implementation of the Scheme. Studies carried out in this regard involved actuarial analysis, computerization requirement, financial procedure, management information system, guideline and draft law on the NHIS (WHO, 1987, FRN/NHS, 1999).

It was not until 1992 that the Federal Ministry of health presented a memorandum of the Federal executive council praying for immediate implementation of the NHIS. In 1995, the National Health summit endorsed the memorandum to set up a NHIS as soon as possible at its 42nd meeting. However, the National council on Health (NCH) approved the re-packaging of NHIS to ensure full private sector participation in the scheme. The enabling law, decree 35 of 1999, (New act 35 of 1999) was signed in May, 1999. The NHIS came into full operation in Nigeria in 2001 (NHIS 2000, 2001).

Objectives of the NHIS

The main objectives of the scheme include the following: (NHHIS, 1999)

(i) Ensure that every Nigerian has access to good health care services;
(ii) Protect families from the financial hardship of huge medical bills;
(iii) Limit the rise in the cost of health care services;
(iv) Ensure equitable distribution of health care cost among income groups;
(v) Maintain high standard of health care delivery services within the scheme;
(vi) Ensure efficiency in health care services
(vii) Improve and harness private sector participation in the provision of health care services;
(viii) Ensure adequate distribution of health facilities within the federation;
(ix) Ensure equitable patronage at all levels of health care;
(x) Ensure the availability of funds to the health sector for improved services.

Nevertheless, NHIS is constrained as at present by several factors in Nigeria. Some of these include poverty, poor supply of drugs or vaccines, inadequate trained health personnel and dwindling funding of health care. Others are: employers/providers' resistance to contributing their own quota, general poor state of the nation's health care services, cultural belief and

religious systems, dilapidated health infrastructures among a host of others. Only recently, the current Minister of Health, Professor Chukwu lamented on loss of confidence in NHIS, the Nigerians' eagerness to get treated abroad and unpatriotic Nigerians (NTA, 2011). To what extent are health services provided in institutions (hospitals) and community-based contexts? What are the sources and amounts of money for health care services and health development? What types of services are actually received by clients of the systems and to what extent are health services systems able to provide for people? This paper explains in a comparative methodological way.

METHODOLOGY

This paper adopts a comparative analytical methodology. This will enable us to compare health development at the Local Levels in Britain and Nigeria. We will use Przeworski and Teune categorisation to achieve explanation of regularities, similarities and differences in the two systems. (Przeworski and Teune, 1970). The choice of Nigeria and Britain for this comparative study is not without bias. Nigeria is the author's/researcher's country of origin, but the author is also a British citizen.

Secondly, both countries have a wealth of information in the area of Health Development at the Local Levels under study. Thirdly, Nigeria became Independent from British colonial subjugation in 1960 and the Health system as other systems in the country follows the British system. Fourthly, the author has been a Local Councillor for many years in the Local Council being compared and has chaired Health/Social Services, Education, Leisure Licensing Committees and Community Councils, at the Local Level in Britain. In addition, the author has lived, studied, researched, worked and practiced in Britain as a Lawyer/Solicitor of the Supreme Court of England and Wales and Commissioner for Oaths. (London Government Directory 1994, 1998, 2002, 2006). Also, a lot can be gained in the examination of the significant similarities, differences and regularities in the historical political, economic and social structures of the countries being compared as these factors relate to health development in those areas at the Local level. In addition, at least, four other distinct objectives can be realized from an analysis of two or more polities; objectives that could not be realized if analysis were confined to a single polity. First, cross-polity comparison makes possible the construction of classifications, typologies and rankings. Second, cross-polity comparison can yield a panoramic description of the universe of polities. To what extent do certain traits prevail? What overall qualitative generalizations can be made? What trends can be discerned?

A third objective is the identification of uniformities of polity characteristics. In what ways do certain polity characteristics cluster together, thus defining the type of polity and distinguishing it from another type? Are there certain process regularities and certain behavioural regularities that recur from polity to polity? These are questions to which comparative analysis can provide answers. The fourth and final objective of comparative analysis is explanation and this is the highest objective. If a comparison of two or more polities reveals differences the analyst must attempt to explain these differences. (Scarrow, 1968; Roberts, 1972; Almond, 1956; Apter, 1958; Heckscher, 1957; Macridis, 1955; Neuman,

1957).In addition to our utilization of comparative methodological analysis, this study also uses a multi-layer approach. The paper is based on:

a) Review of extant literature on the flash points in Health Development in Nigeria and Britain.
b) Government records, gazettes and/or documents in the two Local Government Councils being compared;
c) Memoranda on health development submitted to the governments;
d) Local council committees and workshop reports;
e) Informal discussions with local councilors, directors of health, of the two local councils being compared;
f) The case studies of the two local government councils relied on a combination of approaches, including the use of:
    a. focus group discussions (FGD)
    b. participant observation;
    c. desk research; and
    d. interviews – both Focus Group Approach and In-depth interviews

A focus group interview is a structured group process used to obtain detailed information about a particular topic. It is particularly useful for exploring attitudes and feelings and to draw out precise issues that may be unknown to the researcher. A focus group is composed of six to nine participants who are brought together to discuss a clearly defined topic. Typically, focus groups are composed of homogeneous people, all representing a particular segment of the population. A focus group session should last about 1-½ hours with two hours being the absolute maximum time. A group facilitator keeps the discussion on track by asking a series of open-ended questions meant to stimulate discussion.

Advantages

1. Relatively easy to undertake
2. Results can be obtained in a short period of time
3. Social interaction in the group produces freer and more complex responses
4. The researcher can probe for clarification and solicit greater detail
5. Responses have high face validity due to the clarity of the context and detail of the discussion

Disadvantages

1) Requires highly skilled moderator
2) Groups are often difficult to assemble
3) Individual responses are not independent of one another
4) Because the group is hand-selected, the results may not be representative of the general population.

In-depth, qualitative interviews are excellent tools to use in planning and evaluating Health Development. An in-depth interview is an open-ended', discovery-oriented method that is well suited for describing both program processes and outcomes from the perspective of the target audience or key stakeholder. The goal of the interview is to deeply explore the

respondent's point of view, feelings and perspectives. In this sense, in-depth interviews yield information.

There are (key characteristics) that differentiate an in-depth, qualitative research interview from a regular interview. Some key characteristics of in-depth interviews include:

- **Open-ended Questions**. Questions should be worded so that respondents cannot simply answer yes or no, but must expound on the topic.
- **Semi-structured Format.** Although you should have some pre-planned questions to ask during the interview, you must also allow questions to flow naturally, based on information provided by the respondent. You should not insist upon asking specific questions in a specific order. In fact, the flow of the conversation dictates the questions asked and those omitted, as well as the order of the questions.
- **Seek understanding and interpretation**. You should try to interpret what you are hearing as well as seek clarity and a deeper understanding from the respondent throughout the interview.
- **Conversational.** You should be conversational, but your role is primarily that of a listener. There should be smooth transitions from one topic to the next.
- **Recording responses**. The responses are recorded, typically with audiotape and written notes (i.e., field notes).
- **Record observations.** You observe and record non-verbal behaviours on the field notes as they occur.
- **Record reflections**. You record your views and feelings immediately after the interview as well.

In essence, in-depth interviews involve not only asking questions, but the systematic recording and documenting of responses coupled with intense probing for deeper meaning and understanding of the responses. Thus, in-depth interviewing often requires repeated interview sessions with the target audience under study. Unlike focus group interviews, in-depth interviews occur with one individual at a time to provide a more involving experience.
Also, used as Data sources are;

Library Sources
Books, Auto-Biographies and other publications which are written either by the political actors themselves or by scholars, or Health practitioners on health Development in Britain and Nigeria.

Government Publications
Publications by the ministries of information and other government agencies, including press releases by such agencies as Local Government council Authorities.

Newspapers/Journals/Periodicals
Newspaper reports of major pronouncements by main political actors (which are not denied) and of government projects or proposed plans for health development. Government budgets

and other press releases by the government or political groups which appear in newspapers and are relevant to the subject-matter of this research, are used.

Recordings of Speeches on the Electronic Media

Recording of speeches by government functionaries over the radio or T,V, are also used where appropriate.

DEFINITION OF TERMS

Challenges are new or difficult tasks that test somebody's ability and skills; it also refers to an invitation or a suggestion to somebody that he/she should enter a competition.

Local: Means belonging to or connected with the particular place or area that one is talking about or with the place where one lives.

Local government: Is the system of government of a town or an area by elected representatives of the people who live there; the organization that is responsible for the government of a local area and for providing services etc.

There are sundry definitions of local government. Local government is a public organisation authorized to decide and administer a limited range of public policies within a relatively small territory which is a sub-division of a regional or national government; it is … a political sub-division of a nation (or in a Federal system, a state) which is constituted by law and has substantial control of local affairs 'including the power' to impose taxes or to exert labour for prescribed purpose; local government is a territorial non-sovereign community possessing the legal right and the necessary organization to regulate its own affairs; and in Nigeria, local government is defined as: "government at local level exercised through representative councils established by law to exercise specific powers within defined areas. These powers should give the council substantial control over local affairs as well as staff and institutional and financial powers to initiate and direct the provision of services and to determine and implement projects so as to complement the activities of the state and Federal Government in their areas, and to ensure, through devolution of functions to these councils and through the active participation of the people and their traditional institutions, that local initiative and response to local needs and conditions are maximized. (Olayiwola, 1987).

In general terms, local government administration is aimed at bringing government nearer to the people, catering for local needs, encouraging local participation in politics and ensuring the preservation of local traditions, history and culture of the people as well as relieving the central or federal government of the burden of over-centralization. Local government administration is also designed to provide essential social and economic services for the locality, mobilize the people for community development, make for simple administration of justice at the local level and serve as a link between the people and the state/central government among a host of other functions. This list is not exhaustive. (Olayiwola, 1986).

Medicine: Diseases, illness and sickness are associated with medicine. Medicine is used in all societies, including slavery, feudal, capitalist and so on. Medicine could mean different things. It could mean institution of healing, for instance, the medical school, and it could also mean any form of therapy as in psychology, without the use of drugs. That is psychological therapy

administered by a psychiatrist or a psychologist. In pre-capitalist societies, medicine could be in form of religion and prayers, or consultation with the ancestors. One thing that is associated with medicine is that it is used for treatment and the prevention of diseases in society.

Health: The medical conception of health is based mainly on the 'germ theory' of disease. That is health is the absence of any disease in the body. Sociologically speaking, health is both a medical and a social concept. Erinosho and Oke (2004) noted that in Nigeria, the social and cultural factors of the environment are crucial in the definition of health. In the same vein, the World health organisation (WHO) for a very long time rejected the conception of health based purely on the absence of any disease in the body but embraced a definition which says health is not just the absence of a disease or infirmity but the state of complete physical, mental, and social well-being. Health is therefore not just freedom from pain, discomfort, stress and boredom which themselves extend beyond the competence of clinicians to diagnose and treat, but positive expression of vigour, well being and engagement with one's environment or community. In this view, to attain good health we need health services not only health care (hospitals, dispensaries, doctors etc. It is within the context of the sociological and World Health Organisation's definition of health that health is considered in this paper.

Health Care: Health care is an aspect of health services. It involves institutional tools developed for repairing and preventing illness in society. These include: health personnel, health institution (basic tools) and the like.

Health Services: Health services refer to all that an individual needs in order to maintain a state of complete physical, mental and social well being. They embrace all basic economic and social services such as environmental sanitation, education, water and employment. Ityavar (1985) observed that lack of a job will have implication on health. Health means more than availability of institutions and doctors etc.

Health Institution: There are two types of health institution in Nigeria, the indigenous and the scientific. Each has its own role and ideology. They operate under different norms, values or practices. Science is manned by health (germ theory) the idea that diseases can only be eradicated by the use of western medicine. The scientific or western conception of medicine lays emphasizes on medicine, building of hospitals, the training of doctors and the like. Nigeria has followed this line of western model. Contrary to scientific model, the indigenous method of medicine lays emphasises on the social and moral relations. Here culture is very important. If an individual is sick and he/she goes to see a native doctor, he/she is asked questions on the relationship between him/her and the people around him or her and this is psychotherapy. The native doctor usually acts as a psychotherapist (Ityavar 1985). The methods of training in the indigenous and western medicine are also different. In the indigenous set up, training involves apprenticeship or a period of time while in the modern medicine doctors are trained in medical schools for a period of six years or more.

CONCEPTUALIZING DEVELOPMENT

Development is an ongoing process that depends on and promotes Scientific discoveries, new technologies, and new patters of social, political and economic interaction within a given interaction within a given democratizing society or state. For example, democratization,

accountable government and a respect for human rights are features of political development contained by the generic sense of development. (Olayiwola, 2011, 2011[(a)], 2011[(b)] 2011[(c)] Development is a normative concept referring to a multidimensional process. Development must be relative to time, place and circumstance (Mclean and Macmillan, 2003). Some of the necessary conditions and ingredients for development to be sustainable are: increased economic efficiency expansion of national economic capacity, technological advance, economic and industrial diversification and adaptability in the face of shocks, changes in social structure, attitudes, motivation, spiritual and cultural attainments, personal dignity, group esteem, the increasing satisfaction of basic needs such as food shelter, metical car, education, health and in the Nigerian case electricity and security to mention just a few. The concept of development includes not only economic, social and political changes, health development is included. (Olayiwola, 2011)

THE IMPORTANCE OF HEALTH DEVELOPMENT AT THE LOCAL LEVEL

Taking a specifically health orientation as the reason for including the importance of health development at the local level, the functions performed by the local government are not only germane but of paramount importance. They include: sanitary inspection, sewage, refuse and nightsoil disposal, control of vermin; slaughter houses slaughter slabs; public conveniences; cemeteries and burial grounds; bake houses, eating houses and laundries; control or keeping of animals. In the list also are: Health services centres and clinics of all kinds, ambulance and preventive health services; control of beggars and prostitutes, and repatriation of destititutes; home for destitutes, the infirm and orphans; piped sewerage systems. (Philip Mawhood, 1979).

CHALLENGES OF HEALTH DEVELOPMENT AT THE LOCAL LEVEL: THE BRITISH LONDON SOUTHWARD BOROUGH COUNCIL

The London Boroughs

The Local Government Act 2000 triggered some fundamental changes to the way councils are run. It set out three possible models, and left it to each individual local authority (and its residents) to choose which system to implement. The three options are:

- A directly-elected mayor and cabinet: The mayor, once elected (for a four-year term), selects his or her cabinet from among the councilors. The cabinet member need not all be from the same political party. A directly-elected mayor has much more power than the traditional, largely ceremonial, mayor.
- A leader and cabinet: The leader is elected annually by the council, and the cabinet members are either appointed by the leader or elected by the council. Again, the cabinet can be either single-party or a coalition.
- A mayor and council manager: The mayor is directly elected for four years to guide and influence the day-to-day work or a professional officer, who plans policy and takes decisions.

Whichever structure is chosen, all councils must have at least one overview and scrutiny committee, made up of councilors who are not cabinet members. Such committees, which have to reflect the political balance of the council, can make policy and budget proposals,

monitor and review performance, and call in or review decisions made by the executive. In London, 29 of the 32 boroughs are run by a leader and cabinet, while three (Hackney, Lewisham and Newham) have a directly-elected mayor and cabinet system. All the cabinets in London have between seven and 10 members.

Members of the Council

Leader:
Other group leaders:
Mayor

Executive

Leader
Deputy Leader
Environment & Transport
Education & Culture
Communications & Performance
Regeneration & Economic Development
Housing
Resources
Social Services & Health
Community Safety, Social Inclusion & Youth

Ward	**Member**	**Party**
Brunswick Park	Aalison Moise Vicky Naisah Ian Wingfield	LAB LAB LAB
Camberwell Green	Dora Dixon fyle John Friary Tony Ritchie	LAB LAB LAB
Cathedrals	Daniel McCarthy Catriona Moore Mark Pursey	LIBDEM LIBDEM LIBDEM
Chaucer	**ABDUR-RAHMAN OLAYIWOLA**	**LIBDEM**
	Richard Thomas Lorraine Zuleta	LIBDEM LIBDEM
College	Kim Humphreys Lewis Robinson William Patrick Rowe	CON CON CON
East Dulwich	Norma Gibbes Charlie Smith Sara Welfare	LAB LAB LAB
East Walworth	Margaret Ambrose Catherine Bowman	LIBDEM LIBDEM LIBDEM

LOCAL HEALTH ISSUES AND THE ENVIRONMENT RELATING TO HEALTH DEVELOPMENT IN LONDON SOUTHWARD BOROUGH COUNCIL

Local Health Issues

Black and minority ethnic communities have patterns of health, and mortality that differ from the UK population and resemble that of their country of origin. Over time their patterns of health become similar to that of the local population. Sickle cell disease and diabetes are important local health issues for black and minority ethnic communities who experience higher rates of incidence.

Sickle cell disease and thalassaemia

Sickle cell disease is more common in people from the Caribbean and Africa. Approximately one in ten Black Caribbeans are carriers of sickle cell disease trait. A screening test is available to detect trait carriers.

Estimated numbers of people with sickle cell disease and trait in Southward

	Black Caribbean	African	Total
With SCD Southwark	119	60	179
with SCD trait Southwark	1,897	944	2,641

Thalassaemia is more common in Asians and people from the Mediterranean and Middle East. In Asians, rates are around five per cent for carriers – around two in every 1000 births to Asian parents.

Diabetes

Diabetes is a serious disease that can be life threatening unless properly managed. It can be diagnosed with a simple blood test. People of Asian origin appear to be at five times the risk of developing diabetes compared with people in the white population. By the age of 65 about a third of Asians have diabetes. Black Africans and Black Caribbeans are also more prone to develop diabetes. Because of the demographic profile of Southwark's population local GPs see about twice as many diabetic patients as the national average.

Environment

The quality of the environment in Southwark is poor in many respects, and this has recognized effects on health. Overcrowding, lack of basic amenities and a poor standard of built environment all contribute to poor health. Levels of air pollutants, including nitrogen dioxide, particulates and ozome, are regularly exceeded in Southwark

OUTDOOR AIR QUALITY

In Southwark the Health of the Nation Group is looking at ways to improve air quality locally. Road transport contributes a greater proportion of some air pollutants in London than in many other parts of the country: 86 per cent of small particles, around 80 per cent of nitrogen dioxide, around 98 per cent of carbon monoxide and 20 per cent of sulphur dioxide. Apart from road vehicle emissions, fuel burning and industry produce these and other pollutants including ozone, lead, benzene and 1,3-butadiene. Susceptible groups of people

may experience adverse health effects during air pollution episodes. Individuals respond differently to air pollutants, because of factors such as age and pre-existing medical conditions. Personal exposure factors are also important, for instance how hard the person is breathing (are they exercising or walking briskly), length of exposure, air temperature, weather, humidity and presence of other allergens in the air. There is less evidence about the long-term effects on health of air pollutants; however it is likely that high levels of particulates may be associated with development of respiratory problems in the long-term. Deaths from respiratory disease are greater in LSL than in the country as a whole. Poor air quality may be a contributing factor.

AIR QUALITY MONITORING IN SOUTHWARD

In Southward there are two continuous automatic monitoring sites measuring levels of carbon monoxide, nitrogen dioxide, ozone (one site), particulates and sulphur dioxide. In addition 37 sites measure levels of nitrogen dioxide.

MORTALITY IN YOUNG PEOPLE AND ADULTS

Overview

Information on mortality is widely available, and used as a basis for comparison of causes of deaths between different populations. Trends in some mortality rates may be indicators of the general health and wellbeing of a population, or a sensitive indicator of adverse trends (e.g infant mortality rates). Mortality data also includes age at death, and is used to estimate the pattern of premature mortality within a population, which may be reflected in a reduced life expectancy. Life expectancy is a reasonable indicator of health within a population. Mortality rates are generally poor indicators of levels of disability or chronic ill health in a population.

MORTALITY IN CHILDREN AND YOUNG PEOPLE

Deaths in children are relatively rare. About half the deaths occur in the first year of life, half of these in the first week of life (called a prenatal death). Southwark has an increased percentage of low birth weight babies (around nine or ten per cent compared with seven or eight per cent nationally), and these are at greater risk. Low birth weight is associated with poverty, poor material nutrition (probably before and during pregnancy), parental smoking and maternal drug and alcohol use. (Southwark LBS).

COUNCIL ELECTIONS 2010

Local council election results 2010

Results are in for all 21 wards. View the full local council election results by ward.

Ward	Labour	Liberal Democrat	Conservative	Other
Brunswick Park	3 (hold)	0	0	
Camberwell Green	3 (hold)	0	0	
Cathedrals	0	3 (hold)	0	
Chaucer	1 (+1)	2 (-1)	0	
College	2 (+2)	0	1 (-2)	

East Dulwich	0	3 (hold)	0	
East Walworth	3 (+1)	0 (-1)	0	
Faraday	3 (hold)	0	0	
Grange	0	3 (hold)	0	
Livesey	3 (hold)	0	0	
Newington	2 (+2)	1 (-2)	0	
Nunhead	3 (hold)	0	0	
Peckham	3	0	0	
Peckham Rye	3 (hold)	0	0	
Riverside	0	3 (hold)	0	
Rotherhithe	0	3 (hold)	0	
South Bermondsey	0	3 (hold)	0	
South Camberwell	3 (+1)	0	0	Green (-1)
Surrey Docks	0	3 (hold)	0	
The Lane	3 (hold)	0	0	
Village	0	1 (+1)	2 (-1)	
Total*	**35 (0+7)**	**25 (-3)**	**3 (-3)**	**0 (-1)**

HEALTH DEVELOPMENT IN THE EGBEDA LOCAL GOVERNMENT COUNCIL OYO STATE

Egbeda Local Government was created along with 17 other Local Governments in 1989, and is one of the thirty-three (33) Local Governments in Oyo state of Nigeria. Until 1989, what now constitutes Egbeda Local Government Area was carved out of the Old Lagelu Local Government Area (LGA). Egbeda Local Government Area is located to the East and North East of Ibadan City, the state capital: it is bounded on the West by Ibadan North East Local Government Area, on the North by Lagelu Local Government Area, on the south by Ona-Ara Local Government Area and on the East is the Irewole Local Government Area, on the south by Ona-Ara Local Government Area and on the East is the Irewole Local Government Area; which is now Osun State of Nigeria. It has Landmass of about 410 sqkm. Egbeda Local Government with its Headquarters at Egbeda, is divided into 11 wards. It has a fertile landmass with farming population scattered all over the rural areas.

There are about 195 settlements in the Local Government Area, over 60% of these settlements are urban in nature, the urbanized ones are found along the Ibadan-Ife Road as far as Adegbayi and on the Ibadan-Iwo Road as far as Olodo. Also included in the urbanized section of the Local Government Area is the Old-Ife Road Area, the New-Ife Road Area, the New Gbagi Market and Agugu-Ogbere Road which have formed a huge urban sector ending at the New Airport Area. Apart from these parts which may be seen as part of the Metropolitan City of Ibadan, and which form the main urban section of the Local Government

Area, other semi urbanized settlements include ERUNMU, OWOBAALE and EGBEDA, which is the Local Government Area Headquarters.

Obviously, the urbanized part of the Local Government Area is the most populated; about 75% of the population live in the urban area. These include the Old-Ife and New Ife Roads Areas; and the Iwo Road Area. The rate of acquired land in Egbeda is very high. Hardly can one go through any direction in the Local Government without interjection of either Federal or state acquisition. On Iwo Road, there is the Muslim Pilgrim acquired land and Ajoda Extension, on Ife Road is the New Gbagi Market, Olubadan Housing Estate, Airport and Ajoda land extending close to the boundary at Asejire Water Works.

THE POLITICAL FUNCTIONARIES OF THE LOCAL GOVERNMENT AREA

The political functionaries of Egbeda Local Government can be viewed from two main perspectives, there are, the elected functionaries and the appointed functionaries. The Apex of the political functionaries of the Local Government is the Executive Chairman, who is the political head of the council. The Chairman is responsible and accountable for the day to day administration of the council and also presides at the meeting of the Council. He controls all the proceedings of the whole executive and the Legislative arms of the council's government. Next in the political hierarchy is the Vice Chairman, who takes charge of the council in the absence of the Chairman. The Secretary of the Council comes next in the hierarchy of the political head of the local government area. Next are the leader and deputy leader of the legislative council. Next in hierarchy are the supervisors, who are appointed by the Chairman of the Council from the general populace. At the time of this study, the political structure is not yet in place as there is a new government in the state.

HEALTH AND HEALTH RELATED PROBLEMS OF HEALTH DEVELOPMENT AT THE LOCAL LEVEL IN EGBEDA

Introduction

The health sector is a very important one. This fact had already been realised by this Local Government to the point that the former Oyo State Primary Health Care Director chose Egbeda Local Government Area "as having the capacities that could be developed in order to make the LGA a 'Model LGA' which could serve as an example for other LGAs to follow and perhaps even as a kind of 'Training Centre'.

However, illness is not uncommon among the inhabitants of the LGA. The proportion of the people who were ill in the last one month before the survey is shown below. The result reveals that 20.4% of the people were ill during that period.

Number of people who were ill in the month before survey

Option	Absolute Frequency	Relative Frequency
Yes	90	20.4
No	352	79.6
Total	442	100.0

Adults of over 40 years of age constitute the largest proportion of such sick people (46.7%). They are followed by those within the age bracket of 5 years to 9 years and 25 years to 29 years. The details are shown thus:

Age group of those who were ill in the month before survey

Age Range	Absolute Frequency	Relative frequency
0 – 4 years	6	6.5
5 – 9years	11	12.2
10 – 14years	5	5.6
20 – 24years	55	5.6
25 – 29years	11	5.6
30 - 34 years	5	12.2
35-39 years	-	5.6
35 - 39 years	42	-
40 and over		46.7
Total	90	100.0

AVAILABILITY OF HEALTH FACILITIES

The locations of health centres as well as the various types available within the LGA are private hospitals, all of which are located at the urbanised part of the LGA. Also there are clinics, maternity centres and dispensaries which serve both the urban and the rural people of the LGA. The spatial location of these health centres are such that the whole LGA is covered. There is no settlement that lies more than five kilometres away from an health institution. It can be observed that there are overlapping of the catchment rings at the central part of the LGA where most of the settlements are:

Prevalent Health Problems

Malaria fever and other fevers (an increase in body temperature) account for the highest symptoms of illness in the LGA. While malaria fever accounts for 40.0% of such symptoms, the other fevers account for 22.2%. Stomach ache and headache take 15.6% and 10.0% respectively. Some of the people (6.7%) also suffer from guinea worm and general weakness of the body.

Types of illness

Symptoms	Absolute frequency	Relative frequency
Headache	9	10.0
Malaria fever	36	40.0
Other fever	20	22.2
Stomach ache	14	15.6
Guinea worm	6	6.7
General weakness	5	5.5
Total	90	100.0

Place of treatment when ill

Place	Absolute Freq.	Relative Freq.
Home	15	16.7
Health Centre	20	22.2
Maternity Centre	20	22.2
Nowhere	35	38.9
Total	90	100.0

In spite of the many public and private health facilities within the LGA, a high proportion of the residents of the LGA who were ill either treat themselves at home or did not get treated at all. While 38.9% of the people did not seek treatment anywhere, 16.7% treated themselves at home. Only 22.2% each seek treatment at the health centres or maternity centres. This situation is not a good one, bearing in mind the dangers inherent in being treated by untrained health personnels and the huge sum of money expended on health care by the Local Government each year. There is therefore an urgent need to mount health campaigns aimed at educating the people on the need to patronise the government approved health facilities when ill.

CHILDREN – SPECIFIC HEALTH PROBLEMS

Infant mortality rate in Egbeda LGA, though not too high when compared with the national figure, still needs to be controlled. From table, it was observed that about 3.8% of the children born are now dead with the remaining 96.5% still alive this mortality rate of 38 per 1000 is by far lower than the state's average of 207/1000. Accordingly, of the eight infant deaths recorded, 50% were caused by malaria fever, 12.5% by cholera, while diarrhea/dehydration accounted for 37.5% of the deaths. Like in most African Rural Areas, observed deaths took place at home. This might be attributed to the lack of government owned hospitals (where patients could be admitted) or to the fact that a higher proportion of the people (55.6%) as observed.

Causes of Death of Children

Diarrhea/Dehydration	3	37.5
Accident	-	-
Poisoning	-	-
Cholera	1	12.5
Malaria Fever	4	50.0
Total	8	100.0

Seek treatment at home or nowhere when they are ill. The latter however, appear to be the more likely reason.

FEMALE – SPECIFIC HEALTH PROBLEMS

The only problems discovered to be specific to the female sex was that related to child bearing. Majority of the women, (75%) have not previously lost any pregnancy due to abortion. However, 25% of the women respondents have lost their pregnancy either twice or even more than twice.

Number of pregnancy lost due to abortion

Options	Absolute frequency	Relative frequency
None	36	75.0
Once only	-	-
Twice only	6	12.5
More than twice	6	12.5
Total	48	100.0

Who took delivery of the baby?

Attendant at Birth	Absolute frequency	Relative frequency
Relatives	60	26.7
Nursing Sisters	102	45.3
Staff Nurse/Midwives	16	71.1
Aid/Attendant	2	0.9
Nobody	48	20.0
Total	225	100.0

OLD PEOPLE SPECIFIC PROBLEMS

Accordingly, about 19.0% of the people in the LGA are over 49 years old. 5.4% of the people are in fact over 65 years of age.

Almost all the old people interviewed complained of three specific health problems viz: body pains especially arthrulgia and arthritis (pain or inflammation of a joint and back pains), eye defects (especially cataracts), and tooth ache.

Also many of the old people consider loneliness as a big problem. They however will live with relatives, rather than spend the rest of their lives in the old people's homes.

CULTURAL BEHAVIOURS AND PRACTICES RELATING TO HEALTH

In the rural part of Nigeria, the people are easily disturbed by filth and dirt, hence children are taught the importance and advantages of taking bath and cleaning the mouth in the morning. Egbeda LGA is not an exception as one of the early morning duties of children and housewives is the sweeping of the inside and surrounding of houses. Also, the carcasses of dead animals are naturally and allowed within village boundaries, as such are removed as soon as discovered. The effect of all these is a natural prevention of diseases which could have otherwise been experienced.

However, the story is different when the urban part of the LGA is considered. Most compounds see general cleaning only on environmental sanitation days. Some of the people agreed that the remains of a dead animal knocked down by a vehicle may remain on the road for days while those living around will not remove that as they believed it is the duty of government agencies. There are a number of practices inimical to people's health that are still being carried out in the LGA. One of such practices is that of the use of lantern in the room at night with the windows closed. Also in the rural parts of Egbeda LGA, washing of clothes and bathing are still carried out in streams which supply the people with drinking water. Goats, sheep and free-range chicken are still allowed to roam freely within the

neighbourhood, thereby soiling the inside and outside of buildings. The health implications of these practices cannot be over emphasised. Such include fire outbreak which have been known to have destroyed life and properties, spread of water and air borne diseases, and the obnoxious odours emanating from deposited domestic and chicken's waste products. (Adesina et al, 1993).

CONCLUSION AND RECOMMENDATIONS

This paper has focused attention on a comparative study of health development in London council in Britain and Egbeda, Oyo State Local Government in Nigeria.

The findings of the study have been reported in the body of the paper.

The following recommendations are made:

(1) The National Health Service (NHS) in Britain needs to be funded adequately while the National Health Insurance Scheme (NHIS) in Nigeria deserves a better treatment and implementation

(2) Politicians in Britain need to address the issue of racism and racial discrimination on health development matters while the Nigerian politicians need to make hospitals and clinics in Nigeria better to prevent the wealthy going for medical treatment abroad as if sick people do not die in foreign countries.

(3) Britain needs to review its tax system which is highly over regulated as far as health development is concerned including the cancellation of "mad Tax"

(4) The Emergency services in Nigeria – the fire Brigade, the ambulances, and the rescue teams need to be strengthened as in Britain where a rescue team will reach the scene of a road traffic accident in a matter of minutes, for example.

(5) At the moment Nigeria's health system has deteriorated to the extent that hospitals are just mere consulting clinics medical Doctors, Nurses and health practitioners need to be better treated by the government to avoid constant/incessant strike/industrial actions

(6) The inadequacy of health care delivered in the two countries needs to be eliminated by a determined concerted effort and political will health is wealth. A Healthy Nation is a wealthy Nation.

(7) There is a need for more emphasis on preventive rather than curative medicare, categorical public health programmes, health education, communication and information dissemination as well as employer based health insurance and social security insurance for the elderly, the children, the beggars, the physically challenged the mentally sick and a host of other vulnerable people without which millions of people will be left without health care and coverage and will stimulate health care cost inflation

(8) Little attention is paid to changing revenue sources on health development as at now. This has to be addressed.

(9) Since health has now become a vital dimension of development in which local government needs to play an increasingly important role, the following problems which confront local government in general and particularly on health development matters need urgent attention to be addressed:

(i) Bribery and corruption which retard the growth and development of people and local government.
(ii) Inadequate funding – The local governments in Britain and Nigeria do not receive enough money to carry out their functions.
(iii) Inadequate trained personnel – In many local government in Britain and Nigeria, there is scarcity of professionals to carry out certain assignments.
(iv) Racism, tribalism, nepotism and favouritism – This is common during recruitment, transfer, discipline and promotion of staff.
(v) Political interference: Central and State governments often deny them the required autonomy to work effectively.
(vi) Embezzlement of funds – Public funds meant to develop the local governments are often embezzled and misappropriated.
(vii) Inappropriate structure – Some local governments in Britain and Nigeria are too small or too large in size.
(viii) Negative attitude to work by local government workers due to poor conditions of service.
(ix) Inefficient method of revenue collection.
(x) Boundary disputes exist among some local governments.
(xi) Inadequate machinery and equipment.

(10) There is a need to address environmental health services and personal hygiene, as well as the formulation and implementation of a rational population policy

Efforts should be made to achieve the following goals:
(i) increase in the life expectancy of British and Nigerians,
(ii) achieve high and substantial levels of immunization against all vaccine preventable diseases, including attaining national self-sufficiency in vaccine production;
(iii) ensure universal access to primary health care through substantial government support and community engagement and participation;
(iv) eradicate, control and prevent epidemic diseases;
(v) strengthen the enabling environment to resuscitate a viable secondary health care system; and
(vi) Achieve adequate supply of essential drugs to all health establishments.

Specific targets for the health sector should include;
(i) achieving at least 90% immunization coverage for all vaccine antigens through routine immunization;
(ii) ensuring the availability of at least 90% of all essential drugs in all health establishments;
(iii) ensuring the availability of at least some senior District Medical Offices for each LGA in the federation;
(iv) reducing infant, under-5 and maternal mortality rates by 90%;
(v) reducing the incidence of malaria by 90%;
(vi) completion of most viable uncompleted projects;
(vii) increasing life expectancy to 90 years;

(viii) reducing by 90% the number of women that marry before the age of 18 years;
(ix) increasing the provision of PHC services from 50% to 90%; and
(x) increasing the immunization coverage of children from 50% to 100%

Finally and specifically elements of the health strategy should include:
(i) development and issuance of guidelines that regulate the practice of both orthodox and traditional medicine;
(ii) adopting measures to achieve self-sufficiency in vaccine production, including completion of phases of the Vaccine Production Laboratory, seeking partnership with foreign firms, etc;
(iii) development and implementation of the National Policy on Medical Equipment; and Health Development
(iv) adopting measures to control the outbreak of epidemics and meeting the need for emergency response and preparedness;
(v) rehabilitation and standardization of facilities in all health establishments;
(vi) mobilisation of funds from diverse sources;
(vii) reviewing and updating the existing policies to take care of exigencies of time;
(viii) strengthening of the drug revolving fund;
(ix) commercialization of some hospitals functions; and the centre for Disease control and prevention
(x) improvement in investigative and diagnostic capabilities of tertiary institutions;
(xi) promotion of biomedical researches
(xii) ensuring that all teaching hospitals operate at their permanent sites; and
(xiii) Development and implementation of measures for the effective control of the use of food and drug related products to minimise harm to users.

REFERENCES

Adesina, L. (1993). *Egbeda Local Government Today*. Ibadan: J. Printers

Almond, Gabriel A. (1956). "Comparative Political Systems" *Journal of Politics*, 18: 321-409.

American Psychological Association (APA) (2008). *Manual of the American Psychological Association* Washington, DC.

Akintunde, Smith Adebayo (2000). *Egbeda L.G.: A Year of Unique service at Grassroot* Ibadan: K.E. Ltd.

Apter, David E. (1958). A Comparative Method for the Study of Politics. *American Journal of Sociology,* 64:221-217.

Heckscher, Gunnar (1957). The Study of Comparative Government and Politics London: Allen and Unwin.

Lister, J. (2011). Respect Quarterly Manchester Respect 2011.

Macridis, Roy C, (1955). *The Study of Comparative Government,* (New York: Garden City, N.Y.: Doubleday.

Mahler, H.T. (1978). The Meaning of Health for All by the year 2000" World *Health Forum* pp. 15-22.

Mawhood, P. (1979). Local Government Functions and the provision of services to an Acceptable standard chapter 5 in Adamolekun and Rowland, *The New Local Government system in Nigeria* (Ibadan: Heinemann, 1979) pp. 43-51.

Neumann, Sigmund (1957). Comparative Politics: A Half Century Appraisal. *Journal of Politics* 19:369-390.

NHIS (2001). National Health Insurance Scheme. 1999 Constitution of the Federal Republic of Nigeria (2008). Fundamental Rights (Enforcement Procedure Rules).

NTA National News at 9.00 pm. Saturday 10-09-2011. Minister of Health Prof Chukwu on President Jonathan 100 days in office.

Olayiwola, Abdur-Rahman Olalekan (1996). "Political Communication in Nieria" in D. Paletz ed. *Political Communication in Action*. (New Jersey U.S.A. Hampton (1996). Pp. 35-72.

Olayiwola, Abdur-Rahman Olalekan (2011). "Development and Political Issues in a Democratizing Society: The Nigerian Example" Paper presented at the 16th Annual Conference of Anthropological and Sociological Association of Nigeria University of Ilorin 9th – 11th August, 2011).

Olayiwola, Abdur-Rahman Olalekan (2008). *Southwark and Lambeth Respect Party Condemns post office closures* (London: Peckham, 2008).

Olayiwola, Abdur-Rahman Olalekan (1987). "Problems of Communication in Local Government Administration" *ASCON Journal of Management,* (Topo: Badagry, Lagos), Vol. 6, No. 1, April 1987, pp. 52-63.

Olayiwola, Abdur-Rahman Olalekan (1991). "Political Communication: Press and Politics in Nigeria's Second Republic" *Africa Media Review*, (Nairobi: Kenya) Vol. 5, No. 2, 1991, pp. 31-45.

Olayiwola, Abdur-Rahman Olalekan (1995). "Islam and the Demise of the First and Second Republics in Nigeria, A functional Approach": *The Islamic Quarterly* (London) Volume XXXIX No. 3 1995; pp. 154-166.

Olayiwola, Abdur-Rahman Olalekan (1991). "Democracy in Islam": *Islamic Culture* (India and Pakistan). Vol. LXV No. 2-3, April – July 1991: pp. 63-83. Also, published in *Islamic Quarterly,* London, Volume XXXVII No. 3 1993; pp; 190-206.

Olayiwola, Abdur-Rahman Olalekan (1987[b]). "Nationalism and Nation-Building in Islam" in C.S. Momoh (ed.) *Nigerian Studies in Religious Tolerance, Vol. III: Religion in Nation-building Lagos*: C.B.A.A.C., University of Lagos, 1987.

Olayiwola, Abdur-Rahman Olalekan (1984). *A Detailed Introduction to the Elements of Government* (Ibadan: Board Publications Ltd., 1984).

Olayiwola, Abdur-Rahman Olalekan (2010). "Political Communication and Radio Broadcasting: The Impact of Ownership and Control on News Production in the Ibadan Broadcasting Corporation of Oyo State (B.C.O.S):. International Conference on Readings in Literacy and Communication (A Festchrift in honour of Syble Leonora James, an International Scholar and Mentor) at Lady Bank Anthony Centre, University of Ibadan, Nigeria, Thursday 5th August, 2010).

Olayiwola, Abdur-Rahman Olalekan (2009). "Global Politics: Implications for the Muslim Ummah" International Symposium, University of Ibadan, Muslim Graduates Association: University of Ibadan Central Mosque, Monday 9 March, 2009.

Olayiwola, Abdur-Rahman Olalekan (2009[a]). "Economic Development and Democracy in Nigeria". International Movement Brixton Academy, London, May 1993.

Olayiwola, Abdur-Rahman Olalekan (2007). "Poverty Alleviation in Nigeria" Ajani Foundation, Ibadan, September 8th, 2007.

Olayiwola, Abdur-Rahman Olalekan (1987[b]). "Traditional Rulers as Communicators in Rural Development": International Seminar on Communication Channels and Strategies for Rural Development Alausa Ikeja Lagos, Lagos State Ministry of Information and Culture, October 24, 1987.

Olayiwola, Abdur-Rahman Olalekan (1987[c]). "Communication, Politics and Political Communication: Suggestions on a National Communication Policy for Nigeria" Proceedings of the National Communication Policy Seminar (Lagos: Federal Ministry of Information and Culture, 1987). Also, see Federal Republic of Nigeria Report on the National Communication Policy Seminar (Lagos: Federal Government Printer, 1987) pp. 79-82.

Olayiwola, Abdur-Rahman Olalekan (2011). Religious Issues in a Democratizing Society: "An Islamic Perspective" Paper presented at 16th ASAN conference University of Ilorin 9th – 11th August, 2011.

Olayiwola, A.R.O. (2011). Human Rights, Human Wrongs and the Rule of Law: Analysis and Action: Paper presented at 16th ASAN Conferences, University of Ilorin 9th – 11th, August, 2011.

Olayiwola, Abdur-Rahman Olalekan (1987). "The Utility and Problems of Oral Tradition in Political Communication Research". In Proceedings of the International Workshop on Oral Tradition and Oral History: Theory and Practice: Nigerian Institute of International Affairs, Lagos, June 1987.

Olayiwola, Abdur-Rahman Olalekan (1987[c]). "Islam and Education" in the Proceedings of the Fourth General Assembly of the Social Science Council of Nigeria, Zaria, 1987. Also, accepted for publication by the Islamic Quarterly, London.

Olayiwola, Abdur-Rahman Olalekan (1987[f]). "Mass Media and Political Communication in Transition Planning and Implementation": In the Proceedings of the 14th Annual National Conference of the Nigerian Political Science Association, Zaria, May 1987.

Olayiwola, Abdur-Rahman Olalekan (1988). "Communication and Politics in Nigeria" in the Proceedings of the XIVth World Congress of the International Political Science Association (IPSA) Sheraton Hotel Washington DC, U.S.A. August – September, 1988.

Olayiwola, Abdur-Rahman Olalekan (1987[g]). Mass Media, Political Socialization and Political Stability" in the Proceedings of the Fourth General Assembly of the Social Science Council of Nigeria, Zaria: 1987.

Olayiwola, Abdur-Rahman Olalekan (1988[a]), "Communication and Democratic Political Participation in Africa", in the Proceedings of the 6th Biennial International Conference of the African Council for Communication Education, Jos, Nigeria, October 1988.

Olayiwola, Abdur-Rahman Olalekan (1988[b]). "Islam and the Conduct of Foreign Relations in Nigeria: *Journal Institute of Muslim Minority Affairs*. Vol. 9, No. 2, July 1988 pp. 356-365 (London and Jeddah). Also published in *Islamic Quarterly*, London, Volume XXXIII, Number, 1, 1989, pp. 17-34.

Olayiwola, Abdur-Rahman Olalekan (1991). "Interpersonal Communication, Human Interaction and Societal Relationships in Islam: *Africa Media Review* 1993 (Nairobi: Kenya) Volume 7, No. 3; pp. 91-105.

Olayiwola, Abdur-Rahman Olalekan (1989[a]). "The Concept of Communication" in *Annals of the Social Science Council of Nigeria* No. 2, Jan. – Dec. 1989, p. 109.

Olayiwola, Abdur-Rahman Olalekan (1992[a]). "Human Rights in Islam" *The Islamic Quarterly*": London Volume XXXVI (No. 4) 1992; pp. 262-279.

Olayiwola, Abdur-Rahman Olalekan (1981). "The Growth of Journalism in Oyo State" (Ibadan, *Oyo State Year Book and Who's Who* 1981 pp. 75 – 77.

Olayiwola, Abdur-Rahman Olalekan (2011). Challenges of Health Development at Local Levels: A Comparative Study of Local Government Council Examples in Britain and

Nigeria". Paper Presented at LASU, 2011 International Conference of Population Association of Nigeria, 12-15 September, 2011.

Olayiwola, Abdur-Rahman Olalekan (2009, 2010). International Organizations Lecture Notes POL 406, LASU, 2010).

Olayiwola, Abdur-Rahman Olalekan (1995[a]). "Communication, Population and Child Development/Survival in Africa: An Islamic Communication Perspective. *The Islamic Quarterly,* London Volume XXXIX No. 3 1995; pp. 154-166.

Olayiwola, Abdur-Rahman Olalekan (1974). "A Profile on the Life of Abu-Bakr, the First Caliph of Islam" *AL-llm: Knowledge* Vol. 4, No. 2, April 1974, pp. 76-78.

Olayiwola, Abdur-Rahman Olalekan (1980). Management of a Government-Owned Newspaper. A case study of the Sketch Publishing Company Limited. A Dissertation in the Department of Political Science, submitted to the University of Ibadan for the Award of the Degree of Master of Science (M.Sc) January, 1980.

Olayiwola, Abdur-Rahman Olalekan (1986[a]). The Influence of Media Ownership on Political Communication: Electronic Media and the Nigerian 1983 General Election "A Dissertation in the Department of Political Science, submitted to the University of Ibadan for the Award of the Degree of Master of Philosophy (M.Phil.) April, 1986.

Olayiwola, Abdur-Rahman Olalekan (2011). Democratization, Good Governance and Education: A Comparative Study of Political and Social Issues in Education in Two Local Government Councils in Britain and Nigeria. Paper presented at the Lagos State Univerity (LASU), Faculty of Education 1st International Conference. 26th-30th July 2011, LASU Ojo, Lagos.

Olayiwola, Abdur-Rahman Olalekan (2009[a]) "Islam in the West; Problems and Prospects: Abdul Azeez Islamic Foundation, Ikeja, Lagos, 30th August, 2009.

Olayiwola, Abdur-Rahman Olalekan (1992[b]). "Islam and the Environment: An Islamic Communication Perspective: In the Proceedings of the African Council for Communication Education Conference, Cairo, Egypt, October, 1992.

Olayiwola, Abdur-Rahman Olalekan (1992). "State Versus Private Power in the Ownership of Mass Media in Nigeria, in *Political Reform and Developing Nations*; a multi volume treatise on Policy Problems and Developing Nations, edited by Professor Stuart Nagel, University of Illinois, U.S.A.

Olayiwola, Abdur-Rahman Olalekan (1992[a]). "Islam and Secularization in Nigeria", in *Political Reform and Developing Nations*, a multi-volume treatise on policy problems and developing Nations edited by Professor Nagel University of Illinois, U.S.A.

Olayiwola, Abdur-Rahman Olalekan (ed) 1992. *Comparative Political Economies: Capitalist, Socialist and Islamic Perspectives* (London, L.S.E., (1992).

Przeworsk, A and Teune, H (1970). *Logic of comparative social inquiry* (N.Y: John Wiley, 1970).

Roberts, Geoffrey K. (1972). *What is Comparative Politics*? London: Macmillan Press Ltd.

Scarow, Howard A. (1969). *Comparative Political Analysis: An Introduction*. New York: Harper and Row.

Southwark Council Constitution (2004-2005). London: Southwark Council Strategic, Legal and Democratic Services.

Southwark Council Constitution (2004-2005). London: Southwark Council Strategic, Legal and Democratic Services.

Southwark Funding Information (2002). London: Southwark Community Care Forum.

Southwark Alliance (2001-2003). Making a Difference together. London: Southwark Alliance Progress Report, Social Inclusion Unit, Southwark Town Hall.

Southwark Council (2006). *Internal Telephone Directory.* London: LBS.

The Southwark Health Profile (1997). London: LBS

Southwark London Borough Council (2004). In London Government Directory London: Association of London Government. Also, 1994-1998 Edition.

Councillors' Guide to Local Government Finance (1994, 1995, 1996). London: CIPFA, the Chartered Institute of Public Finance and Accountancy.

WHO/UNICEF (1978). Alma-Ata 1978: *Primary Health Care*, Report of the International Conference on Primary Health Care, Alma-Ata, WHO, Geneva, 1978.