PRIMARY HEALTHCARE POLICY IMPLEMENTATION IN PLATEAU STATE, NIGERIA, 1990-2010

BY

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CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

One of the bedrocks of the formation of modern state is to enhance the welfare of the citizenry. Government, as the foremost agent of the state, is saddled with the responsibility of transforming this noble goal into reality (Agbaje and Adebanwi, 2003). As a means of achieving this, public policies are formulated and implemented. The quality of public policy output, in its formulation and implementation, depends on a number of interacting and intervening variables which include the content of the policy, the political leadership, nature of bureaucracy, various groups competing for values and resources as well as the given political economy.

Against this backdrop, policy failure has been a source of concern for social scientists and, despite that, there are still no clear explanation for why some executed policies are not achieving intended goals. In the 1970s, the works of Pressman and Wildavsky (1973) marked the beginning of policy studies that dealt specifically with policy implementation. They examined why well-designed federal policies fail to be implemented in local contexts. The usual response of researchers is to blame it on bad execution. The implementation gap (Brewer and de P, 1999) became the focus of this area of policy studies. Despite the ample amount of implementation studies, the issue persists. Browne and Wildavsky (1984) states that, after many years of research on public policy implementation, "we know surprisingly little". Hargrove (1975) refers to the study of implementation as the "missing link" in policy analysis. More than three decades later, Sabatier (2007) stated that implementation "continues to be the missing link in public policy theories". As a consequence of this, better understanding of issues influencing the way policies are put into practice is still required.

Failure of policy implementation in sectors such as health, education, water and sanitation, energy supply, and social security are particularly important, given that these sectors involve delivery of essential public services to the population. Fuhmei (2015), stressed that the global financial crisis has led many countries to reduce spending dramatically, with health care being a common target of such reductions. However, the provision of health care is important for improving a population's health, which in turn

can lead to more productivity, better economic performance, and then more fiscal resources. Poor service delivery therefore, especially in the developing world, calls for a major concern. International organisations, such as the World Bank, have stressed the need to improve the provision of basic services. The World Development Report 2004 is devoted to "making services work for poor people". It argues that services are failing in access, quantity, and quality (World Bank 2007). Also, the World Health Organisation (WHO) and the Inter-American Development Bank (IDB) recognise that improving the provision of services is one of the key measures to achieve the Millennium Development Goals (MDGs). These organisations urge governments of developing countries to focus on the provision of basic services such as health (Stein and Tommasi 2008; WHO, 2005; World Bank 1994a).

Africa is regarded as one of the most poverty-stricken continents in the world (Chen and Ravallion, 2004; Gugler et al, 1978). In contrast to global trends, poverty has been on the rise in Africa over the past three decades (Lowell, 2010; Harris, 1975). Basic public and social amenities for the most vulnerable are either unavailable or inadequate. There is a mutually-influencing relationship between the state of poverty in Africa and health status of the population (Adebusoye, 2009; Olaniyan, 1995; Atkinson, 2002). The failure of public health systems is particularly alarming, resulting in low life expectancy, high mortality and morbidity levels, especially in rural communities as well as among women and children.

There have been efforts by the international community to reverse the tide of poverty. A significant initiative in this direction is being the introduction of primary healthcare (PHC) system of delivery which Nigeria has adopted. Since 1975, the provision of basic health services (BHS) to the generality of the populace in Nigeria has been cornerstone of the health component of the country's national development plans. The BHS scheme metamorphosed into PHC following the 1978 Alma Ata declaration and resolutions.

In Nigeria, the provision of PHC services devolves on the local government councils (LGCs). The National Health Policy focuses on decentralisation and community participation as measures to improve the quality of healthcare and achieve comprehensive primary health care (FMoH, 2004). Community participation and decentralisation are the

leading principles of health care reforms in developing countries since the 1970s. Heavily promoted by the World Health Organisation and later the World Bank, they are not only perceived as the solution for low health system performance but also considered as improving equity in the health care system.

Plateau State thought it necessary to evolve a health policy document considering the health needs of its people as required by the National Health Policy in 1992. The primary goal of the policy is to provide quality health for all its citizens by the year 2000 and beyond, meaning attaining the level of health that would permit them experience socially and economically productive lives at the highest possible level. Despite the desire by the Plateau State government to ensure more qualitative and equitable distribution of health care delivery to it citizenry, glaring evidence shows great challenges facing the delivery of health care to the people.

After more than two decades of the implementation of the current health care policy in the state, various past and present governments seem not to have given the necessary attention to the health care sector, as evident in the quality of health care delivery services rendered to the people. The deterioration in government-owned healthcare system is causing many people to die prematurely from diseases that are preventable or curable whereas these people could have lived longer, healthier and more productive lives at relatively little expense (PSEED, 2006; Golit and Mutihi, 2010). Deteriorating health care systems in the state are particularly alarming, resulting in high mortality and morbidity rate especially in rural communities and among women and children. According to PSEED report (2006), maternal mortality ratio is estimated at 710 per 100,000 and under-5 mortality rate is 68 per 1,000 live births in Plateau State (PSEED, 2006).

By 1990 and 2011 maternal mortality in Nigeria had almost doubled from slightly above 16,000 to over 31,000 and the country had one of the slowest rates of decline in child mortality (Plateau State Strategic Health Development Plan, 2015). Nigeria has some of the world's highest infant, child and maternal mortality rates. One child in twelve dies in the first year, and one in eight does not live to age five. Similarly, a woman's chance of dying from pregnancy and childbirth in Nigeria is one in thirteen (WHO, 2013). Surprisingly, many of these deaths are preventable and curable diseases

such as typhoid, malaria, pneumonia, diarrhoea, measles and HIV/AIDS. Among women, the lifetime risk of maternal death is one in twenty three (WHO, 2013). According to a survey report on maternal and child health by UNICEF in 2013, Nigeria loses about 2,300 under five years olds and 145 women of childbearing age in a day, making it the second largest contributor to the under-five and maternal mortality rate in the world. At least, 6.3 million children under age five died across the world in 2013, nearly 17,000 a day. The Ministry of Health acknowledges that the public health systems indicate only limited success in meeting the preventive and curative requirements of the general population (MoH, 2008). In 2003 Plateau State ranked fourth in the prevalence of HIV/AIDS in Nigeria with the prevalence rate at 8.5 percent, though it marginally improved to 6.9 percent in 2008 in spite of the millions of naira spent on HIV/AID programmes as claimed by the state (NACA, 2005).

Data from a 2006 survey report by National Demographic survey showed that only 43.3 percent of the people in the state have access to medical health service while 30 percent of the population is located about 60 minutes away from the nearest PHC facilitys, 47.1 percent of the children are stunted in growth with about 17.9 percent wasted and 3.2 percent under weight, it also shows a very low nutritional level in the state. According to the 2009 National Demographic and Health Survey (NDHS, 2009), 29% of Nigerian children under five years are considered underweight. Today Nigeria is among the ten countries in the world with the largest number of underweight children, with an estimated 6 million children under five who are underweight. Children who are undernourished have lower resistance to infection and are more likely to die from common childhood ailments such as malaria, diarrhoeal diseases or respiratory infections. In Nigeria, it is estimated that malnutrition contributes to over 50% to mortality among children aged under-five years (UNICEF, 2009 and UNICEF, 2006).

~~while 30 percent of the population is located about 60 minutes away from the nearest health delivery of~~ PHC policy isservices is not producing the expected outcomes and successful implementation requires a detailed vision of the process, which involves different departments and different areas as observed by Maria and Chiara (2013) depending on the health care process concerned. The study therefore sets out to examine the implementation of health policy in the delivery of primary healthcare (PHC) services

in Plateau State. Indeed, the study is interested in investigating the factors that can influence the success or failure of health policy implementation in delivery of PHC services in Nigeria and particularly in Plateau State. It is notably to state that more recent information on Plateau state is difficult to come by therefore the need for this study,

1.2 Statement of the Problem

Several decades of failed development efforts in the delivery of public services in Nigeria and similar poor results from other developing countries have been of interest to researchers on public policy (Babura, 2003). A considerable proportion of the discussions in health policy literature are centred on the formulation of policies, however policy issues do not end with the policy formulation; in fact, it is only the beginning of policy-to-action continuum (Bhuyan et al., 2010; Georgina, 2011). Notably, greater emphasis is given to research focusing on outcomes which is whether policies have achieved their goals while implementation processes are largely neglected. However, there is need to highlight that understanding the nature of policy implementation is also important because policies, once approved, are not always implemented as planned (Calista, 1999).

The focus of this study is to understand why health policy in Nigeria (with a special emphasis on Plateau State) are not carried out as intended, based on the apparent challenges facing the delivery of healthcare in the state specifically and the country generally. The above question is addressed in order to determine the issues that contribute to the success or failure of implementing policy practically. Effective policy implementation leads to better health service delivery. To achieve this objective, a closer look at the way the PHC policy has been implemented in about two decades of its enactment contributes to a better understanding of those factors that can enable or constrain policy implementation.

It is necessary, therefore, to focus on some factors that are perceived to influence policy implementation processes in achieving expected outcomes. The study focuses on four factors that may influence processes of policy implementation: conformity of the content of the state policy alongside the national one, type of service delivery arrangements (decentralisation to local governments), influence of the interest and

commitment of the political leadership on implementation and, finally, the level of community participation in the implementation of the policy.

Though decentralisation and community participation are leading strategies for healthcare reforms, studies about the processes of implementing them to impact on quality of healthcare hardly exist, therefore, the gap in the literature about information on the actual practice decentralisation and community participation is needed and this study fills that gap. Health policy literature also reveals that extensive work has been done on health policy at the international and national levels, mostly by international and donor agencies, with a sharp neglect of the sub-national levels of which Plateau State is one, resulting in scanty information about policy implementation at the local levels. This study, focusing on the local level, fills this gap; the study also gives particular attention to the factors that have also received very little attention in public policy and service delivery literature, despite its increasing relevance, constituting another gap to be filled

It is worthy to not that studies relating to health issues are largely left in the hands of Medical Professional such as doctors, nurses and other clinically-oriented health workers but the growing realisations that socio-economic and political environments have implications for health calls for research in the health related issues by non Medically inclined fields of study which this study tries to fill.

In a nutshell, the problem of this study is to examine why the implementation of the Plateau State primary healthcare policy in the delivery of primary healthcare services has not led to any visible improvement in the healthcare delivery to the people.

1.3 Research Objectives

The main objective of the study was to examine the implementation of primary healthcare policy in delivery of basic services in Plateau State. Secondary objectives include:

- Critically review the Plateau State health policy on PHC delivery alongside the national one.
- Examine the implementation status of the PHC policy in Plateau State.
- Examine the influence of the nature of political leadership orientation on implementation of the policy.

- Assess the extent of community participation in the implementation of the policy.

1.4 Research Questions

The following research questions were asked to guide the study.

- To what extent was the Plateau State primary healthcare policy an offshoot of the national one?
- How was the policy implemented to benefit the people in Plateau State?
- What was the influence of the political leadership on the implementation of the policy in Plateau State?
- What was the nature of community participation in the implementation of the policy in Plateau State?

1.5 Research Hypothesis

The need to ensure that the objectives of study are scientifically achieved normally leads to the formulation of hypothesis that would be empirically tested. In fulfilment of this, two hypotheses were formulated. These are:

1. Quality of services is a function of the type of service provided.
2. Quality of service is a function of community participation.

1.6 Justification of the Study

Many streams flow from the political economy of a nation, one such stream is that of a nation's healthcare system. The seemingly intractable healthcare problems and challenges experienced by many countries raise questions on how one can understand the problems and challenges facing the healthcare systems today. It is therefore necessary to understand how health policy is being implemented in PHC service provision to the people since it is the entry point into the healthcare systems of many nations, including Nigeria.

There is a growing realisation that socio-cultural and economic environment have implications for health and ill-health, this was attributed by Candice, et al (2014) who state that 'socioeconomic status (SES) has an important effect on health'. This, in turn,

explains why issues relating to health are no longer left exclusively in the confines of medical professionals such as doctors, nurses, midwives and other clinically oriented health workers. In realisation of this, Prakash (2008) refers to water engineers as health workers that are not found in the Ministry of Health or hospitals, yet their performance has a very significant effect on the health of the people. In the same vein, Daramo (1981) has captured political scientists, research experts and some organisations that contribute to solving health problems as health workers in Nigeria since their performance, especially on governance, affects healthcare delivery to the people. The main objective of this research work is to assess problems associated with health policy implementation, an area in which public policy and political scientists are involved. While one may have a feeling of inadequate health facilities and poor service provisions, it is important to assess the implementation problems associated with the delivery of these services. Thus, the rationale as a political scientist involved with public policies is to focus the study of policy implementation on public healthcare systems.

In healthcare delivery, most developing countries are facing the need to transform their large and highly-inefficient health systems which have been operating along the same policy lines for mostly more than fifty years following their founding in the early post-colonial period. Despite important advances in the health status of many populations, there is awareness that more could be done to remedy the pervasive problems that still remain, and prepare to face future challenges due to rising and changing demand coupled with increased costs.

In the face of these policy challenges and with significant influence from the international health policy arena, there is a consensus among policymakers, health providers and beneficiaries of the need for structural changes in the health sector. However, there is no similar shared understanding of what the content of health reform agenda might be. The definition of the problems to be solved, the means to solve them, as well as the speed and scope of policy change are all contentious issues, as they each affect the interests of different groups and individuals. Health policy literature reveals that extensive work has been done on health policy at the international and national levels, mostly by international and donor agencies, with a sharp neglect of the sub-national levels of which Plateau State is one, resulting in scanty information about

healthcare delivery through policy implementation at the local levels. This study which focused on the local level fills this gap as well as pays particular attention to some factors that have also received very little attention in public policy and service delivery literature, despite its increasing relevance, constituting another gap to be filled.

Health policy is also a highly political process, mobilising many groups within the state and society, the interests of which may be affected by the envisioned policy changes. As a result, the political dimension of health policy formulation, legislation, and implementation has come to the foreground as it has proved to be a key factor in determining the feasibility of health policy change as well as its final outcome. A careful analysis of the political context and the policy process, especially implementation, can be extremely useful in the formulation of political management strategies that can markedly increase the political economy of healthcare delivery. It can also help donor agencies and policymakers promoting health reform to fine-tune their support and target it to relevant areas, thus making more effective use of the resources directed towards initiating and consolidating health policy change.

The bulk of health research in developing countries largely focuses on the formulation and the outcomes of the health policy but generally overlooks the implementation process of the policy (Navarro, 1993). According to Navarro (1993) the majority of health research examines the macro forces of healthcare and the relationship between the micro forces. Thus, a considerable proportion of health research has inward focus alongside being directed towards clinical and curative medicine, rather than other areas outside the health sector such as political, economic and social forces that shape healthcare. However, in order to understand the healthcare sector, it is also necessary to understand the macro political, economic and social forces that shape and influence it. Notably, it is precisely this area of scholarly research that is systematically excluded from health research. Navarro (1993) is of the view that a substantial amount of health research and teaching contributes very little to understanding the changing nature of the forces and actors within healthcare. Moreover, its narrow independent approach limits the relevance of health research considering that the majority of health problems require social, economic and political interventions rather than medical intervention.

The significance of this study lies in its potential to examine effectiveness of implementation of government policies for the delivery of high quality healthcare and provide information for future health policy formulation and implementation for Plateau State. The study provides more understanding on the factors that can affect the implementation of health policies in the delivery of PHC services to the people and the governance arrangement underpinning healthcare delivery. PHC policy implementation is particularly critical because the rationale underpinning these systems is on community-level interventions, especially for the rural poor who find it difficult to access and utilise the healthcare facilities as healthcare costs are often a hindrance to seeking health care (Njoroge, et al, 2014). The study therefore provides useful insight into potential transformational avenues as well as explanatory factors for understanding the challenges currently faced in its implementation.

The study is concerned with understanding policy implementation, it would serve to elucidate the extent to which health policies are, or are not, carried out as intended, leading to the success or failure of policy in practice. It also contributes to a better understanding of those factors that enable or constrain policy implementation. Through understanding policy implementation, it provides insight into the appropriateness of current policies while making recommendations and contributions to the knowledge base of policy implementation in the literature of public policy analysis and service delivery.

As mentioned above, previous efforts to document the process and outcome of health policy mostly centred on policy formulation, however policy issues do not end with policy formulation; in fact, it is only the beginning of policy-to-action continuum (Bhuyan et al., 2010), therefore those efforts lacked completeness. There is need to highlight that understanding the nature of policy implementation is also important, because evidence shows that policies, once approved, are not always implemented as planned (Calista, 1994). Therefore, a focused research is needed on the implementation process as well as on actors involved in the implementation of the policies as their views, goals, strategies, interests and commitment to policy determine how the policy will be implemented (Navarro, 1993).

These findings can be used to identify the gaps between policy planning and implementation. This kind of research is more important in settings like Nigeria, where

formal monitoring and evaluation of policies are lacking and sub-optimal policy implementations are going on. In the present scenario, this kind of research is urgently needed and can be very useful in Plateau State.

1.7 Scope

The study focused on the implementation of health policy in the delivery of PHC services by local administrations in Plateau State. The period of coverage is from to 2010. The focus is on the implementation stage through which policies are put into effect and transformed into action. The analysis began from the implementation stage. It did not probe the coalition of forces that brought about the policy; therefore, it did not cover details of dynamics of agenda setting, planning and formulation of the policy. It dwelled on understanding of factors that constrained policy implementation at the primary healthcare levels without including the secondary and tertiary levels. These factors included the content of the policy, the type of delivery arrangement, political leadership commitment and the involvement of communities in the implementation of the policy.

1.8 Limitations

A major limitation of the study was its inability to discuss in-depth all the key areas in the 1992 Plateau Health Policy with most key informants, rather, it was informants' choice and expertise which guided the discussion. The potential informants, who refused to participate in the study, might have offered some important information. Some of these persons were of the view that they were not related to the health policy, though some worked in the State Ministry of Health.

Another challenge was the refusal of some interviewees to be captured on tape or even be quoted in respect of significant information on budgets on healthcare in Plateau State to an extent; this affected the work as it limited the ability to quote real people.

Securing appointments with some politicians was hard in the first instance due to their busy schedules, and also meetings as scheduled were equally sometimes difficult

because some appointments had to be rescheduled very close to the agreed time and, in other cases, and appointments were cancelled and never rescheduled.

In trying to locate the facility operators also, challenges were faced since only one or two health workers were usually present during first visits for questionnaire administration. Therefore, second and, in some cases, third visits to the facilities were made for administration and retrieval of the questionnaire which was extremely time consuming.

However, these limitations to the study did not weaken the research. Through persistence, resilience and persuasion, some of the documents needed were released and interviews that were cancelled were very few, therefore by conducting interviews with many stakeholders as possible, information hitherto missed, held back or unaware by some was drawn from others.

1.9 Organisation of chapters

This study is composed of six chapters. Chapter one presents a general introduction of the study and chapter two reviews literature and gives the theoretical framework, chapters three offers detailed methodology of the study, chapter four provides answers to the first research question on Plateau State primary healthcare policy content. The fifth chapter presents, interprets and discusses the field data addressing the other three objectives of the study, while chapter six contains the summary, conclusion and recommendations of the study.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.0 INTRODUCTION

An appropriate starting point for the study of public policy is to determine an explanatory framework to guide the analysis. The study attempted to identify government response in addressing the glaring health challenges experienced in the provision of primary healthcare to its people. This chapter therefore provides a review of the relevant literature upon which this thesis is based. It strives to explore the phenomenon under study by reviewing the attempts of various scholars and practitioners' works on the phenomenon. In the first section, previous related works on concepts of health and healthcare systems, health policy and historical facts related to health care developments are reviewed. In the second section, concept of primary healthcare strategy and its evolution as well as Plateau State healthcare system in the context of history and current trend are reviewed. The last section examines theoretical approaches in public policy as well as articulating the service delivery and political economy framework of the study.

2.1 CLARIFICATION OF CONCEPTS

2.1.1 The concept of Health

Over the years, many concepts of health have been proposed and practised with all concurring. However that health itself is not a precise or simple concept. The controversy has been nurtured by many interests, including managers of health services, radical observers of the health scene and many who are interested in health and illness. However, the contribution of those actively involved in the delivery of healthcare has emphasised one facet of the debate, which is the implications of the practical application of any concept. They are concerned with the use of concepts to create models that can be used for the delivery of health. Much of this essentially practical, rather than theoretical, interest is created by the obvious inability to affect the health of particular groups of clients, primarily the unrelieved sick and the incurably ill.

For the purpose of this study, the researcher proposes two opposing paradigms, namely negative and positive models of health.

The negative model sees health as the absence of the constraints of illness which implies that an individual is healthy if not ill. For this model, health and wellness are synonymous (Murcott, 1979). The positive model sees health as the active management of life in a particular way (WHO, 1946). These two models may be seen as two successive stages. The study works first at the negative model, which denotes, as widely assumed in 1948 when the National Health Service was established by the United Nations, that health is the opposite of illness, and illness is synonymous with the presence of disease (Kajang, 1999). The renewal of health in a diseased individual is the result of the removal of the disease. The major problem and foremost area of debate are considered to be achieving equal access to treatment, which is a financial and logistical issue. Chinyere et al (2006) observe that this is not the only available model around which to create National Health Service. It is inevitable, however, that the model could be used not only because the medical profession is based on it but also because it fits the whole character of the welfare state, which is not a revolutionary institution but a bureaucratic rationalisation of existing individualised services.

This view brought much to advances in medical science during the 19th and 20th Centuries. The achievements in surgical technique and antibiotic therapy show that such approach could have spectacular recognition. This is to the effect that preventive and environmental services which have also produced very significant results receive comparatively little emphasis. Thus, the health services of nations in the 19th and 20th Centuries were primarily designed to cope with those who were ill (Kajang, 1999).

Before discussing the problem of this model, it is noteworthy that, for many individuals, this approach was a benefit for the many people for example those with cancers were healed by surgery, blindness was cured, fractures were corrected and disability was avoided (Donnison, 1977). All these and many more successes provide a justifiable boldness of the negative model, which suggests that the relationship between illness and disease is a complex one. Because people generally have to feel ill before they consult a doctor, many cases of disease are not seen by doctors, at least in the early stages, and as a result do not receive medical treatment, although they may be treated in other ways by other people. Similarly, many people fall ill but the doctor may be unable to describe their problem in terms of the disease state that he understands and, may

therefore, either offer no help or prescribe treatment related to separate condition (Cape, 1979).

Scientific aids for diagnosis have rapidly reached the status of determinants of diagnosis rather than aids because of their increasing superiority. Treatments are directed towards the scientifically-described symptom rather than towards the person as a whole. Thus, one is presented with the patients being discharged as cured because for an example their haemoglobin or blood pressure is now within normal limits, despite the fact that they still complain of the feelings of illness that first took them to the doctor. Because of the nature of this model of illness and because expectations of cure have increased dramatically, doctors find it hard to sustain interest in patients for whom a cure will not be possible. Either they refuse to admit the possibility of failure and turn no increasingly strange remedies or attempt to push the patient out of the system (Wilson, 1975).

However, care as well as cure is a lawful response to illness and can equally rest on the knowledge base of a sickness-oriented training where care is required other than in relation to sickness. Thus, although the specific medical emphasis on the definition of disease and cure at all expense has distorted the current use of the illness/wellness model, nations cannot abandon their responsibility of treating illness to help those the national health service currently neglects such as those with chronic illness, degeneration disorders and terminal illnesses. Notably, while emphasis on prevention of illness is not incompatible with this model, financial antagonism sometimes seems to encourage the promulgation of this view. Advocates of the prevention model are divided into two camps: those concentrating on personal responsibility and those concerned with wider environmental problems. The former school has been embraced by government policymakers seeking relief from demands on the health service in the transference of the patient's role from victim to agent of his own misfortune (Park, 2008). It ignores the obvious fact that people live inside a closely-synchronised framework and are not free agents. As humans, our choices are constrained by the economic necessities of society. In any case, we must note that such individualised measures are largely based on preventing illness.

In presenting the positive model, Salt (1997) offers a wellness inventory that contains a self-administered questionnaire which readers can use to assess their wellness and identify the activities of life they equate with high level wellness. Many elements of the questionnaire relate to obvious ways of avoiding disease.

Under the private model, health is seen as a positive concept, not merely the absence of disease. The positive model of health is rooted in the WHO definition of health as ‘‘a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948:1). This means that any ideal assessment of health, on an individual or collective basis, cannot be based upon or restricted to measurement of mortality and morbidity.

According to Harrison (1993), one of the challenges this seems to pose is the difficulty to persuade all to accept the fact that there is more to health than death and disease. Medical staff and hospitals are not necessarily the major determinants of health status. Interestingly though, when people are asked to talk about what being healthy means to them and what makes for a healthy community, they do not talk about the absence of disease or about medical service; they talk about well-being, feeding, shelter, clean water, good roads, peace, sense of esteem, and income. This suggests that the problem is not so much one of educating the public, but encouraging them to trust their own initiative in defining and promoting health, indicating that, the health of any community should be assessed in terms of their physical, mental and social well-being or fitness as much as, but not more than, their mortality and morbidity rates.

The second model of health, as listed by Davies, is the ecological model of health. This model recognises the fact that the determinants of health are multi-factorial, incorporating both physical and social environmental factors from the individual level, culture and global ecosystem. The model considers the determinants of health to be more than simply the provision of hospitals and medical services; rather, health is determined by a broad range of public policies where government is expected to continue to play the traditional role of enhancing health and well-being. Under the socio-ecological model of health, each local government or community is out to develop a systematic epidemiology with respect to causation of good health and assessment of the different determinants of health (Davies and Kelly, 1993).

The third model is conveyed by the World Bank that inequalities in health which are rooted in inequalities in access to basic prerequisites for health presents a number of problems for government. The first is whether data exist to document inequalities in health. The second and more important is whether government has capacity to implement measures that address inequality in access to basic determinants of health. Governments often have powers to confront some of the symptoms of these inequalities, but they frequently lack the power to deal with the fundamental economic and social factors underlying such problems as unemployment, inferior healthcare acquisition and inferior education associated with poverty (poor income). That notwithstanding, inequalities in health and inequalities in access to health can be documented as well as monitored, and comparisons can be made between different government health plans, management of plans alongside formulation and implementation of policies (WHO, 2006).

The following section therefore focuses on reviewing the literature on health systems in Nigeria during the colonial era and post-colonial era as these were periods of healthcare developments.

2.1.2 Health System

It is essential to identify organisations and institutions that devote themselves to the betterment of health. However, in order to fully understand how the system works, it is important also to consider the different actors and actions these organisations execute to achieve their goals.

A health system "consists of all organisations, people and actions whose primary intent is to promote and maintain health" (WHO 2007:18). A health system is the sum total of all the organisations, institutions and resources whose primary purpose is to improve health, does not include people and actions but only organisations and resources as components of a system. The different emphases of these definitions collectively offer a better perspective.

In a similar way, other definitions of a health system differ in their emphasis on certain elements or components though they have the same basis. Weisbrod et al (2003); Basch (1999) have generated definitions of health systems in their efforts to map out and classify the diverse arrangements of healthcare provisioning around the world. Basch

bases his definition on the provision of different types of health services and resources allocated to them. Basch classifies healthcare services as "promotive, preventive, curative or rehabilitative services", but leaves out of the definition the organisations or people involved, only referring to their actions as "organised arrangements". In contrast, Roemer (1984:198) takes a corporate approach and defines a health system as the combination of resources, organization, financing, and management that culminate in the delivery of health services to the population". Notwithstanding the different emphases and specificities, definitions of health systems converge in the same basic components and purposes.

The main components of a health system, therefore, are as follows: organisations, which can be public, private, commercial, charities, local and international, people, such as the bureaucrats in ministries of health, professionals general practitioners, nurses, patients, students in medical school, and so on; actions, for example, performing a surgery, training new doctors, providing vaccination; and resources, either human, financial or material used to achieve goals. In order to understand how all of these interact and where they are situated within the health system, it is useful to identify their functions.

The framework set out by WHO is widely accepted and used by both policymakers and academics. It distinguishes four main functions of a health system service delivery, resource generation, financing and stewardship. The provision of health services is perhaps the function most people are familiar with. It refers to the point where patient and health professionals meet: an appointment, a surgery, receiving vaccination, and so on. The resource regeneration function refers to investing in human resources, physical capital and consumables. It is about providing the system with the necessary elements to operate. In order to do this, the system has to collect funds and purchase goods and services. Finally, the fourth function of a health system is stewardship, which means the responsible management of the entire system. Most of this management is done through regulation and setting norms and rules (WHO, 2000).

Some definitions refer to healthcare systems rather than health systems but for the purpose of this thesis, healthcare and healthcare systems are used loosely and interchangeably. The definition of healthcare systems is more specific and refers to the

provision of, and investment in, health services to individuals or the wider population (WHO, 2000). Hence, healthcare is part of a health system but does not cover all of it. It does not include the generation of human resources and the stewardship functions of health systems. However, in some cases, both terms are used indistinctively. This study uses the term health systems in line with the more general approach and the term healthcare when it focuses on delivery of health services more specifically. Although the focus of this thesis is on service delivery, it is important to be familiar with the system as a whole in order to see the conditions under which health policies are generated and implemented as well as how the different actors involved in the system interact and relate to each other. This context sets the background for further analysis.

2.1.3 Health Policy

The fact that health is a human right, an economic and sensitive issue, improving the health of nation has been a factor to governments and politicians in both developed and developing countries. The main concern is how to practically improve the health of the population. Governments first define the health vision and targets. These visions and targets are in the form of formal and informal health policies, rules and regulations.

Health policy is the broad statement of objectives, goals and means that create the framework for activity, 'it is the strategy to achieve Health for All' NHP, (2004:1). It includes what governments decide to do or not to do, and is often in the form of explicit written documents, but may also be implicit or unwritten (Buse et al., 2005). The central intention of health policies is to create supportive environments that enable people to attain and live healthy lives and combat health problems irrespective of their status (Conley, 2001; WHO, 1998). Health policies are expected to offer methods and opportunities to develop collaboration among different sectors, organisations and people to attain a common goal of promoting health (WHO, 1986; Byrant, 2002). Experiences have shown that only little can be done to promote economic growth and improve social welfare unless appropriate policies are present (Thomas and Grindle, 1990), this is seen by the statement of Siddharudha, et al (2015) that "Health for All" still eludes public health experts despite many approaches to prevent disease and promote health. A country's health policy determines the access to and quality of healthcare services,

determining what services will be available, who will provide, who will receive, and who will bear the costs and, ultimately, affects the life expectancy and the state of nation's health (Weissert and Weissert, 2006). The Ottawa Charter on health promotion identifies building healthy public policy as a fundamental step to create supportive environments, strengthen community actions and reorient health services for promoting health (WHO, 1986). However, policies are not always implemented as planned and do not necessarily achieve desired outcomes (Calista, 1994). Therefore, contents of the health policy and people involved in making and implementing it determine the healthcare delivery in a country (Buse et al., 2005).

An increasing number of countries have incorporated health sector in their policy agenda as they attempt to improve the health status of their populations while maintaining or reducing their public expenditure (World Bank, 1994b; Walt and Gilson, 1994). In some instances, these policies have had important components of income redistribution, as they have tried to redress imbalances in access to health services and distribution of health resources (World Bank, 1994b). In others, concern with the financial sustainability of existing health systems has dominated the health reform agenda.

Healthcare policies vary in content and scope, but they share certain features, mainly involving changes in the institutional configuration of the healthcare system, in the role of the public and the private sectors, and ultimately, in the nature and amount of services accessible to different groups of the population (Berman et al., 1995).

In developing countries, health policy efforts in the last decade have centred around four main concepts or principles. These include:

1) The separation of financing and provision of health services

2) The introduction of cost-effectiveness analysis to establish policy priorities and resource allocation.

3) The introduction of user fees and expansion of compulsory insurance.

4) The growth of the private sector's role in areas previously considered the exclusive jurisdiction of the state (Grindle, 1996)).

Health policy, involving institutional change, have included the decentralisation of policy decision-making and resource management to the sub-regional and local levels (Sachs, 2001) and institutional changes involved in the modernisation of the state.

According to Grindle, (1996), policy-makers have based the re-configuration of healthcare systems on two major changes. One is the creation of new actors or organisations mainly in the private sector that are to assume roles and responsibilities, such as the provision and articulation of healthcare services under a new scheme of collaboration between the private and the public sector. The other is the transformation of the old actors, or existing public institutions, so they may operate under the new rules of the game.

In the case analysed in this study, policymakers considered the creation of new actors, and the transformation of old ones as concomitant conditions for consolidating their healthcare sector reforms. Policy choices on this matter only vary with respect to the priority given to either of these two challenges as well as in the choice of timing for their implementation. As analysed below, these choices are made according to the vision and the assumptions made by reformers, in light of the political obstacles and opportunities they encounter during the reform process. From this perspective, the successful implementation of either of these two initiatives with the absence or partial implementation of the other can only be seen as the completion of one phase in the long and multi-linear process towards health reform, and not as the successful completion of the latter.

2.1.4 Accountability

Accountability is the acknowledgment and assumption of responsibility for actions, decisions, and policies including the administration and implementation within the scope of the role or employment position and encompassing the obligation to report explain and be answerable for resulting consequences. Accountability is ensured through the participation of people to demand better services and monitoring of services through the clients themselves. Cohen and Peterson (1997:12) 'state that political and legal oversight, institutional competition, and administrative mechanisms are needed to promote accountability'. Accountability in turn "promotes the efficient and effective mobilization and management of resources." (Cohen and Peterson, 1997: 5).

2.1.5 Political Leadership

Political Leadership refers to the ruling class that bears the responsibility of managing the affairs and resources of a political entity by setting and influencing policy priorities affecting the territory through different decision-making structures and institutions created for the orderly development of the territory. It could also be described as the human element that operates the machineries of government on behalf of an organised territory. This includes people who hold decision making positions in government, and people who seek those positions, whether by means of election, coup d'état, appointment, electoral fraud, conquest, right of inheritance or other means. Hence, this study recognised the contributions of both the military and the civilian leadership class that has managed and directed the state affairs since its independence.

2.1.6 Corruption:

Corruption is most commonly defined as the misuse or the abuse of public office for private gain (World Bank, 1997, UNDP, 1999). It can come in various forms and a wide array of illicit behavior, such as bribery, extortion, fraud, nepotism, graft, speed money, pilferage, theft, and embezzlement, falsification of records, kickbacks, influence peddling, and campaign contributions.

2.1.7 Community participation

Community participation is seen as a process of involving the community by promoting dialogue with, and empowering communities to identify their own problems and solve them.

2.1.8 Mortality Rate is a death rate: There three different types of mortality rates used in this study, they are:

- Maternal mortality rate is deaths related to childbearing divided by the number of live births in that year.
- Infant mortality rate is the number of children dying under a year of age divided by the number of live births that year.

- A neonatal death is defined as a death during the first 28 days of life (0-27 days). Early neonatal death refers to a death between 0-6 days after birth. Late neonatal death refers to a death between 7-27 days after birth.

2.1.8 Health facility ratio is the number of health facilities per population of 10,000 or the number of health facilities per total population utilising public and community-based health facilities.

2.2 Politics and the Health Policy Process

In spite of the fact that health policy initiatives have been converging creating a new paradigm (Gelser, 1995) and displaying striking similarities in the objectives they seek, the passage of reforms through the political process has generated different results. In some cases, policies have encountered effective resistance, as in the 1994 reform efforts in the United States (Steinmo, 1995). In others, such as Ghana's reform, the experience has proved so effective in bringing about change that it has encouraged other countries in the region to follow the trend (World Bank, 1994). But in most cases, the passage of health policy initiatives through the political process has generated mixed outcomes, bringing about positive changes in some aspects of the health system while faltering in others.

In reaction to these experiences, policymakers and donor agencies, who, until very recently, had been mostly concerned with the technical soundness of health reform initiatives, have come to acknowledge the role of politics in the health reform process Berman, (1995). They are beginning to acknowledge that politics is pervasive and exerts considerable influence on the objectives sought, the means used to attain them, and the resulting impact on the health status of the population. Thus, health sector reform contents are beginning to be viewed as much as the result of the political economy surrounding the policy process itself, as of the epidemiological, economic, and organisational considerations embedded in its content (Walt and Gilson, 1995).

Hitherto, the majority of studies on health politics have concentrated on the analysis of groups in society stakeholders or interest groups who, perceiving that their interests may be affected, try to influence the policy process by which health reforms are

formulated and implemented (Ham, 1980; Jeffery, 1991). A few studies have analysed the political institutions that structure the health reform process, and their effect on the capacity of interest groups to effectively influence it (Shamilupa, 1991; Jeffery, 1994; Shepperdson, 1991; Bossert, 2000). Finally, there is a set of studies on policy change in other public sectors that has focused on the individual reformers themselves the change team (Gonzalez, 2005; Scott, 2001; Evans, 1995). This approach has great potential for the analysis of health policy initiatives, since an increasing number of countries are resorting to this policy strategy creating and empowering change teams to pursue health policy change.

2.3 Health Policy Implementation

Health policy analysis has often considered the political factor of health initiatives along the lines of interest group politics in what is described as pluralistic calculations such as groups for versus groups against (Morone, 1994). In this view, the formulation, legislation, implementation, and ultimately the outcome of health reforms, reflect the political pressures from the groups affected by it such as users, providers, taxpayers, and others. The health reform outcome can thus be expected to reflect the interests of the most powerful interest groups and/or the weightiest political coalition (Walt and Gilson, 1995).

While interest group analysis allows furnishes understanding the dynamics of policy reform politics, it offers few answers in the cases where policymakers have decided to continue to support a reform in spite of visible resistance from powerful social groups. A closer look at the limitations and opportunities offered by the institutional context within which these policymakers pursue their reform agenda presents a more complete picture of the political factors affecting policy change.

2.4 The Institutional Context and the Health Policy Implementation

In order to understand the opportunities and constraints faced by health policymakers, some studies have shifted their attention away from interest groups in society and concentrated on the role of political institutions. Their focus has been on the role of institutions in the interplay among stakeholders, as well as in their mediation

between the state and society that takes place during the policy process. The institutional context, in this approach, comprises the state and local political system as well as the formal institutions of government and social representation. But the approach also focuses on the rules of governance formal and informal that directs the policy process and mediates the conflicting views and agendas of political actors ranging from single citizens to interest groups and policymakers among others (Al Alawi, 2006). The underlying assumption is that a country's institutional context sets the ground rules for political competition, thereby determining the degree of access interest groups have to influence the policy implementation. By the same token, institutions determine the room for manoeuvre available to policymakers, and thus the degree of autonomy the state counts on to promote policy change. In this view, a country's political economy context, and particularly its institutional configuration with its formal and informal elements play a determinant role in the nature of health policy and its political feasibility.

Berman (1995), for instance, argues that different political institutional arrangements can explain the striking differences in the final outcomes of similar health policy initiatives promoted in Switzerland, France, and Sweden. In studying the politics of social policy in the United States, and later on, reacting to the failure of the health policy efforts in the 1990s, Atkinson (2002) has also placed institutions at the centre of his analysis. The importance given to institutions in the political analysis of health reform has been echoed by other scholars, such as Easterly (2006), who contends that the recent failure of the U.S. health reform attempt is due in part to the lack of a careful institutional analysis. After a historical review of health reform efforts in the U.S, Steinmo and Watts, (1995) conclude that a political strategy including the use and modification of the institutional setting would have enhanced the chances of health policy reform.

Finally, in other industrialised countries, Liu et al (1999), after examining the cases of Germany, Japan, Canada, and Great Britain, submit that to succeed in reforming their healthcare systems, policymakers have tried to increase state autonomy in order to counter the interest group mobilisation of providers, and that they have done so by carefully using the opportunities offered by each country's particular institutional setting. Thus, he argues that state autonomy in the process of health reform is as much a result of

the institutional framework as it is a product of the policymakers who are leading the process.

However, relating the institutional framework to the outcome of policy reform is not as self-evident as it may appear. Studying different political regimes in Latin America, Remmer (1990) shows that there does not seem to be any empirical relation between type of political regime and the state's capacity to promote policy change. Also, the content of policy reform cannot be automatically associated with a specific institutional configuration. This means that the analysis of the political feasibility of reforming the health sector needs to go beyond the institutional configuration of the country and look at the dynamics of the political process in which health reforms are immersed.

The distributional outcome of health reforms is a case in point. Interest group studies tend to show that, in a democratic regime, there is a high possibility of powerful interest groups capturing the state, and thus perpetuating an inequitable status quo. However, there have been instances in which these same democratic institutions have given greater access to politically-weak groups who have, consequently, been able to influence policy in their favour by exerting political pressure to increase the government's incentives to confront the interest group coalition resisting change.

This demonstrates the need to focus the analysis on the group of policymakers in charge of policy reform, since this is where the political elements affecting the formulation of health policy converge. Their profiles, agenda, potential for manoeuvrings within the state, relations with other groups in society will play a significant role in the state's capacity to bring about policy change: "To understand why governments sometimes undertake radical and risky reforms, scholars need to think about who the people are who make policies, what their interests are, and what shapes their interests" (Bossert, 1998:695).

2.5 Pre-Colonial Health Status in Nigeria

Records of healthcare service of the period before the colonial administration in Nigeria are based on oral history. The traditional system of care focused on traditional medicine and the traditional healthcare system is the way communities attended to

disease and illness. The system includes folk knowledge, traditions and values, health behaviour rules, and patterns. It had supportive social institutions and identified personnel and structures of the delivery of preventative health and restorative therapy (Okafor and Onokerhoraye, 1986). The traditional healthcare system responded appropriately to the economic and social situations. It relates to the fact that economic costs of traditional medical care were relatively well-adapted to local resources. Payment for treatment could take the form of gifts such as animals, foodstuff or some assistance in farm labour or house construction, even given out client's daughter to the healer (if a, male) or older child for marriage. The amount of payment varied with the severity of illness and time required for full recovery (Olujimi, 2003). The main disadvantage associated with the system is poor hygiene of the traditional medicine practitioners which was responsible for very high infant mortality and morbidity rates in that era (Schram, 1971). The predominantly insanitary environment contributed to the prevalence of epidemics such as leprosy and measles that were responsible for high mortality rate.

2.5.1 The Colonial Health Service in Nigeria

The public health services in Nigeria originated from the British Army Medical Services (FRN, 1988). The intervention of the army with the colonial government in the colonial era prompted the government to offer treatment to the local civil servant and their relatives and eventually to the local population living close by government stations. This led to the emergence of what was regarded as the colonial medical services. (Egunjobi, l983b). According to Daramola (1981), the objectives of the colonial medical services were to provide health services for the colonial officers and administrators including members of their family, members of the armed forces and the police and the members of the senior civil servants.

The colonial medical service was made available to the local population only as an incidental service and not intended for the generality of Nigerians. Comprehensive services neither could nor however be offered due to limited resources both terms of human and material.

2.5.2 The Nigeria 1946-1956 Ten - Year Development Plan

Nigeria took the first initiative to plan for health service development in 1946 as part of the exercise that produced the overall ten-year plan for development and welfare

(1946-1956). The main thrust of the health sector of 1946-1956 plan recognised that improvement in health of the nation cannot be improved by clinical medicine only but also through preventive methods too; therefore, it made a steady advance in factors contributing to healthy lifestyle such as good water supplies, housing, and sanitation (Asuzu, 2004).

The revision of the 10-year plan became expedient as Nigeria adopted a federal system of government in 1954. The implementation of the revised plan was extended to 1960, when Nigeria became independent. A breakdown of the implementation of the plan among various sectors shows that education was given a steady top priority in the 1951-1955, and 1956-1960 periods, followed by transport and communication. The most substantial decline was in the neglect of health (Egunjobi, I983b).

2.6 Post-Colonial Health System in Nigeria

After Nigeria became independent in 1960, health became the responsibility of each of the regional governments. There was a definite attempt on the part of the government to assume a leading role in the provision of health services. All the regional governments had a policy whereby all civil servants received free medical services from government health institutions. Nonetheless, no government in any part of the federation had any form of health service which adequately met the health needs of all the, people (Daramola, 1981).

2.6.1 First National Development Plan (1962-1968)

The First National Development plan was the attempt by the Federal Government to address the health problems in Nigeria but it was not given the deserved attention in terms of monetary allocation. The planned expenditure for health sector for federal health programme was N20.6 million. This constituted 2.7 per cent of the total planned capital expenditure (First National Development plan, 1962-1968). Thus, the investment in health sector was merely regarded by the economic planners as consumption–oriented, not growth-promoting compared to investment in power and industry (Egunjobi, 1986). This was demonstrated by the allocation of 25.9 per cent of the total expenditure to Kainji Dam construction during the plan period (National Bureau of Statistics, 2010).

The evaluation of health projects in the 1962-1968 plan showed the implementation of the plan was ineffective since the Federal Government spent only N5.9 million (26.2%) of the N20 million allocated to health (Egunjobi, 1986). The bulk of the meagre expenditure went into the curative programme despite the recognition of the desirability of preventive medicine when the plan was formulated.

2.6.2 Second National Development Plan (1970 - 1974)

The focus of the Second National Development Plan was reconstruction of the war-damaged areas since the Nigerian civil war broke when the plan was about to be implementation. The health sector of the plan reflected this as well, stressing the importance of healthy population in the process of reconstruction and development. In addition to the programme directed at specific health problems of the war-afflicted areas, other policies were aimed at tackling the problem of rising demand for health services and shortage of medical personnel. The Federal Government and all the state governments earmarked 107.6 million (5.2%) of the total public sector capital to health in order to achieve the objectives of the plan (National Bureau of Statistics, 2010). By this allocation, health sector came sixth to transportation, education, agriculture, defence and manufacturing industry on the scale of priority.

Government expanded facilities in the medical schools and teaching hospitals in the country that the first plan created, in order to increase the number of doctors and other personnel from these institutions.

2.6.3 Third National Development Plan (1975-1980)

Federal Government in this plan provided more policies relating to planning, training and undertaking of medical research to enhance effectiveness of implementation of the plan. The Federal government also set out to pay more attention to the health sector through the allocation the sector received; all the governments devoted 2.5 per cent of their total estimates to health (National Bureau of Statistics, 2010). Notably, the planned expenditure on health in the third plan was higher than in the previous plans, but when compared to the other sectors, health was still rated low on the priority scale.

The Basic Health Services Scheme (BHSS) was introduced as part of the health programmes in the plan period. The BHSS essentially was to bring curative and preventive medical facilities within relatively easier reach of the general population

(Daramola, 1981). The strategy involved in the BHSS was the establishment of a Basic Health Unit for each 150,000 population. Eradication and control of preventable diseases such as malaria, tuberculosis, and measles and smallpox were emphasised. The plan period included the setting up of 5,000 new health clinics, and 1,500 mobile health clinics for the rural institutions (Ejembi, 1983). The training of more public health inspectors and nurses who were to carry out house-to-house inspection for environmental sanitation was also undertaken.

Third National Development Plan even though contained a better health programme plan, was not implemented effectively and the results were like the first two previous plans that did not achieve their intended goals. (Daramola, 1981). There still exists an impenetrable barrier between the planning sector, and the executing sector of the government machinery. It is remarkable that many of the noble objectives of the health sector in the plan were not accompanied.

2.6.4 Fourth National Development Plan (1981-1985)

The Fourth National Development focused towards providing a comprehensive healthcare system offering promotional, protective, restorative and rehabilitative services to an increasing proportion of the population. Comprehensive healthcare system was provided at three levels. These were basic healthcare facilities that provided basic health services at health centres, clinics and out-patient department of hospitals in rural, sub-urban and urban areas.

Primary Healthcare replaced the Basic Health services, the state and local governments were implementers in the Fourth Development plan and this laid the foundation for the continued provision of primary healthcare services by the local government levels. It also addressed the problem of manpower development, control of preventive and other diseases, medical research and strengthening of health planning. (Osemwota, 1992).

2.7 The Nigerian Health System after Fourth National Development Plan

The change of the five-year national development plan approach to long-range 15-20 years perspective plan and three-year rolling plan began in 1986. During the first three-year rolling plan of 1986 -1992, two major developments in health sector took

place. The vigorous implementation of PHC was witnessed while the launching of the final phase of national health policy that started (as draft in 1986) took place in 1988. However, the main thrust of the policy of 1990-1992 rolling plan was directed towards the implementation of both curative and preventive healthcare, primary healthcare and rehabilitation of secondary as well as tertiary health institutions.

The Nigerian National Health System provides for three tiers of healthcare, namely primary, secondary and tertiary, and these are managed by the local, state and Federal Governments respectively. Primary health centres are supposed to be the first point of contact for patients, providing preventive, curative, and health promoting and rehabilitative services. Any patient that cannot be managed at the primary healthcare level can be referred to other levels of care as appropriate.

At the secondary care level, patients are referred for specialised services from the primary health care level, through outpatient and inpatient services of hospitals for general medical, surgical, paediatrics, obstetrics, gynaecology and community health services. This level also supports peripheral units through regular supervision and provision of technical expertise.

The apex of the healthcare system in Nigeria is the tertiary level consisting of teaching hospitals and other specialist hospitals which provide care for specific disease conditions or specific groups of patients. In Nigeria, many secondary and tertiary health facilities are crowded with patients presenting simple ailments that can be managed at the primary health centres.

2.7.1 Politics of Healthcare Delivery in Nigeria

Like many other countries of the world, Nigeria has experienced interference of politics in decision-making on matters of health delivery and medicine. The pre-eminence of politics in policy formulation in general and healthcare delivery system in particular cannot be overemphasised. Politics and political processes usually mean the relationship of power authority or influence in the context of governance. The political process seeks to identify popular concerns to access the power distribution within a population to drive allocation of available resources and decide on the required course of action (Yuri, 1984).

In health planning, the influence of politics is well-recognised as a complement which, when integrated, should combine technical understanding of the healthcare

problems with preference for the healthcare of beneficiaries and culminate in maximisation of satisfaction. Known dichotomies between social statuses, which manifest more in rural urban differences, affect morbidity, mortality and access to health services. Attempt to improve on these features by government requires political support because health does not necessarily develop priority by itself. This explains why the political culture of a particular country influences the definition of health (Anderson , 1972; Akinkugbe, 1981).

While health is treated as an individual responsibility leading to the encouragement of private sector participation in some countries, it is a basic right guaranteed by the state (Heindenheimer, 1976). Recognition of the influence of politics in healthcare planning and management led to the Alma-Ata declaration on primary healthcare which insists that there is the need for strong political will and support at national and community levels (Akinkugbe, 1981). This is also based on the fact that the economics of health planning and management stresses cost recovery as a vital determinant. Some authors (Rice et al, 1967) have even gone to the extent of trying to cost human lives. A nation, in the event of dwindling resources, faces tough choices on how to allocate resources between competing national demands. It is worthy to mention that even public expenditures decisions within or between ministries are usually made as a result of complex interplay of social, cultural, economic and political factors.

To elucidate the influence of politics in health, Kajang (1999) concludes that, generally, the performance of any healthcare system needs to be judged in relation to the objectives inherent in the prevailing ideology in each country and to support this fact is seen from the attention some political environments give to issues related to health of their people like Annalisa (2015) made the remarks 'that Italy's health care system is characterized by universal coverage, good performance in terms of both good health indicators and low health care expenditure since the government pays attention to its healthcare system and also Eli (2010) stated that ever since their inception, Community Health Centres have received substantial legislative attention, in a remarkable display of bipartisan harmony' which has significantly improved the wellbeing of its citizenry.

Therefore, the health-planning process of a country has to rely on theoretical and political models that recognise the constraints of political life. However, while management may indeed help to sort priorities and guide policymakers, it is not politically-neutral and cannot, by itself alone, increase rationalisation and maximise the use of resources. That the implementation of social services, including health, is affected by political systems implies the need to clearly recognise it in fashioning management alternatives for the health sector. It must also be recognised that within any political system, the health system is affected by different groups of actors in overlapping areas. Specifically, decisions affecting health delivery at local level are made in essential areas that include central government, states, local governments, external donors and private sector.

Policymakers are influenced through a variety of executive structures. While the central government may draw up plans for healthcare, they need to get the states and local government support to put their policy intentions into practice. This again calls for political manoeuvring. In the case of Nigeria, civil servants largely dominate the implementation of health services and there are always considerable disagreements about policy goals between politicians, professionals and administrators. The health provider may be faced with situations in which medical goals conflict with political goals. The development of the health system and PHC in particular are based on a national philosophy in Nigeria that governs general development. Since the country become independent in 1960, great efforts at development have led to the formulation of various national development plans with health as an important component. A major ingredient in all of these plans was the health of the population which was seen as a stimulus of economic growth and social development. In 1988, the national health policy, based on principles of social justice and equity, was formulated. Consequently, PHC was adopted as the cornerstone of the health system. During this period, the Bamako Initiative was adapted for the provision of essential drugs in all local government areas (LGAs) which gave a further boost to the PHC concept. It is therefore necessary to review literature on primary health care.

2.7.2 The 1988 National Health Policy

The national health policy and strategy to achieve healthcare for all Nigerians, promulgated in 1988, was the first comprehensive national health policy. The policy identified a three-tier structure for the national health delivery system with primary healthcare as the cornerstone. In selecting primary healthcare, the policy intent was to use health as a vehicle to promote development while focusing on the major causes of morbidity and mortality that are largely preventive. Sixteen years later, the document was revised and retained the three tier system comprising primary, secondary and tertiary levels.

The National Health Policy document approved by the Armed Forces Ruling Council in 1988 is made up of 12 chapters (National Health Policy, 1988). Chapter one gives the major declaration of the Federal Government concerning using PHC as the strategy to bring health to all Nigerians. It equally emphasises the involvement of communities or individuals and in the planning and implementation of their healthcare. Chapter two reviews the state of the health services, the health status of people as well as the pattern of ill-health and its determinants. The national philosophy of social justice and equity is related to the issue of health in chapter three. It defines PHC as the first entry point into the healthcare delivery system. The PHC programmes are explicitly spelt out in chapter four. Chapter five of the document gives the description of the national health system. The description covers, among others, the constitutional background, the involvement of voluntary agencies and private sector in the provision of healthcare at the three levels of care, namely primary, secondary, and tertiary.

The implementation strategies for the achievement of the goal of the policy are the focus of chapter six. Thus, the roles and functions of the organs for the implementation of the health programme at different levels of government are spelt out. Chapter seven addresses the national health system management and he effective management of health services demands the establishment of a national health information system. Chapter eight, treating the national health policy document, focuses on the national health information system, which is expected to be used by the government as management tool in measuring the achievement of the goals of the health services. Chapter nine enumerates the responsibilities of the government in ensuring the

training of health manpower to meet the challenges of health for all. The use of the most appropriate health technology at all levels of the healthcare system is the preoccupation of chapter ten. This covers health promotion, disease prevention, diagnosis, therapy, rehabilitation as well as drug production, quality control and preservation.

The contributions of research to the development of health sector are realised. Hence, chapter eleven focuses on national health research. The concluding chapter of the National Health Policy document is chapter twelve, as finance is sine qua non to the implementation of any health plan (or programme), so the chapter focuses on health care financing designed to achieve the goal of the policy (National Health Policy, 1988).

2.8 Evolution of Primary Healthcare Delivery Approach

The preceding section explored the relevant literature on public policy implementation and healthcare in general and, specifically focused on the primary healthcare strategy in delivering healthcare to the people. It started by tracing the evolution of primary healthcare approach and then traced the history of healthcare development in Plateau State as this is an important step to be taken because the burden of the study was to examine the implementation of PHC policy in Plateau State. Therefore, tracing the history of PHC and its importance is required for critical analysis of the content of the policy. Also, Plateau State healthcare development is reviewed in this chapter since it is the state chosen as the case study for this research.

2.8.1 Background History of Primary Healthcare System

Since the advent of modern medicine, its chief beneficiaries are the rich people who could afford it. However, for the first time in the history, health of poor people in the world became a notable issue in the policy process through the concept of primary healthcare (PHC).This is particularly true of Nigeria, which was a British colony until it secured independence in 1960. The wheel of world policies experienced the first counter-rolling in 1960s when the United Nations (UN) started advocating a new economic order focussing the basic needs of the common people. Individualistic medical approach of the physician-centred health policies encountered community-centeredness with a view to ensure not only medicine but also shelter, food, clothing, safe water, education and healthcare (Walt and Rifkin, 1990). By 1972, the executive board of World Health

Organisation (WHO) resolved to revamp the focus of the organisation towards people most in need of healthcare. Thereafter, in partnership with interested organisations, WHO went through rigorous exploratory processes to conceptualise the various aspects of healthcare which became crystallised in 1978 (Bryant and Richmond, 2008). In 1978, the governments of 134 countries along with several voluntary agencies met in Alma-Ata (then in USSR) at the Joint WHO-UNICEF conference and called for the acceptance of the WHO goal of Health for All by 2000 AD and asserted PHC as the key to achieving the target (Park, 2008).

Emergence of PHC was not absolutely greeted with clement approval by all international stakeholders since commencement. Specifically, it has faced stern criticisms starting from 1979 until this moment. Some people even termed it poor treatment for the poor people for its cheap and low-technology options. Walsh and Warren, (1979) criticise it for being too costly and unrealistic for most countries. Some developed countries argue that PHC is irrelevant to them and relevant to only the developing and least-developed countries (Baum, 2007). Clinicians consider it a threat to their age-old predominance of medical establishment. It also lacks the ongoing growing concern for environmental sustainability issues (Baum, 2007). Even one of the greatest health leaders of the time, Mahler, a prime advocate of PHC and the Secretary-General of WHO could not foresee the changing economic and political climate of the globe giving way to free market paradigm shift. Oil crisis, global recession, and structural adjustment programmes introduced by the development banks -all these factors played a role in taking national budgets away from social services like healthcare.

Economic intricacy coupled with neo-liberal politico-economic ascendancy during the 1980s and early 1990s influenced the health system specialists to adopt efficiency and sustainability-based health-sector reform rather than equity and social justice-based health-for-all movement. Due to the diminishing resources and a tendency of coarsely depending on objectively-verifiable indicators imposed by the large donor organisations, selective approaches or package programmes gained popularity over the comprehensive approach. Emergence of HIV/AIDS, re-emergence of tuberculosis, and failure of malaria control programmes accentuated this propensity of changing policy

priorities. These selective, rapid and easily-measurable approaches seemed attractive to the large funders. Several such selective models then emerged rapidly, for example Child Survival Revolution championed by James P Grant, Essential Service Package (ESP) and many more (Lawn et al, 2008). These approaches had some relative advantages over the comprehensive approach in terms of ability to give impressive output within a short period, aggressive attack on high prevalence health problems, readily-available support from some donor agencies and also. By nature, it is less resource-demanding. However, politicians are noted for exploiting it for selfish purposes.

These constant challenges posed by the paradigm shift of the world health policy personnel along with normal desire to evaluate a long-expected programme like PHC necessitated a mid-term review in Riga, Latvia in 1988. The review recognised the outstanding achievement of the PHC however slowness and even stagnation in some countries were also highlighted. Revitalisation of the whole programme was demanded with new analyses, partnerships, mechanisms and resources. The meeting suggested empowerment of the people, district health system strengthening, emphasising the issues of the least-developed and developing countries among others (Bryant and Richmond, 2008). Although the target of Health for All by 2000 had not been met, the need to further advance towards it was reflected by the Director-General of WHO, Dr Margaret Chan in the introductory message of The World Health Report 2008; Primary Health Care now more than ever: "While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remain true" (WHO, 2008:1). This warrants an in-depth understanding of the current PHC scenario at the local level, its evolution in the light of changing contexts and a strong evidence base.

The primary health care strategy has emerged as the key strategy for meeting basic health needs especially in developing countries. The term primary healthcare in part replaces the earlier term, basic health services or rural health services, used in the mid 1970s in Nigeria. In most developing countries, the health situation was poor because of a number of factors. For example, large proportion of healthcare resources is concentrated in the large cities where these resources are devoted to expensive and

sophisticated technology to serve a minority of the community to the detriment of providing basic care for the majority. In addition, the people are not adequately involved in the planning, implementation and evaluation of the health services or in taking decisions about their health system (WHO, 1978).

The people's priorities, rarely formed the basis for health planning and organization. Management decisions are usually centralised with little or no community participation at peripheral level, thus making health services seem imposed on the people (Mills, 1995). Healthcare services are usually agency-based, curative-oriented and physician-centred. Thus, the health status of people in these communities could not improve. It, therefore, becomes clear that healthcare will require the development of health system with more coordination with other health-related sectors and better organisational structures to ensure increased and effective involvement of the people and total coverage (WHO, 1979). By the 1960s, some health workers and policymakers had started to work out new approaches to resolve the problems of the conventional health systems (Monica, et al, 2003). The successful attempts of such health workers in meeting the health needs of people through new approaches preceded the global interest in the development of the primary health care concept.

WHO and UNICEF, therefore, in 1971, set up the Joint committee on Alternative Approaches to Meeting Basic Health Needs of Population in Developing Countries (WHO, 1975). They presented a report on the experiences of 11 successful attempts to provide broad access to healthcare in order to meet basic health needs of the people in low-income countries. These attempts stressed several activities and use of community resources that are not medical-oriented or physician-centered. It was on the basis of this report that the world Health Assembly advised the World Health Organisation to initiate ways of adopting new approaches to healthcare in developing countries. The report also stimulated the world body to propose an international conference on primary healthcare in order to share experiences on the new approaches to healthcare.

From 1975 to 1977, some national and regional meetings on primary healthcare were scheduled by WHO and the other organisations to develop background materials for

the international conference on primary healthcare in 1978. For example, the Christian Medical Commission sponsored a meeting of member-group from 20 countries to deliberate on primary healthcare in 1977 and the worldwide community of non-governmental organisations (NGOs) met in Halifax in May, 1978 to finalise a position paper on primary healthcare which was presented at WHO–UNICEF International Conference, on primary healthcare at Alma Ata, 1978. These meetings enhanced discussions and interest on the concept of primary healthcare. The World Health Assembly (WHA) adopted two relevant resolutions which asserted that health was a universal human right and that governments should provide accessible, affordable and socially-relevant healthcare for all (WHA/28/88, 1975).

In 1977, WHA adopted the resolution WHA 36.3 that by year 2000, all people in all countries should have a level of health that would permit them to lead socially and economically productive lives. This implies that all the people would use better approaches than hitherto for preventing diseases and alleviating unavoidable disease and disability, and that the people themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of diseases. The resolution preceded the international conference on PHC held in Alma-Ata in 1978 9WHO, 1979)

The declaration of Alma-Ata in 1978 brought to a conclusive end the acceptable definition and adoption of the PHC approach as the key strategy to meeting the basic health needs of all peoples. The WHA in 1979 launched the Global Strategy for Health for All by year 2000 by adopting the resolution of Alma-Ata, 1978. In the same year, United Nations General Assembly also endorsed the Declaration of Alma-Ata in resolution 34/58. In 1981, WHA adopted the Global Strategy for Health for All by 2000 to promote and support the appropriate organisation and effective operation of comprehensive health system that involves communities and health-related sectors in responsible and coordinate ways (WHO, 2000).

2.8.2 Concept of Primary Health Care

The international conference on PHC unanimously adopted the declaration of Alma-Ata which stated that PHC is the key to attaining health for all, and defined it as "the essential health care based on practical scientifically sound and socially acceptable

methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of a country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individual, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process".(WHO-UNICEF, 1978).

2.8.3 Philosophy of Primary Health Care

The philosophy of PHC is understood by the need to meet the basic health needs of all segments of society, especially those most deprived of healthcare. It implies that other health services should be designed in support of the needs of the peripheral community activities. According to this philosophy PHC should be fully integrated with the activities related to community developments. The local population be actively involved in the planning, implementation and evaluation of their healthcare activities. It must depend on available community resources must be relied upon Primary healthcare should be part of the official healthcare system, and be undertaken by workers most suitably trained for the performance of PHC activities.

WHO (1979) further explains that the philosophy of PHC is rooted on the fundamental right and duty of the people to participate individually and collectively in the planning and implementation of their healthcare to ensure that they have a level of health that will permit productive life. Therefore, the PHC philosophy is the attainment of essential healthcare for all as part of overall development and in the spirit of social justice.

2.8.4 Basic Principles of Comprehensive Primary Healthcare

Equity

Equity in health is understood to mean fair share of, and opportunities in, distribution and access to, health resources and services. In healthcare research, equity is

often used to highlight the idea of social justice in service delivery, although it is not clear what equity stands for (Waters, 2000). There are two forms of equity. Horizontal equity is reached if equal need receives equal treatment, which would be the case if all poor citizens or all pregnant women with complication are provided with the same quantity and quality of care. Vertical equity suggests different provisions of care for different needs or unequal treatment of unequal need (Mehrotra, 2002; Green, 1992).

This is especially pertinent, considering the inequitable health systems most countries inherited at independence. Countries developed national health policies, stating equity as one of the objectives and indeed the infrastructural development initiatives focusing on the rural areas were meant to operationalise this objective. Unfortunately, it meant a reallocation of limited resources, which led to taking away resources from the already under-funded services serving the urban elite, who were the new decision-makers. The equity policy objective was therefore not fully implemented.

There are huge disparities in allocation of resources between the rural and urban areas, access to services is similarly skewed and the health outcomes, as shown by infant and maternal mortality rates, confirm the disparities.

Though countries indicate commitment to equity, this has not been realised and much more effort is required.

Community Participation and Involvement

Community participation is seen as a process of involving the community by promoting dialogue with, and empowering communities to identify their own problems and solve them. Participation of the community in PHC is evidenced in most countries through the formation of community health committees, village health committees and health centre or area health committees and the selection of community health workers for training. Furthermore, community representatives are included in health facility or inter-sectoral management structures such as district health boards, district development committees and hospital management boards. The management committees represent a very important element in the institutional setting of the system with regard to their main role in planning, management and control of health services. They form an interface

between the health system and the population and, hence, represent and promote the people's participation and ownership.

It is almost universally acknowledged by national and international health planners that community participation is the key to the successful implementation of primary healthcare (PHC). In the Alma Ata Declaration, community participation contains involvement in all phases of primary healthcare. The WHO promotion of community participation was greatly influenced by the China example of barefoot doctors. This programme consisted of part-time health workers which provided basic health services in rural areas. It was very successful in China. For the transfer of this experience, it is important to notice that mobilisation for health in China was part of a much wider socio-economic and political upheaval (Cornia, 2001).

The 1978 Declaration of Alma-Ata identified community participation as the process by which individuals and families assume responsibility for their own health and welfare as well as those of the community, and develop the capacity to contribute to their community's development (WHO, 1978).

Community activities are most successfully promoted with reference to the people's own ideas of purity/pollution, cleanliness/dirtiness, and health/illness. Guidelines for successful community participation include: projects undertaken should be ones that the community has identified as priority; demonstrations and activities to promote health might be linked with agricultural initiatives, adult literacy campaigns, or programmes from other sectors; and it is necessary to make sure the community fully understands all the costs in labour, time, money, and materials. If projects or long-term community health programmes fail, a quick, simple analysis should be made of constraints that may be operating. Apart from providing healthcare services based on their expertise, community also helps in ensuring professional commitment to achieving the goal of health for all.

In the last three decades, there has been an increasing demand for a shift of emphasis from acute care to the prevention of disease and promotion of health, education and research. Health workers should try to achieve the maximum possible while trying to solve other deep-rooted problems to make health the right of every individual.

The Inter-sectoral Approach

The Inter-sectoral approach to health as promoted in the Alma Ata Declaration recognises that many health problems are caused by other factors, the state, the professional discourse, the organisation of work and social networks. The influence of other socio-cultural, economic or political variables on health is now a widely-accepted reality within the scientific community (Marmot, 2001). Especially the notion of diseases of poverty plays an important role for the primary healthcare approach (Greinacher, 1989).

The interrelatedness of poverty and health status was acknowledged in Alma Ata. The influences of poverty on health, whether it is through lack of information/education about health, lack of hygiene and sanitation, lack of food and shortage of water are manifold. In development theories, it was long held that economic development of a country would benefit the poor also. Reality proved this theory wrong. Health policy needs to address the root causes of disease. It is insufficient to start at the curative end. Therefore, other sectors also have to contribute to achieve health for all as proposed in Alma Ata, either through direct interventions (for example, safe water) or through indirect interventions. Other sectors have other priorities than the health ministry. Together, they compete for limited resources from the central budget. Hence, conflicts of interests and power struggles belong to the daily political life at the local or central level.

Equity in distribution of other resources, economic resources, education, or access to water has benefits for health. From the experience of European countries, it is legitimate to say that more equity in resource allocation will enhance equity in health and produce a higher health status. This approach chooses a long-term perspective by trying to eliminate the causes of disease.

Appropriate Technology

Appropriate technology is a principle of primary healthcare, meaning the employment of personnel and resources according to healthcare needs and the socio-economic context of a country (Green, 1992). Indicators to be considered are besides the costs, efficacy, effectiveness and acceptability of the health intervention as well as sustainability. One criticism on healthcare in developing countries brought up by the

primary healthcare approach is the use of capital-intensive Western medicine without adjustment to the specific characteristics of a country (Greinacher, 1989).

Health-promotive and Preventive Approach

A health-promotive and preventive approach is another principle of primary healthcare. Preventive measures are often more successful and less expensive and, therefore, the appropriate technology to tackle a certain health problem. However, this is not to condemn curative care as unnecessary but rather to uncover the potential of health promotion and prevention. Knowledge about health is no guarantee for healthy behaviour but it clearly influences individual choices. A better understanding of health also has benefits for the patient-doctor relationship and fosters accountability. Among the eight elements of primary healthcare, education comes first, since it is a prerequisite for successful community participation and prevention measures, especially in the areas of hygiene, sanitation, nutrition for children and babies, prenatal services and family planning, this knowledge can enhance the health status (Mcdonald, 1993). Health promotion for the prevention of diseases is one major goal of the World Health Organisation.

2.8.5 Elements of Primary Health Care

A major purpose of PHC is to ensure that essential healthcare services are provided to communities, through their own efforts, when and where they need them and at a cost they can afford. The original Alma-Ata document (WHO, 1978) outlines eight of these essential services. Evaluation of PHC should therefore address the level of provision of these services, which include health education, maternal and child health (including family planning), water and sanitation, food and nutrition, immunisation, prevention of endemic diseases, treatment of common ailments and provision of essential drugs. A brief discussion follows on some of the important considerations for providing these services.

Health Education

In tracing the origin of health education, Bryant, et al (2008) notes that at an early age, failure of community members to accept modern allopathic remedies have been attributed to "ignorance or 'lack of information." By this, health education is captured as a means of giving of information to increase knowledge. Later, research shows that knowledge in itself is not sufficient to bring about the desired behavioural changes to improve health. Other barriers to health action must also be removed, including economic and social factors. Thus, the role of health education generally, and in PHC especially, has been transformed to include provision of a combination of learning strategies that enable people, through their own voluntary participation to take action compatible with high standards of health.

Immunisation

Nigeria has one of the world's biggest populations of children but is lagging behind dramatically in immunisation. It is one of only three countries where polio is still endemic – the others are Afghanistan and Pakistan. In Northern Nigeria, rates of maternal, newborn and child mortality are amongst the highest in the world (Center For Disease Control, 2013).

Years of experience regarding immunisation programmes have shown that simply making the service available is not enough. Often, only half of the children are presented at the vaccination centre and only half of them return for the second and third shots. For immunisation to work, parents need to understand what is being offered, and they must also be able to get their children immunised without making major sacrifices in the time and effort needed to cope with the day-to-day business of survival in poverty. Therefore, mobilisation of all sectors is one of the best strategies for success in immunisation

With a 13 percent immunization rate for children between 12-23 months, Nigeria has the lowest vaccination rate in Africa. This recurring issue needs to be urgently addressed; the well-being of women and children in our respective states should be our prime focus now. Nigeria needs to integrate maternal, newborn and child health interventions into our health care services. Government should support data generation to

ensure evidence-based policies and interventions and also make sure they are spread nationwide (Center For Disease Control, 2013).

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Water and Sanitation

The poorest fifth of humanity still lacks clean water and safe sanitation. The consequences for health, productivity, and the quality of family social and economic life, weaken every other aspect of human development. In particular, progress of all kinds is held back by the diversion of so much of the time and effort of women and girls to the task of providing water (UNICEF, 2009). Access to safe water and hygienic sanitation is therefore an aim of PHC as well as a measure of community development.

Food and Nutrition

One of the most striking problems in contemporary times is humanity's demonstrated inability to eradicate hunger, which has been man's constant companion since his first days on earth. Because hunger and malnutrition are widespread, it is not surprising that reliable figures on the true dimensions of hunger were, for a long time, unavailable while under nutrition was closely linked with poverty and consequently the indicators used to measure the phenomenon were not standardised.

Maternal and Child Health

UNICEF, (2009) states that there are many social, cultural, and economic factors which affect the health of mothers and children especially in developing countries. These countries are usually socially as well as economically underdeveloped and the complications which can occur to mother and child are often the result of an unhealthy social and physical environment. Socio-economic status has a great influence and it has been established that social factors such as poor hygiene, overcrowded housing and faulty nutrition have been major causes of infant and child death. Reports from round the world suggest that, in developing countries, most births are attended by traditional birth attendants (TBAs) who take a special interest in midwifery. In addition to attending to women at childbirth, many also provide some form of antenatal care, in addition to care for newborn, and in some areas promote family planning and attempt treatment for sub-

fertility (Handley, et al, 2009). TBAs' legal right to practise in this way varies from country to country, but even where they have no legal recognition and are not registered, it seems that they are tolerated. PHC services should take cognisance of this existing resource and integrate with them for better performance and update indigenous maternal and child healthcare.

Provision of Essential Drugs

In many developing countries, efforts to restructure the health system and orient it in the direction of PHC have been handicapped by a general lack of drugs, particularly at the peripheral level where need is greatest (Lewis and Peterson, 2009). The World Health Organisation launched its Action Programme on Essential Drugs and Vaccines in 1981. Since then, the guidance provided has helped many organisations and countries to choose the drugs appropriate for their healthcare programmes (Jeffrey, 1991). Jeffrey listed the advantages of using a standard essential drugs list as 1) careful selection of drugs can be made based on the best information available and on real needs, 2) correct dosages are easier to remember, thus safety in drug usage is increased, 3) less wastage occurs than switching from one drug to another, therefore it is more cost-effective, 4) ordering, storage and distribution of drugs are easier to manage, 5) reliable data on drug consumption is obtainable. Essential drugs can be provided through community participation in the form of a revolving drug fund. Highlighting the benefits of such fund, Lambo (1989) asserts that it has restored confidence of patients in public institutions and increased patronage.

Prevention of Endemic Diseases

Endemic, particularly communicable, diseases are a major source of ill health, lost productivity and suffering in communities of the developing world. An example is guinea worm. In the 21 endemic countries of Africa and south Asia, men and women cannot work in the fields. Harvests are lost. Children cannot attend school. Earning and learning are undermined and, with them, the foundations of community development, such local disease problems torment many of the world's poorest and least-to-be-reached villages (UNICEF, 2006). Large-scale vertical disease eradication programmes have been

attempted in the past. Reporting one campaign, Farid (1980) asserts that in 1950-1955, spectacular successes were reported from WHO malaria eradication pilot projects in many malarias' countries of the world. In Africa south of the Sahara, the pilot projects using DDT residual spraying led to a drastic reduction in malaria morbidity and mortality, but no interruption of transmission could be realised because of lack of basic health infrastructure to maintain the gains of eradication. Therefore, disease control must be integrated into a strong local health service as envisioned in PHC.

Treatment of Common Ailments

The appropriate treatment of common diseases and injuries is one of the key elements in providing a just and equitable health service. Simply, mastered technologies have in fact begun to open up the possibility to win the struggle against easily-treated and prevented diseases. One such treatment modality which merits universal implementation by all health services, oral rehydration therapy (ORT), is for the control of diarrheal disease and resulting dehydration. Muhammed (2006) states that ORT for diarrhoea was made possible by the discovery that adding glucose to a solution of salt and water can increase the body's rate of absorption of the fluid by 2,500 per cent. It is simple to make, and UNICEF (2009) estimates that if every means possible is utilised to bring this message to mothers in developing nations, as many as 13,000 children could be saved every day. This simple and appropriate curative action opens the way for the mother (and community members generally) to learn about other important measures through which they can guarantee their own healthcare through their own efforts. Mahier (1987) and Williams (1987) sees the mother as primary healthcare worker, and says one of the unique features of ORT is its focus on the mother as the first line of defence against the threat of diarrhoeal dehydration. The mother is usually the first person in the home to take action or seek advice from a relative, traditional healer, local drugstore owner, or a trained healthcare worker.

2.8.6 Primary Healthcare in Nigeria

Nigeria is one of the countries that ratified the Alma Ata declaration. Sequel to the Alma Ata conference, a committee on national health policy was set up. The committee chaired by Professor A.O. Lucas, recommended health system based on PHC and linked this to national development goals. Though the committee's report was submitted in

1984, it was ignored until 1988 when its recommendations were largely infused into the national health policy.

The Nigerian Primary Health Care System (NPHCS) replaced the Basic Health Services Scheme (BHSS), which was incorporated in 1976 into the third National Development Plan of the Federal Government. The scheme established a three-level hierarchical network of health centres while its activities were mainly carried out by the Federal Government with little involvement of the state and local governments. However, the NPHCS was aimed at increasing the proportion of the population receiving healthcare from 25% to 60% with the attendant characteristics of reorientation; equitable distribution of health resources; inter-sectoral collaboration, and community participation. The establishment of the National Primary Health Care Development Agency (NPHCDA) which was passed into law in 1992 by the Federal Government was intended to create a platform for achieving this lofty goal. Notably, despite the subsequent establishment of the ward health system which was primarily to promote active community participation, there still exist a lack of community involvement in planning and implementation.

2.8.7 Pillars of PHC in Nigeria

Based upon the Alma Ata declaration, primary healthcare can be said to consist of seven core issues:

1. Foundation of the Health System: PHC is the first level of contact of individuals, the family and community with the national health system. It brings healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process.

2. Priorities: This addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.

3. Science/ Evidence-Based: PHC should be based on the application of the relevant results of social, biomedical and health services research and public health experience.

4. Culture Sensitivity/ Social Relevance: PHC system of healthcare delivery is a system of socially-acceptable methods alongside technology and it reflects and evolves from the economic conditions as well as socio-cultural and political characteristics of the country and its communities.

5. Equity and Social Justice: This is an integral part of the PHC system, that healthcare should be made universally accessible to individuals and families in the community.

6. Community Participation: A system in which the people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare. This requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary healthcare.

7. Sustainability and Self-reliance: Healthcare should be at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

2. 8.8 PHC Strategy and National Health Policy

The inception of the national health policy, which officially became operative in October 1988, adopted the concept of primary healthcare as the main vehicle by which the goal of health for all Nigerians would be attained (Aregbeyen, 1997). According to WHO (1979), primary healthcare is essential healthcare based on practical, scientifically-sound and socially-acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost the community and country can afford as well as maintain at every stage of their development in the spirit of self-reliance and self-determination.

The PHC began in Nigeria in 1986 with experimental 52 local government councils. Subsequent upon this, the country was divided into 4 zones - A, B, C, and D. As at 1990, 8 LGAs in different parts of the federation were developed into models of PHC delivery centres, namely Akko in Bauchi, Oturkpo in Benue, Calabar in Cross River, Guyuk in Gongola, Zaria in Kaduna, Oyun in Kwara, Owo in Ondo, and Oyo in Oyo State. Out of 453 LGAs in Nigeria in 1990; 293 were upgraded to provide PHC, leaving 159 LGAs to be upgraded (Osemwota, 1992).

During the1990-1992 plan period, the Expanded Programme on Immunisation (EPl) was extended to cover 30 per cent of children fewer than 2 years of age, while about 30 per cent of pregnant women were immunised against tetanus. Also, significant progress was made in Oral Rehydration Therapy (ORT) programme. Also accomplished was the setting up of PHC committees at the local, district and village levels; the training

of village health workers and traditional birth attendants; upgrading of health centres to serve as referral point for villages in each district.

The 774 LGAs have been further divided into health districts. In each district, there is a minimum of a health centre that serves as referral point for its catchment area, which is regarded as the entry point into the health-delivery system at the grassroots level. Unfortunately, the level of equipment and staffing at this level does not allow effective fulfilment of the expectations of the PHC programmes. It is notable that the apparatus for inter-sectoral cooperation is not is widespread as it should be (Lambo, 1980 and National Planning Commission, 1998). However, there is need for improvement in the implementation of the PHC programme, particularly in the rural areas of the country.

2.8.9 Institutional Arrangements and Regulatory Framework

The institutional responsibilities and relationships in the Nigerian health sector are guided by the interpretation of the constitution of Nigeria with regard to the sharing of responsibilities between the three tiers of government which implies that it is the state governments that have principal responsibility for primary healthcare delivery, with the extent of participation of Local Government Authorities (LGAs) in the execution of these responsibilities determined by each state government.

The Federal Ministry of Health (FMOH) is the central government institution in charge of sector-wide policy development, financing, regulation, monitoring and evaluation using its agencies including National Primary Health Care Development Agency (NPHCDA) which is an executing agency responsible for primary health service delivery. The agency was established and backed by law in 1992 by the Federal Government.

The national health policy adopted by the democratic government in 1999 outlines the roles and functions of each tier of government in primary healthcare. While the Federal Government is responsible for overall policy formulation, coordination, and adherence to internationally-recognised standards, the state government with the active participation of local governments is responsible for actually delivering primary healthcare services. However, neither the national health policy nor the 1999 Constitution clearly delineates the responsibilities and authorities of the states and local governments.

Instead, the official language seems to suggest that state governments have the ultimate responsibility for delivering primary healthcare while the role of local governments can vary within a state and across states, depending on each state policy and socio-economic conditions.

The Fourth Schedule of the constitution provides the functions to be performed by local government councils:

> The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters: (a) the provision and maintenance of primary, adult and vocational education; (b) the development of agriculture and natural resources, other than the exploitation of minerals; (c) the provision and maintenance of health services; and (d) such other functions as may be conferred on a local government council by the House of Assembly of the State (Constitution 1999).

Local Government Authorities (LGAs) were established and recognised as the third tier of government for participation in the delivery of most local public services along with state governments and entitled to statutory revenue allocations from both the federal and state governments for the discharge of applicable responsibilities. In the late 1980s, there was a national initiative to overhaul the primary healthcare system through the adoption of a new national health policy in the context of which the federal and state governments issued directives giving LGAs full jurisdiction over the delivery of primary healthcare services.

Local government councils are constitutionally designated to provide primary healthcare (PHC), which is currently the weakest arm of the health system. The National Primary Health Care development Agency (NPHCDA) is a centrally-funded Federal Government body mandated to support the promotion and implementation of high-quality primary healthcare services. Although health accounts are yet to be fully established, it is estimated that about 5% of national budget is spent on health. This is far below the Abuja declaration of 15% of national annual budget agreed among heads of African countries. The national health policy document, revised in 2004, indicates that local governments are expected to be the main implementers of primary healthcare policies and programmes, with the Federal Government responsible for formulating overall policy and

for monitoring and evaluation while state governments are providing logistical support to the LGAs such as personnel training, financial assistance, planning and operations. Yet, the 1999 Constitution of Nigeria is unclear with regards to the autonomy of local governments in providing basic services, such as primary healthcare for which they have been given responsibility through segmental directives. This contributes to the inefficiency of the local government functionaries to deliver quality primary healthcare services.

The national health policy also emphasises the role of community participation in the delivery of primary healthcare services. It indicates that local governments shall mobilise communities to participate in the provision and maintenance of health services, eliciting the support of various formal and informal community leaders.

2.9 Plateau State: Historical Legacy of Healthcare Systems

The health services of Plateau State have evolved through a series of historical developments including a succession of policies and plans by previous administrations. The health services are adjudged unsatisfactory and inadequate for the needs and demands of the public as reflected by the low state of health of the population.

The government medical services of Plateau State began as an extension of services provided nationwide by the army surgeon, nursing sisters and other personnel attached to the hospitals of military cantonments. The simple *garrison* or *barracks* type of medical care gradually evolved by 1902 into a fully organised government medical services nationwide, serving the entire civilian populace irrespective of status or origin. The all-Nigerian services disappeared by 1954 with regionalisation of the civil service, when the various regions established their own medical services.

Notably, in Plateau State, the introduction of scientific medicine began to emerge slowly with missionary activities, and by the last decade of the 19th century, medical pioneers of the Anglican, Sudan Interior Mission (SIM) and Sudan United Mission (SUM) had begun organised medical work. In this connection, was the pioneering work of Dr Andrew of the SIM, who spent a great deal of his career in preaching in the markets of Jos, practised medicine in dispensaries, wrote a book of medical hints for missionaries and was the first to successfully establish, in 1914, a sanatorium at the little village of

Miango on the western edge of Jos Plateau. Other health institutions followed, for example Cambridge University Missions (CUM) established health clinics at Panyam and Kabwir in Bauchi-Plateau in 1914; RCM at Kwa about 1911(this later moved to Shendam); SUM at Vom in 1922; SIM at Jankwano Jos in 1927; RCM at Our Lady the Apostle Hospital, Jos in 1945 and the Seventh Day Adventist Mission at Jengre in 1947.

The first attempt at planning ahead for the development of health services in Plateau State took place in 1946, as part of the colonial government initiative to produce the overall ten-year plan for development and welfare (1946-56) covering all aspects of governmental activities in the country. Since Nigeria was still a colonial territory, the proponents of this plan were mainly expatriates. It included 24 major schemes designed to extend the work of existing government departments but it was not an integrated development plan in the current sense of the world. These schemes were neither properly coordinated nor related to any overall economic target. Nevertheless, it was a modest, realistic well-thought plan for its time and purpose, and it served as the basis for subsequent health plans.

Since the creation of Benue-Plateau and subsequent Plateau State 1967-1975 policies have been enunciated and aimed at correcting the national development plans or government decisions or specific health problems (MOH, 1992).

The government of Plateau State launched its State Health Policy (SHP) in 1992 which acknowledged the need for a comprehensive health policy to address health problems and improve life conditions (Plateau SEED, 2004). The 1992 SHP is the current health policy document for Plateau State. It aims to reform the health sector in order to prevent disease, promote health, and improve the overall health status of the population in line with the principles of Health for All. A brief analysis of its contents will be presented in the later part of this chapter.

2.9.1 Organisational Structure of Primary Health System

Under the Nigerian concurrent legislative list, the constitution allows the provision of a decentralised healthcare system across the three tiers of government, namely federal, state and local. It is constitutionally-recognised that local government agents have the principal authority and responsibility for PHC delivery.

At the federal level, the National Primary Health Care Development Agency (NPHCDA) has the mandate to support the community health model. The agency is headed by an executive director, who is a political appointee. The agency has a mandate to mobilise financial, human and technological resources for PHCs throughout the country as well as provide technical support to states and LGAs. Part of this support is to develop PHC standards and guidelines to monitor, supervise and evaluate the delivery of PHC services across the country.

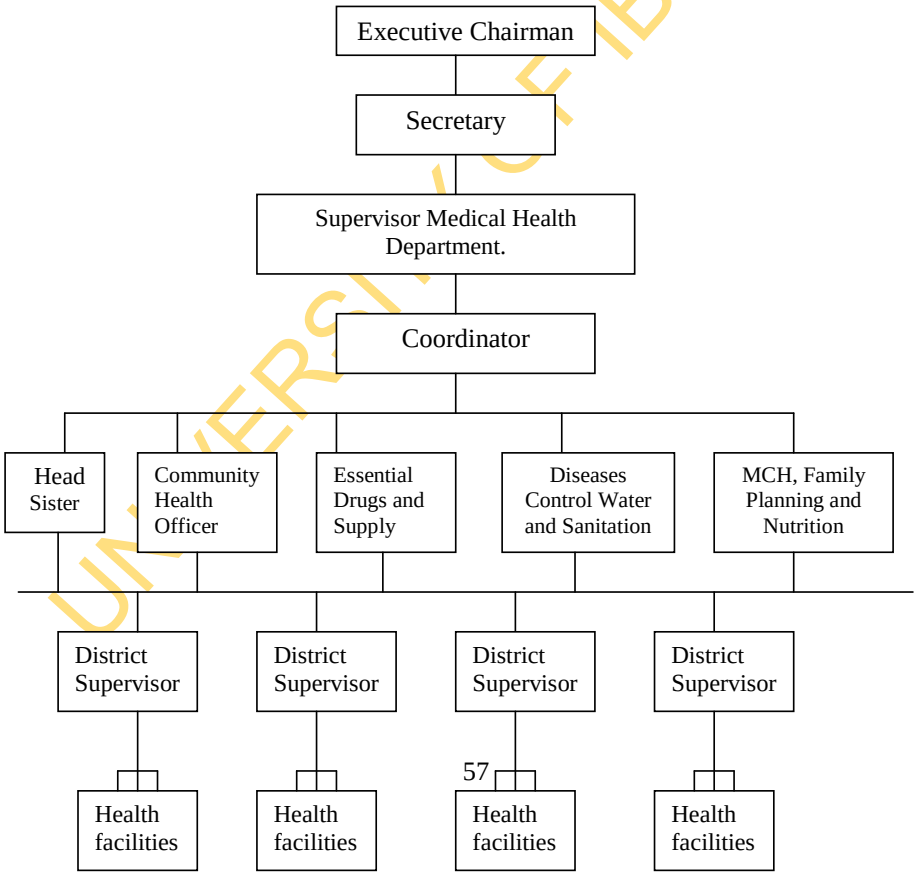
There is an equivalent of State Primary Health Care Development Agency (SPHCDA) at the state level but not active in all states. At the state level, the key health players are the Commissioner for Health, the Permanent Secretary, the Director of Public Health, Director of Planning Research and Statistics (DPRS), Executive Chairman of the Hospital Management Board, and the Executive Director of the SPHCDA (in states where active).

At local government level, the Local Government Chairman is the political head of the PHC system while the Primary Health Care Coordinator is the most senior public health officer. Depending on the type of facility, there is usually an Officer in Charge, nurse, midwife and a number of Senior and Junior Community Health Extension Workers (CHEW). Health posts usually have only an Officer in Charge who is likely to be a CHEW. A junior CHEW assigned to the community is helped by a number of volunteers like Village Health Workers (VHW). The recruitment and payment of health workers come under the responsibility of State Ministry for Local Government rather than the State Ministry of Health (SMoH).

At the local government level, there is a further decentralised administration in place. This is known as the ward system. Where functional, there is a Ward Development Committee (WDC), which has members from smaller committees in the villages. At the local government secretariat, they have a management committee, which has representatives of committee members from various wards. Smaller committees include community development committees in villages with representatives at the ward and LG health committee. The Village Health Committee is usually chaired by the village head. The committee serves as a gateway to the community (FMoH 2006).

The healthcare delivery at the LGA is headed by a Supervisor of Health, while PHC is headed by a PHC Coordinator and assisted by a Deputy Coordinator. The PHC coordinator reports to the Supervisor who in turn reports to the LGA Secretary. The different components of the LGA PHC are manned by personnel of diverse specialties. There are three levels of operation of PHC in LGA, namely (1) Village level, (2) District level (3) Local Government level. Figure 3.1shows the typical organogram of the LGA PHC setting in Plateau State.

Figure 2.1: The Organogram of LGA – PHC



Source: Ministry of Health Plateau State, 2013.

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Theoretical Framework of Studies

2.10 The Theoretical Framework

To examine the implementation of Health Policy in PHC service delivery, the study examined policy implementation and service-delivery frameworks before stating the theoretical framework adopted by the study; it used Political Economy Analysis Framework.

2.10.1 Public Policy Process

Public Policy studies are basically about politics and public administration, but they also draw on other social sciences like economics, sociology and psychology. Harold Lasswell a major proponent of Public policy studies sees politics as concerned basically with "who gets what, when and how" and argues that political processes involve people with a set of demands, expectations and values who interact in avenues where decisions are taken, and about strategies to overcome deprivations, but to influence outcomes and effects. Lasswell is considered a pioneer of policy studies and, his works mark the development of the field (cited in Parsons, 1995).

Regarding definition, there is neither a firm academic agreement on the definition of public policy nor a singular approach to the analysis of policy. Jenkins, for example, defines policy as a set of interrelated decisions, concerning the selection of goals and the means of achieving them within a specified situation (Heclo, 1994a). Heclo puts the emphasis on the course of action or inaction rather than on the decisions. Ferman (1990) understands public policy as whatever government chooses to do or not to do.

In this study, the research looks at the importance of both decisions and actions. Therefore, public policy is understood in this study as a course of action or inaction taken by the federal, state and local governments and that involves making decisions about goals, means and ends. The definition is suitable for the case study examined which is the Plateau State Health Policy on delivery of primary health care (PHC) services.

Having clarified the definition of public policy adopted in this study, it is important also to discuss some approaches in policy implementation literature. There are different approaches in the literature that address the problem of policy implementation and service delivery improvement

2.10.2 Implementation

Policy implementation is often seen as one vital stage in policy-making process because nearly everything done in public administration must have some bearing on implementation (Pressman et al, 1984). When public policies are made, they are only just pronunciation of intentions. Such intentions do not materialise without adequate action which is known as implementation. Writing along this line, Ikelegbe (1996) opines that adopted policy is merely a statement of intentions, expectations, goals, prescriptions, standards and requirements. It is merely a carefully drafted set of exhortations, directions and hopes. According to Adamolekun (1983), policy implementation refers to activities carried out in the light of established policies. It refers to the process of converting financial, material, technical and human inputs into outputs – goods and services. Dunsire, (1978) defines policy implementation as a stage of policy making between the establishment of a policy (such as the passage of a legislative act, the issuing of an executive order, or the promulgation of a regulatory rule) and the consequences of the policy for the people it affects. It also involves a wide variety of actions such as issuing and enforcing directives, disbursing funds, making loans, assigning and hiring personnel among others Indeed, Makinde and Egonmwan explain that studying policy implementation suggests an effort to describe and explain the process by which policies are transformed into public services, direct attention to the process of delivering public services (which is at the heart of intergovernmental system), and provide explanations for the realisation or non realisation of programme objectives . (Makinde, 2005; Egonmwan, 2004).

Policy implementation has been viewed as the most critical part of the policy process as it determines the success or failure of a policy. Scholars like deleon and deleon (2002) have agreed to this by stating that although implementation may be among the most devilish of wicked problems (for policy analysts) it remains a critical part of public policy. It is therefore, the major explanation for the failures or successes of public policies.

In the practical realm, policy implementation has been described by Egonmwan (1991) as one major problem confronting developing countries. He observes that implementation often turns out to be the graveyard of policy and where the intentions of

the designer of policies are often undermined by a constellation of powerful forces of politics and administration in co-operation with people. This explains the complexities involved in policy implementation as well as blames the designers and the implementers for frequent implementation failure. He therefore suggests the need for an analysis of policy implementation process as a pre-analysis of policy implementation process as a pre-condition for successful policy implementation.

Beckman, (2003) elaborates on this by describing implementation analysis as scrutinizing of the preliminary policy specifications to determine their clarity, precision and reasonableness, and staff, organizational and managerial capabilities to determine the degree to which the proposed policy alternative can be specified and implemented in bureaucratic/political setting. In other words, implementation analysis should investigate (i) the technical capacity to implement, (ii) political feasibility and (iii) the technical and political, strategies for implementation. William's analysis is highly illuminating as it identifies and brings to the forefront such factors that can help policy implementers overcome all potential blockages.

Emanating from this position is multi-variant dimension to the understanding of public policy implementation. This, according to Sabatier (1999), identifies governmental institutions, various levels of government, interest groups media and bureaucracy as very crucial to the understanding of public policy implementation. He is of the opinion that, while a focus on single level of government or institution is of great value in the understanding of specific decisions, it is inadequate for understanding the policy process over any length of time.

O'Toole (2000) understands it as "what happens between the establishment of a policy and its impact in the world of action." These authors focus on processes and actions taking place after a policy has been enacted.

The definition adopted by the researcher for implementation draws on elements of the above perspectives to highlight the most relevant aspects to examine when studying implementation. In this study, implementation is defined as a process that takes place between policy design and its observed results or impact. It includes decisions and interactions among different actors. Implementation cannot be fully understood without

looking also at the influence of policy content on implementation and the underlying perceptions, views and behaviours of actors associated with the policy itself.

Early studies of public policy were concerned with inputs and outputs, resources needed to achieve predefined goals and did not consider the influence of bureaucracy as well as service providers on the effectiveness of a policy (Parsons 1995). It was not until the works of Pressman and Wildavsky (1973) that attention turned specifically to policy implementation, for example what happened between goals and actual results. They were concerned about policies failing to achieve their aims and did not blame it on bad design or poor evaluation, but on those in charge of carrying them out. This opened up research opportunities in a somewhat under explored terrain. Hargrove (1975) labels policy implementation as the missing link because it had been neglected by policy analysts. From the time of this call for a deeper understanding of policy implementation, a vast literature has been created exploring it. And yet, there is still no consensus among academics or practitioners about the factors that facilitate or constrain the implementation of public policies. Implementation continues to be the missing link (Robichau and Lynn, 2009).

Three generations of implementation studies have been broadly indentified and accepted (Howlett and Ramesh 2003; Hill and Hupe, 2006). The first generation is best illustrated by the works of Pressman and Wildavsky (1973) who stress the need to scientifically explain why policies are not delivering the expected results.

The second generation is dominated by a debate between the top-down and bottom-up approaches, which take opposite analytical position on the implementation process. The subsequent wave of studies which is the third generation, aims to reconcile these approaches and suggest different analytical stands. "Top-down" approaches, also called "rational control models", indicate implementation as a logical sequence or chain of activities (Pressman and Wildavsky 1973). If implementation fails, top-down scholars argue, it is because the strategy or instruments have been wrongly selected, operationalisation was poor, or there was inadequate response to problem. For these models, what matters for effective implementation is command and control, making sure that instructions are obeyed throughout the chain (Gunn 1978 cited in Parsons 1995). They place a central role on decisions made by politicians and see implementation as the

follow-up of those decisions by administrators and service providers. Hill et al (2002) phrase this as the "implementation follows formulation and decision theorem". For example Van Meter and Van, M (1977), classic authors of this approach, highlight the role of decision-making processes by those at the top and see implementation as an administrative process. Implementation failure is about poor management and communication (Hood, 1976).

The main criticism of the top-down view is its neglect of the influence that actors within the process have on the effectiveness of implementation. That top-down view disregards the ideologies, values, beliefs and motivations of implementers (Sutton, 1999). In response, the "bottom-up" literature focuses on human interaction among actors involved in the implementation process and those affected by the policy. According to the bottom-up approach, implementers should be considered in behavioural terms rather than as elements in lines of command (Elmore 1975). Lipsky (1980) statedthat, street-level bureaucrats are the classic example of the bottom-up approach. He argues that bureaucrats in charge of delivering services possess a great deal of discretion in their actions and behaviour, giving them a degree of power to amend or even change policies. Barrett and Fudge (1981) build on this idea and argue that actors operating a policy inevitably interpret it and modify it, making decisions and, therefore, policy during the implementation stage. For the bottom-up approach, effective implementation is therefore determined mainly by the knowledge and experience of people in the front line of service delivery (Parsons, 1995).

The third generation of implementation studies encompasses hybrid theories that bring together elements of both top-down and bottom-up literature in subject (Parsons, 1995). This development was led by eminent scholars like Wildavsky, Sabatier and Elmore, who modified their initial top-down or bottom-up perspectives. For example, Elmore (1985,(in Parsons, 1995) develops the concept of "forward mapping" to complement his previous "backward mapping" analysis, where he suggests first taking into consideration the dynamics of implementers and target groups and then moving up to policymakers. Majone and Wildavsky (1978), Browne and Wildavsky (1984) Heclo (1974b), Bennett and Howlett (1992), Sabatier and Jenkins–Smith (1993) modify their understanding of implementation to learning or evolutionary process, where actors take

their experience of feedback into the process and adapt it to deliver better results (Fischer 2003; Parsons 1995). Lowi (1972) identifies "policy types", namely distributive, regulatory and redistributive, and suggest looking at different factors influencing implementation according to the policy type. The top-down/bottom-up debate was eventually overcome when policy scholars acknowledged the value of different theories and frameworks in bringing different perspectives to understanding the implementation process rather than validating one approach over another (Elmore 1979, Hill and Hupe, 2002 and Parsons, 1995).

One of the most recent contributions to the study of implementation takes the concept of governance as a base. Scholars like Hill and Hupe (2002); Saetren (2005); Robichau and Lynn (2009) put forward a model of governance for implementation studies building on a managerial approach and incorporating elements of political science. The focus is on governance that refers to the way in which collective impacts are produced in a social system (Hill and Hupe, 2002). The model identifies multiple levels of action and variables that influence performance such as citizens' preferences, public choice and policy designs, public management, service delivery, outputs and outcomes (Robichau and Lynn, 2009).

Though much has been written about what makes for effective implementation, there is no consensus about what works best under which circumstances. The different approaches and theories on the issues offer a partial view of facts or, as Allison (1971) captures it, they offer different lenses to look into policy processes focusing on some elements while blurring others policy analysis especially the field of implementation studies, needs more dialogue within itself in order to construct a better understanding or relevant issues Georgina, (2011).

2.11 Service Delivery Review

Policy implementation may be understood as public service provision if the the policies are about the provision of public services, such as health and education. From this perspective, a trend in the literature is to look at the problem of public service delivery, that is, how to get good services for all. The World Development Report (2004) is dedicated to this issue and argues for stronger accountability mechanisms in the service

delivery sequence. It describes two ways of accountability, the comunity-politicians-providers or the community-providers. It argues that, by increasing community participation, they are able to monitor service providers, and, by increasing their voice through the ballot box (for example), they increase their influence on politicians and policymakers. Some of the mechanisms the report suggested for achieving better service delivery are to separate policy-making from service delivery, contracting out, regulation of private providers, performance controls and incentives, and competition in service provision (Osborne and Gaebler, 1999; World Bank, 2003).

Ayinde (2006) describes the desired characteristics of public services as high-quality services managed efficiently and delivered equitably. He argues that models of service delivery such as trust, voice, and command and control, have not given the right incentives to service providers. Instead, he suggests a choice and completion model, where user choice together with provider struggle, may offer better incentives to providers in order to deliver high-quality services efficiently and equitably. The Nigerian health sector is a good example of the different service delivery models.

The World Development Report 2004, dedicated to public services provisioning, describes common ways of service delivery. Governments may contract services out to the private or non-profit sectors, implying that governments are still responsible for financing and provisioning, but services are delivered through non-governmental providers. They may sell concessions to the private sector, which means that the private provider pays a sum of money to the government in order to provide the service. Decentralisation is another way to organise service delivery by transferring responsibility for financing and provisioning to lower levels of government, such as local governments which is the Nigerian system of healthcare delivery (Onah, 2005; Ozor, 2004). Responsibility may also be transferred to communities or citizens themselves, who are in charge of organising service provision.

The public service delivery literature offers a framework to better understand ways of service delivery and evaluate which ones may be more suitable under certain circumstances. It focuses on how to raise service standards and the efficiency of delivery systems. This literature points out relevant issues like community participation and accountability as well as decentralisation as delivery arrangements. However, it does not

provide the necessary tools to analyse the interplay of political actors and how they can influence policy implementation. This study therefore focuses on the translation of policy into action and hence it builds primarily on other theoretical approaches. The goal is to understand how health policy is implemented and the factors that facilitate or constrain this implementation stage.

2.12 Political Economy Analysis Framework

The theoretical framework adopted for this study is the Political Economy Analysis (PEA); it enables the study to examine the political economy context, the policy implementation process, the political leadership orientation and community participation as variables affecting the state's capacity to bring about primary healthcare policy implementation. This framework allows for a more systematic observation of the intervening factors determining the political feasibility of health-policy change. This, in turn enables the study to analyse important variables that may prove valuable in analysing other health-policy experiences. It is distinguished from the materialist political economy associated with Marxism while it focuses on political economic forces, it defines economics in terms of exchange and institutions rather than production and contradictions (Ihonvbere, 1988)

Politics deals with power, authority, public life, governance, and the state and conflict resolution. Politics is the allocation of societal resources that is who gets what; it is preoccupied with taking decisions on national resources in a manner considered authoritative and legal. It has also been defined as all those activities and institutions that relate to the making of authoritative decisions for society. Economics on the other had is concerned with generation and accumulation of wealth or resources. It deals expansively with production, distribution and consumption of goods and services; it also concerns itself with the use of scarce resources to promote the material wellbeing of the society. It has further been described as a way of thinking, provision of material goods, institutions of private property and contracts, or institutional reality of market economy (Todaro, 1992; Ake, 1996). Resources are therefore controlled by both politics and economics,

Political economy is therefore the integration of politics and economics and because of important role of the two, some scholars and policy analyst believes that the two should not be separated, therefore the merger into political economy.

Political Economy is therefore a mode of analysis of the socio-economic and political forces in a society. Despite its long tradition in social sciences, Political Economy Analysis framework has only been taken up relatively recently by development agencies with a view to informing aid strategies and programmes. There is no single conceptual framework for political economy analysis, but the following OECD-DAC definition is useful in capturing some of the main elements (DFID, 2009).

Political economy analysis is concerned with the interaction of political and economic processes in a society, the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time. This definition draws particular attention to politics, understood in terms of contestation and bargaining between interest groups with competing claims over rights and resources. However, it is equally concerned with the economic processes that generate wealth, and that influence how political choices are made.

In reality these processes are closely inter-related and part of a unified set of dynamics which influence development outcomes. Political Economy Analysis is particularly useful for development practitioners since it helps to understand what drives political behaviour, how this shapes particular policies and programmes, who are the main winners and losers and what the implications are for development strategies and programmes (DFID, 2009).

Political Economy Analysis bridges the traditional concerns of politics and economics, it focuses on how power and resources are distributed and contested in different contexts and the implications for development outcomes. It gets beneath the formal structures to reveal the underlying interests, incentives and institutions that enable or frustrate development. Such insights are important if we are to advance challenging agendas around governance, economic growth and service delivery, which experience has shown do not lend themselves to technical solutions alone.

Political Economy Analysis provides a sophisticated account of the deep structures and institutions shaping a state's or country's development. It is concerned

with the interaction of political and economic processes in society; the distribution of power and wealth between different groups and individuals as well as the processes that create, sustain and transforms these relationships over time (Kelsall, 2010; DFID, 2009). The model offers a way to identify and understand the structures, political and institutional factors that influence how policy process operates in practice. It goes beneath the formal structures to reveal the underlying interest, incentives and institutions that enable or frustrate change (DFID, 2009).

With reference to Health Policy, Political Economy Analysis helps to unravel the web of political, ideological and institutional interest that drive policy and programme implementation alongside making the logic behind the choices and preferences clearer. It is important to understand these drivers of policy choice so that future policies can be sensitive to domestic geopolitical and economic realities. Using Political Economy Analysis involves analysing institutions, actors and ideas involved with the policy, their dynamics, interconnectedness and mutual influence (Agbaje and Adebanwi, 2003; Allen, 1992).

Institution: Institution is a system of rules that regulate behaviour by establishing norms, rewarding compliance and punishing violations. A range of formal and informal institutional factors and motivations shapes state health policy choices. Analysis of formal and informal political, economic and social institutions and processes of Plateau State health policy and programme implementation is required in this study. According to Anderson (1975), an institution is a set of regularised patterns of human behaviour that persists over time. By this, Anderson explains that institutions are not represented by physical structures in which the human behaviour exists. It is the differing sets of behaviour, called rules and structures that distinguish one institution from another. Hague and Harrop, (1982 cited in Olaniyi, 1998) state that institutional structures and rules, as well as arrangements and procedures have significant impact on public policy. Anderson (1975) adds that the institutional theory focuses on the formal institutions of government such as legislature, executive and judiciary, while less regard is given to organisations such as pressure group or the mass media or the wide social context within which government operates.

Actors: Actors are constituted by a wide range of international, national, state and local Actors involved in the debate about what and how healthcare is delivered in Africa. These actors imitate WHO programmes to further the institutional arms and political interests in their countries. The study will analyse the types of incentives and motivations faced by key stakeholders involved in health policy on the following terms: What are their views on the policy, and how do they justify those views? To what extent are they able to influence implementation of health policy in PHC delivery?

Ideas: Governments operate within a paradigm of ideas. The study analyses dominant ideas held by key elite, actors, individual and the public about health policy, the role of government in mediating between citizens and the state (health policy), and the merit of state support.

Political economy analysis is not a magic bullet for the resolution of intractable development problems. However, it can support more effective and politically feasible development strategies, as well as inform more realistic expectations of what can be achieved, and the risks involved. It can also contribute to better results by identifying where the main opportunities and barriers for policy reform exist and how donors can use their programming and influencing tools to promote positive change.

Political economy goes beyond simple economics to include social and institutional processes through which economic and political elite choose to allocate resources for their own benefit and then to the wider population (Todaro, 1992). It deals with ways in which politics determines or influences economic activities. Or, how economic circumstances and institutions determine or influence political institutions and processes. Primary Health Care (PHC) is the conceptual product of a specific political economy. It must be understood from the historical context of the global (but particularly European and American) political economy.

In Perspectives on Positive Political Economy Model, Alt et al (1990) posit that for a political system to be instrumental to economic growth, it must have the capacity to offer what they designate as an enabling environment, defined in terms of political stability, respect for human and minority rights, rule of law, minimal official corruption, fiscal discipline and policy fidelity. An assessment of the enabling environment of the

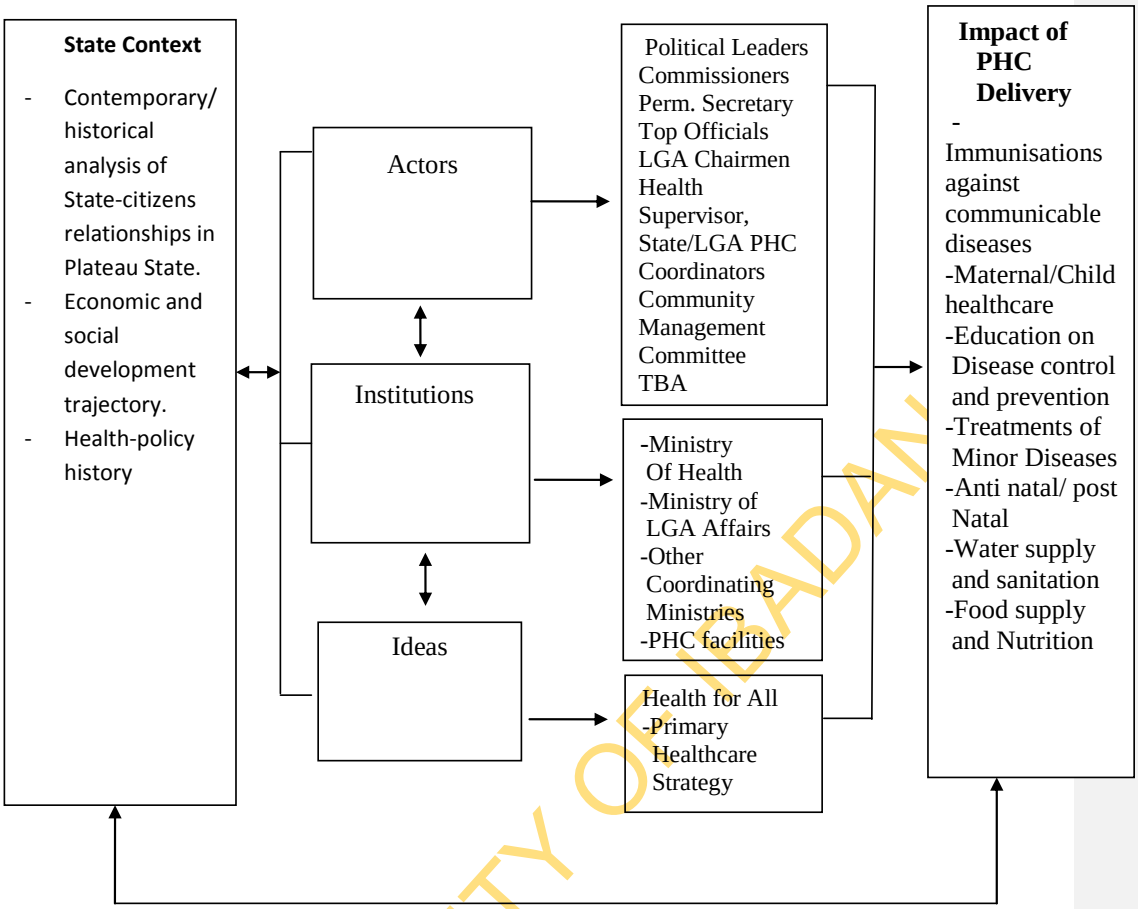
Plateau State political system by reference to some of these indicators is what we undertake in what follows. Our specific focus is on political leadership legitimacy and political stability because of their fundamentality.

The study concentrates on the elements that enhance the political feasibility of implementing the primary healthcare policy by looking at the state's capacity to bring about policy implementation and thus the political feasibility of healthcare delivery is affected by some elements, which is the political economy context of the country, including its institutions, rules of governance, key actors, and policy implementation process, including policymakers' interests acting within the political context to pursue their policy agendas; the political leadership orientation and the community participation in the implementation of the policy.

When a health initiative reaches the public agenda, the country's political economy and the policy process unleashed within it present a series of opportunities and obstacles for its successful implementation. Policymakers interested in promoting the implementation will follow a series of political strategies to enhance the state's capacity to bring about the delivery of the services, and thus increase the political feasibility of the health policy.

The opportunities and limitations presented by the political economy of the country and the policy process on the one hand, and the state's response to them on the other, converge in this change team that is in charge of formulating and implementing the policy. The ability of these policymakers to manoeuvre within this setting has a direct impact on, and reflects the state's capacity to pursue its agenda on health-policy reform. The change team uses a combination of technical skills and political manoeuvrings to build support for the policy implementation and enhance the probability of successfully challenging political leaders' resistance to change. The change team's capacity for strategic political manoeuvring during the health-reform process will prove as determinant to its accomplishment, as the team's technical capacity to implement the policy (Ekekwe, 1985, DFID, 2003a).

Fig. 2.2: Political Economy Analytical Framework for the Study



Author, 2013

In summary, the study has drawn on a number of important anchors for use from the review of literature on public policy and healthcare policy. It is clear that there are two main approaches in the literature that address the problem in policy implementation and service delivery improvements. One approach studies it from a policy analysis perspective and the other in terms of public service delivery. Service delivery has a more practical approach whereas policy analysis is more interested in theorising. The bodies of literature highlight the relevance of factors involved in policy process and, in particular, policy implementation. Views, interest and perceptions of policy actors in respect of the policy, decentralisation of services in delivery of services, community participation as accountability mechanism, performance controls and incentives, institutions as well as in the economic and socio-political contexts are recurrent issues in the debate. To contradict analytical framework, the thesis condensed these into some categories of factors such as roles played by political leadership and other actors' views about the policy, service delivery arrangements, community participation, and institutional managerial practices in place, all in the context of political economy framework.

Having noted the above literature perspectives, this thesis explores the field in order to develop an explanatory tool to investigate why the health policy in Plateau State has not led to quality primary healthcare delivery in the state. By reviewing the position of the selective policy advocates, it becomes apparent that policies ought to meet implementation test. The pursuit of an appropriate framework began with consideration of various policy analysis, especially implementation theories, with the aim of establishing an overall theoretical framework to analyse the implementation of health policy in delivery of PHC services in Plateau State from 1990 to 2010.

CHAPTER THREE
METHODOLOGY

A research method is a strategy of inquiry that moves from the individual researcher's underlying philosophical assumptions to the research design, data collection techniques, data analysis techniques and result interpretation (Kumekpor, 2002; Singleton et al, 1998; Berg, 1989). Generally, scientific research is based on some basic assumptions about the nature of physical and social reality related to valid knowledge about the phenomenon underlying the research, which influences methodology or what is considered acceptable methods for obtaining knowledge or methodology (Boudreau et al, 2001; Chen and Hirschheim, 2004; Galliers, 1985).

This research is essentially a policy-focused empirical investigation into the implementation of PHC delivery as enumerated by the primary healthcare policy in Plateau State

3. 1 Research Design

The study adopted survey and case study research designs. The study, following the guide of Alan Warner (2004), adopted a combination of methods which is flexible, eclectic and pragmatic. Many authors, including Berg, (1998); Klein and Myers (1999) proposed using both qualitative and quantitative methods in obtaining research information. The combination of methods was applied and it helped in exploring the phenomenon from different perspectives (McGrath, 1982). The strength of such a research is its ability to deal with a broad variety of data.

3.2 Data Collection

Data collection, in a mixed-method study, involves techniques such as interviews, questionnaires, focus group discussions and observations. For the collection of data in this study, two main sources found useful for pursuing the research objectives were primary and secondary data. Primary data was obtained through both qualitative and quantitative methods. The qualitative data were obtained through in-depth interview (IDI), while the quantitative data were collected through the use of two sets of questionnaires. Secondary data were collected from publications and works done by other

studies which were not primarily for the purpose of this study. The sources of such data were libraries, internet, personal purchase of secondary materials and direct sources like government establishments, agencies and non-governmental organisations.

3.2.1 Primary Sources

The research involved the use of both qualitative and quantitative data. For quantitative data, two basic survey instruments (questionnaires) were enlisted. The quantitative data were collected through administration of the questionnaire on public healthcare delivery facilities (PHC facility staff) and beneficiaries of PHC services presented in a measureable unit as households. The first set of questionnaires was administered to the PHC staff (health workers) at public primary healthcare facilities in selected areas to elicit information on general facility characteristics and conditions, type and quality of services provided, resources, working environment and incentives, while the second set of questionnaire was administered on the beneficiaries (households) to investigate the level of satisfaction and participation in the implementation of the policy.

Qualitative data were obtained through in-depth interview (IDI) with government officials at both the state and local governments' levels which had jurisdiction over the health facilities. Thirty (30) in-depth interviews were conducted to determine the issues and challenges of implementation of the policy. The interviews were conducted in a manner to further elicit the views and insights of participants on key issue areas concerning the delivery of PHC services. The interviews helped to clarify their interests, opinions, expectations and challenges of the various segments of the primary health policy implementation. Considerable details were first-hand accounts of the implementers' experiences and opinions as implementers and policy drivers.

3.2.2 Secondary Sources

To complement data from the field, the researcher collected secondary data from publications and works done by other studies which were not primarily for the purpose of this study. The sources for such data were libraries, internet, books, journals and periodicals and other direct sources like government establishment reports from ministries involved in healthcare delivery (Ministry of Health, Ministry of Local Government and Chieftaincy Affairs, National Population Commission and Ministry of Finance), other agencies and non-governmental organisations.

3.3 Data Collection Instruments

A combination of instruments such as questionnaire, key informant interviews guides, and content analysis of documents from primary and secondary sources provided the instrumentation for the study. For survey research instrument design, the study adopted the closed ended questionnaire design with the last question left open-ended to allow for an objective response. The questionnaire was characterised with options for the respondent to select from. The variables investigated for the health facility questionnaire were captured in questions which were divided into six sections. The first set of the questionnaire was administered at the facility level to examine PHC service delivery. The socio-demographic characteristics of health workers were covered in the first section. Section two consisted of the conditions and characteristics of the health facilities while sections three, four and five looked into the types of services and quality of services provided as well as the availability of resources (human and material). Lastly, section six focused on the health workers' motivation and accountability alongside the involvement of communities in the implementation of the policy.

The household questionnaire was designed to elicit information such as the personal characteristics of respondents' awareness of health facilities and their patronage, satisfaction with quality of services and types of services received in the public PHC facilities, and also assessed the level of participation of the communities through the respective health management committees in the communities in enhancing the accountability of service delivery providers.

For the qualitative data, a total of 30 interviews were conducted with persons concerned with the implementation and monitoring of the healthcare delivery at the state and local government levels. At first interaction, a brief introduction about the study was given and informants' participation was requested. Further to the informants' agreement to participate, a detailed inquiry was made to obtain appointment for interview that included information about nature of interview, recording of interview, confidentiality and approximate time required. Due to the busy schedules of informants, they were given option of being interviewed in two or more sessions if they were unable to spare time for the interview to be concluded in one session.

Interviews were mostly rescheduled due to the busy nature of informants and some interviews were done in two sessions as informants were busy; the second session usually started by providing summary of the previous session. Before the actual interview call, the researcher interacted with all informants one or more times to build trust. The rescheduling of interview, though inconvenient, was considered positive by the researcher as it provided the opportunity to interact more with informants, thus decreasing the communication gap, building trust and later allowing free discussion in interview. Although the primary language used in the interview sessions was English, the researcher and the informants used Hausa words and phrases to support and elaborate their points of view.

An interview guide was used to conduct the interviews, as a way of focusing the interview to ensure that similar data were collected from each participant (Kvale, 1996).

An interview log was maintained for each interview and notes were taken during interviews to guide the discussion as well as save impressions and feelings during the interview. These notes were further utilised at the analysis step to augment open coding and guide analysis, considering their importance as a data source as depicted by Kvale, (1996). At the end of the interviews, all informants were told that, if they were interested, the researcher would provide the transcript of interview to check for corrections and present the main findings of study.

All interviews were transcribed verbatim in English by the researcher and later checked by independent persons for accuracy. To assure confidentiality, however, informants' names and identities were not included as in transcripts. Afterwards the transcription was done for the purpose of the analysis.

3.4 The Study Population and Sampling Process

An important issue to consider when designing a research study is the type and number of people to include in the study. This is imperative because it enables the researcher to study a relatively small part of the larger population and yet obtain data that are representative of the whole (Berg, 1998). Sampling is the use of definite procedure in the selection of a part from the population (Kumekpor, 2002). It involves selection of a

portion of the population which is considered to be a representative of the population to be investigated (Kumekpor, 2002).

The study area is Plateau State, made up of 17 LGAs divided into three senatorial districts: northern senatorial districts (Jos/North, Jos /South, Jos/ East, Bassa, Barkin–Ladi, Riyom) , southern senatorial districts (Quanpan, Shendam, Wase, Langtang-North, Langtang-South, Kanam) and central senatorial districts (Mangu, Bokkos, Pankshin, Mikang, Kanke). In order to be sure of a wide coverage and representation, a multi-stage random sampling technique was employed in selecting the samples used in the survey. From the 17 LGAs that are divided into the three senatorial districts, one LGA was randomly selected out of each senatorial district; giving a total of three LGAs selected for the study, the selection of specific communities was determined by the presence of PHC facilities and urban/rural characteristics.

This constitutes the first stage of the sampling process, and the three randomly selected representation of the 17 LGAs. The selected LGAs are Barkin-Ladi (Northern senatorial zone), Langtang-North (Southern senatorial zone) and Pankshin (Central senatorial zone). The second stage involved the selection of four health districts from each of the three selected LGAs, giving a total of 12 health districts, and 36 Primary Health Care facilities were selected for the survey in the health districts.

3.4.1 Sample Frame

The population frame of the three selected LGAs of the study (a total of 433, 844 shared as 158,556; 180, 581 and 94,707 among for Barkin-Ladi, Pankshin and Langtang-North respectively) constituted the sample frame. For the second stage of the sampling process, four health districts were selected from each of the 3 selected LGAs. For Barkin-Ladi LGA, the four focal health districts randomly selected were Heipang, Ban, Rakwok and Mazat. For Pankshin LGA, they were Balang-Shippang, Pankshin-Town, Duk and Fumbi. For Langtang LGA, they were Lipchock and Pilgani, Zamzhimin and Keller. From the 12 health districts selected, 36 healthcare facilities for the survey were selected.

3.4.2 Sample Size

A total of 108 healthcare facility staff responded to the facility questionnaire out of 120 administered and 903 households responded to the household questionnaire out of 1200 administered, both representing the sample size for both facility and household questionnaire. Respondents (30) for the interview were purposively selected based on the roles and responsibilities they were playing or had played in the implementation of the policy in Plateau State at the state and local government levels. Key actors at the state level interviewed included politicians (elected representatives), commissioners for health, permanent secretary of the Ministry of Health, directors in the Ministry of Health and other identified key stakeholders involved in the implementation of health policy in the state. At the local government level, those interviewed were the chairmen of the selected local government areas (Barkin-Ladi and Langtang North LGAs); in Pankshin LGA, the chairman could not be contacted in person but he directed the local government secretary to grant the researcher interview on his behalf was after being reached on phone by the researcher. Three PHC coordinators were from the selected LGAs, health supervisory councillors and community management committee members of selected communities and traditional birth attendants.

3. 5 Data Analysis

The data collected from the survey were analysed, using the Statistical Package for Social Science (SPSS). Both descriptive and inferential statistics were employed in analysing the data generated. The descriptive statistics included frequency tables, percentages and pie charts. Regression and Chi square linear trend analysis were performed as appropriate.

The hypotheses formulated were analysed, using statistical analysis method. The two hypotheses were tested, using regression model. Regression is used whenever relationship between two variables exists so as to predict or forecast and logistic regression was utilised. The question coding format for regression analysis given for the first hypothesis is:

For *Y* variables, the variables question is the quality of health received.

While the *X* variables include the type of services provided.

For the second hypothesis, the question coding format for regression analysis is given as:

For *Y* variables is coded as the quality of services.

While *X* variables is coded as community participation.

The equation is given as:

$Y = a + bx_1 + b_2 x_2 + b_3 x_3 + b_n x_n + e$

Where Y= independent variable

a = intercept

$b_{1=}$ Coefficient of the X variables

X_1 signifies the variables and e = the error term.

Secondary data and interviews were subjected to qualitative content analysis. Interviews recorded with the permission of the interviewees were transcribed and, in cases where only notes were used, it was manually transcribed with the promise to preserve the anonymity of the interviewees where they did not want their names divulged, while survey data collected was analysed using descriptive statistics. The qualitative data were used to triangulate the quantitative data to establish reasonable veracity of responses.

3. 6 Description of Study Area

Nigeria, Africa's most populous country, is socially and culturally diverse, with over 250 ethnic groups. Nigeria is a three-tier federation made up of a Federal Capital Territory (Abuja) and 36 states which are divided into 774 local government areas (LGAs). The states and local governments constitute the sub-national governments, grouped into six geopolitical zones, namely the North Central, North East, North West, South East, South-South and South West zones. The LGAs are further sub-divided into 9,565 wards. The ward is the smallest political structure, consisting of a geographical area with a population range of 10,000 to 30,000 people (National Bureau of Statistic, 2009). There are on average, 10 wards per LGA. The ward is the operational area for delivering a minimum healthcare package and same ward is expected to mobilise political commitment for health service delivery and social development. Structurally, each ward

has a Ward Development Committee (WDC) with the functions of identifying the health and social needs of the ward and planning solutions.

Nigeria has a projected 2015 population of 180,821,353 million, with an annual growth rate of 3.2%. A gender disaggregated distribution of the population reflects a 51% male and 49% female composition. Children under five account for 20% of the population and young people under 15 years account for 42% of the population (National Bureau of Statistics, 2013).

Nigeria was ranked 158 out of 177 countries in 2005 United Nations Development Programme (UNDP) Human Development Index. For nearly all the socio-economic indicators, the southern region of the country is significantly better off than the northern region (World Bank, 2007).

Politically, after several decades of military rule, Nigeria returned to democratic governance in 1999. The 1999 Constitution continued the presidential traditions first established by the 1979 Constitution, which was particularly designed to ensure a high degree of separation of powers and checks and balances among the three arms of government. Nigeria is governed by the Peoples Democratic Party (PDP), which has won national elections since 1999. However, opposition parties have won elections in several states in various parts of the country. In the 2011 general elections, the PDP won the gubernatorial election in 28 states. Given Nigeria's federal system, issues of revenue sharing among the various tiers of governments that constitute the federation dominate intergovernmental relations. The 36 states, the Federal Capital Territory (Abuja) and the 774 local governments share about 45 per cent of consolidated revenue of the federation while the Federal Government controls the rest 55% (National Planning Commission, 2004).

The Federal Government has statutory powers to control the sub-national governments for macro-stabilisation. Apart from this, areas such as primary and secondary education, primary and secondary healthcare services, rural roads and infrastructure, water and sanitation and community services, with direct implications for human development and poverty reduction are assigned to both the national and sub-national tiers of government

Nigeria has experienced high levels of economic growth since 2005 while oil revenue has been increasing. Between 2005 and 2006, Nigeria repaid $12billion of its debt to the Paris Club to achieve debt cancellation of $18 billion. But its economy remains largely a mono-mineral economy with oil accounting for about 20% of GDP and 80% of foreign earnings. Nigeria's Gross Domestic Product (GDP) at 1990 constant basic price was about N888billion with the economy averaging a growth rate of 5.6% in 1999-2007 and 6.7% in 2005-2012. The GDP per capita (at constant 2010 $US), as at 2012, was 1071.52, with an average growth rate of 4.2% in 2006-2012 (National Bureau of Statistics, 2013).

The economy has been experiencing structural changes in terms of contribution of sectors to the GDP. The contribution of agriculture which constituted about 64.1% of the GDP in 1960 declined to 42.2% in 2007 and 39.2% in 2012. Industry (which comprises crude oil and gas, and manufacturing) contribution to the GDP which was about 15.3% in 1970 rose to 30.4% in 2004, and has been declined to 23.4% in 2007 and 18.3% in 2012 (National Bureau of Statistics, 2013).

The services sector, which comprises the advancing telecommunication sector, trends an increasing proportion of 9.8% in 1981 to 16.2% in 2007, and 20.3% in 2012. This can be explained by the developmental reforms in the financial sector and telecommunications industry. The transformation in the telecommunications service sub-sector has led to increase in the number of telephone lines, subscribers and services providers, and created massive employment within the country. The World Development Indicator shows that the mobile cellular subscription per 100 people was about 67.68 in 2012 (National Bureau of Statistics, 2013).

Though, the trend above shows the structural change in the dependence of the economy towards one sector, the economy can still be said to be agrarian and primary in nature, as major proportion of its domestic product is from agriculture. The dependence of the economy on the oil sector cannot also be overemphasised as oil revenue accounted for 26.2 per cent of GDP, 89.8 per cent of foreign exchange receipts and 83.0 per cent of government revenue in 2003-2007. The crude oil and gas proportion of exports was about 96.8% in 2007 and oil revenue accounted for 75.3% of federally-collected revenue in 2012 (National Bureau of Statistics, 2013,).

The analysis shows an economy that has been experiencing growth over the last decade. However, the distribution of these increasing income and resources has been a source of concern to policymakers over time, given the exacerbating poverty level in the country. The resource allocation across its tiers of government has been a source of recurring debate. In March 2004, the Federal Government issued a modification that increased states' share of the Federation Account to 26.7% and reduced Federal Government's share to 52.7%, which currently serves as the threshold. .

Plateau State

Plateau State is the twelfth largest state in Nigeria and the main focus of this study; it is roughly located in the centre of the country and it is geographically unique in Nigeria because its boundaries totally surround the Jos plateau, having the Jos plateau totally in its central and northern parts. Plateau State is located in Nigeria's middle belt, with an area of 26, 899 square kilometres. It is located between latitude 80^0 24 N east and 100^0 38 east. The state is named after the picturesque Jos plateau, a mountainous area in the north of the state with captivating rock formations. Bare rocks are scattered across the grasslands, which cover the plateaus. The altitude ranges from around 1, 200 metres to a peak of 1,829 metres above sea level in the Shere Hills range near Jos. Years of tin mining have also left the areas drawn with deep gorges and lakes (PSEED, 2006).

Though situated in the tropical zone, a higher altitude means that Plateau State has area temperature climate with an average temperature of between 18 and 22^0 c. Harmattan winds causes the coldest weather between December and February. The warmest temperature occurs in the dry season months of March and April; hence annual rainfall varies from 131.75cm (52in) in the southern part to 146cm (57in) on the plateau. The highest rainfall is recorded during wet season months of July and August. The average lower temperature in Plateau State has led to a reduced incidence of tropical diseases such as malaria. About 75% of the population live in the rural areas, while 25% live in the urban areas. With Jos as the capital city, the state is divided into three senatorial zones, and 17 local government areas. The indigenes are predominantly farmers of cereals like millet, guinea corn, sorghum, and a few tubers like potatoes, yam and

cassava. The people are predominantly Christians, living with some Muslims and few traditional religious adherents (Plateau State Government, 2012).

Plateau State is home to a number of ethnic minorities in Nigeria. There are over 30 ethno-lingual groups in the state. The more dominant groups are Birom, Angas, Mwaghavul, Tarok and Afizere. The unique climatic condition, rich soils, abundant natural resources and hospitality of the minority groups have partly made Plateau State a miniature Nigeria and home to expatriates. These have also made it possible for Federal Government agencies to be located in the state and businesses to flourish. Plateau State has become the administrative and commercial nerve of the Middle Belt region of Nigeria.

The British began to exert colonial control of Nigeria in the early 20th century. At that time, much of Plateau State was part of Bauchi province. In 1926, Plateau province made up of Jos and Pankshin divisions was carved out of Bauchi. The border changed several times in subsequent years as the government sought not to split ethnic groups. In May 1967, Benue Plateau provinces were merged to form the large Benue-Plateau State. At that time, Nigeria had 12 states. Following the civil war, Benue-Plateau was one several large states which were further split up following pressure on the Federal Government. Under the military administration of General Murtala Muhammed, the country was further divided into 19 states in 1976 and Plateau State was created from Benue-Plateau covering the original Plateau province. In 1996, Plateau State was further sub-divided to create Nassarawa State out of the western half of Plateau State by Sani Abacha's military regime (Plateau State Government, 2012).

The Plateau State administrative structure consists of the cabinet, the house of assembly and local government areas. The state government is run by the Governor, Deputy-Governor, and Secretary to the State Government, Commissioners (cabinet members), Special Advisers, Permanent Secretaries, Board Chairmen and General Managers. In 1976, Plateau State had 14 local government areas (LGAs). New LGAs were curved out of the large area in 1989, 1991 and 1996 so that Plateau State is subdivided into 17 LGAs at the moment. Local governments are headed by a chairman and elected councillors who make up the legislative arm.

Plateau State, with a population of 3,383, 027, makes up about 2.3% of Nigeria's 148 million citizens (2008). Its estimated population for 2015 is 4,131870 based on an annual growth rate of 2.83%. Its estimated annual primary school enrolment is 775, 601. Similar to the rest of the country, the predominant occupation of its population is agriculture although a significant proportion of the population is involved in mining. Its internally-generated revenue comes mainly from Federal Government allocation (Plateau State Health Strategic Plan, 2010).

The Plateau State economy is mainly agrarian as over 70% of the population engages in agriculture or related areas. Despite the resource endowments in agriculture, tourism and solid minerals, the state is economically backward. About 70% is of the state population are believed to be poor. Only 23% of the rural populace have access to clean water, and only 15% have access to sanitation. The adult literacy rate is estimated at 56%. This means that about 44% of the adults are illiterate PSEED, 2006).

Some of the problems inhibiting the growth of the state economy are the very high dependence on the Federal Government where over 90% of the revenue in the state comes from federal allocation. Internally-generated revenue (IGR) is only about 10% or less. Also, there is public sector dominance in the production and consumption. The state government is the single largest employer of labour in the state. As a result, over 65% of the state's revenue is spent on recurrent expenditure, leaving about 35% or less for capital expenditure and service delivery. Another factor is the issue of corruption, characterised by over-invoicing, non-adherence to due process in tendering, procurement, employments and appointments (National Bureau of Statistics, 2013. This system has encouraged the current rent-seeking of the populace. A lot of people therefore prefer contract awards and supplies rather than engage in production and manufacturing. The other factor is inadequate infrastructure and basic amenities such as roads, water, electricity and healthcare. The absence of these tends to discourage the private sector from investing in the state as they have to provide for their own infrastructure which adds up to their overhead and operating cost.

3.7 Respondents' Location

One hundred and eight (108) out of one hundred and twenty distributed questionnaire for the health facility staff responded to the facility questionnaire drawn from 36 PHC facilities in 12 health districts of the three selected local government areas (Barkin-Ladi, Pankshin and Langtang-North). A total of 36 public PHC facilities were surveyed in 12 health districts from three LGAs in Plateau State (Barkin-Ladi, Langtang-North and Pankshin). Barkin-Ladi facilities were geographically more proximate to referral centres, as well as to a range of private facilities when compared to those in Pankshin and Langtang-North LGAs, perhaps as a result of Barki-Ladi LGA's nearness to the state capital (Jos) where most private health facilities are located plus the two tertiary (Jos University Teaching Hospital and Plateau Specialist Hospital) facilities owned by the federal and state's government.

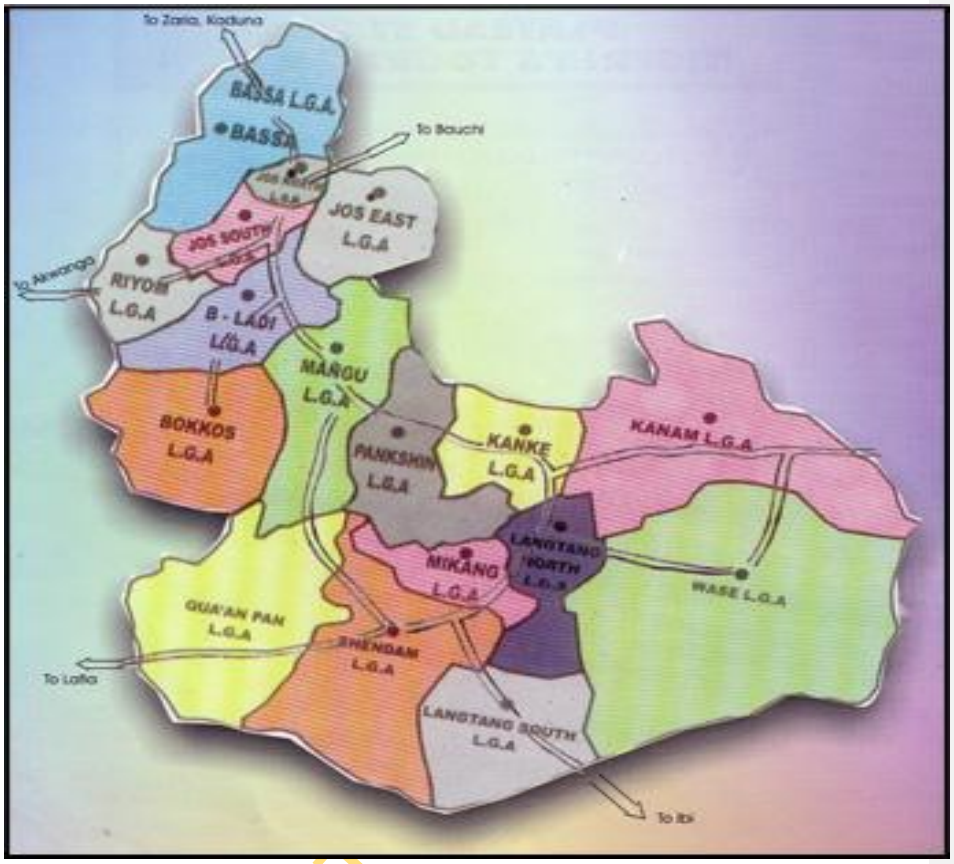
Table 3.1 indicates that majority of the respondents were from Pankshin (41.7%) which has more number of health facilities surveyed due to the large nature of the LG, Barkin-Ladi accounts for 33.3 per cent while Langtang-North Local Government Area records 25 per cent, indicating the lowest.

Table 3.1. Location of Respondents

Health District	LGA	Frequency	Percentage
Heigpang Ban Rakwok Mazat	Barkin-Ladi	36	33.3%
Balang Shippang Pankshin Duk Fumbi	Pankshin	45	41.7%
Lipchock Pilgani Zamzhimin Keller	Langtang-north	27	25
Total	3 LGAs	108	100%

Source: Survey Data, (Author's Field work, 2012).

Plate 3.1 Map of Plateau State



Source: www.plateaustategov.org

CHAPTER FOUR

CONTENT ANALYSIS OF PLATEAU STATE PRIMARY HEALTHCARE POLICY

4.0 Introduction

This chapter analyses the Plateau State PHC policy document to address the first objective of the study that answers the first research question on whether Plateau State indeed has a comprehensive health policy based on the principles of PHC as a strategy required by the overall national health policy for attainment of Health for All. The chapter is divided into sections: the first section describes policy implications of PHC strategy as recommended by WHO to its member-nations and how its principles can be operationalised for policy implications. The second section offers a brief overview of PHC delivery in Nigeria, while the third section focuses on the content of Plateau State PHC policy by reviewing major areas of the policy and, lastly, discussions of the findings of the first research objective are presented.

To analyse the first objective of the study, qualitative research method was used. This method included document analysis and interviews of key actors/stakeholders involved with the primary health policy process in the state. In analysing the content of the policy, particular attention has been paid to indicating how far the policymakers in Plateau State followed the principles of PHC strategy as recommended by the national one (such as equity, participation and collaboration) to ensure proper implementation. Interviews were conducted with some key stakeholders involved with the primary healthcare policy at the local and state levels. The views, opinions and experiences of the interviewees on the PHC policy in the state were sought. Key areas in the 1992 Plateau PHC policy are analysed to find out whether the policymakers have considered the PHC strategy in the policy document.

4.1 Policy Implications of PHC Strategy by World Health Organisation

The WHO initiated the concept of Health for All (HFA) as a goal for all its member states in 1977 to achieve universal healthcare through the primary healthcare strategy (McDonald, 1992). The HFA concept advanced a vision to attain a level of health that would permit all people to lead socially and economically productive lives

(WHO, 1997). With the emergence of the HFA concept like health promotion, prevention and environmental health, the biomedical model of health came under increasing criticism. Governments and international organisations began to realise that the biomedical model of health did not provide solutions to the social and environmental causes of new health problems. Accordingly, it was considered important to pay attention not only to healthcare services and biological determinants of health but also to the socio-cultural, economic and environmental determinants (Brener, 1979; Naidoo and Wills, 2000; Doyal, 1979; WHO, 1997). To meet the new challenge, WHO launched primary healthcare (PHC) at the Alma Ata Conference in 1978 ((HERFON 2006; HERFON 2008) as a strategy to attain the goals of Health for All (HFA) with the values and principles to guide action and policy for health at global, regional, national and local levels (WHO, 1997). The PHC strategy is aimed at unifying the comprehensive health field covering important determinants of health such as human biology, environment, lifestyle, and healthcare services in order to formulate clear health policies that can offer policy goals and interventions covering all the important determinants of health of a nation (WHO, 1997).

In order to achieve the mission of primary healthcare strategy, WHO argues that countries should either formulate new health policies or upgrade their existing policies in accordance with HFA that addresses the principles of PHC approach (WHO, 2000). The principles of PHC must be realised through the formulation and implementation of health policies (WHO, 2004). Many developed countries reformulated their health policies by following the mission of HFA (WHO, 1994). For example, the Swedish government tried to reform its health policy by considering all the important determinants of health, particularly environment and lifestyle in addressing health problems such as cardiovascular disease, mental illness, tumours, injuries and respiratory diseases (de Leeuw, 1999). New South Wales reformed health policies by considering the impact of broader political, economic and social forces upon health of the people in controlling the problem of drug abuse and child abuse (de Leeuw, 1999). New Zealand tried to promote health by ensuring wider participation and collaboration in policy making and implementation in order to reorient its health services, attain equity, and ensure accessibility of health services particularly in remote rural areas (Fleury, et al, 2000). In

the case of developing countries implementation of the principles of the PHC in policy formulation may cause problems because many countries experience a *double* burden of *traditional* infectious diseases (like malaria, diarrhoea, tuberculosis) and *modern* health problems (like HIV/AIDS, cancer, diabetes, accidents, drug abuse), and because resources are lacking and infrastructural conditions are poor.

In developing countries, Nigeria - also took the initiatives of adopting the PHC strategy in the formulation of its national health policy which serves as the guideline to state governments to ensuring they abide by the recommendations, but in developing countries the assurance of equity and wider participation in health policies is more difficult because there are social, economic, gender, territorial, and professional inequalities. In such a wider context policymakers need to formulate health policies that can offer not only delivery of health services but can also enhance socio-cultural and economic environment in order to empower people in enabling them to achieve desired goals and services in an equitable and sustainable way. Health policy should create supportive environments that enable all the people to combat health problems and attain/develop a healthy life. In such an environment, people are enabled to make choices in reducing health risks and developing healthy lifestyles irrespective of their gender and income (Collins et al, 1999; de Leeuw, 1999). Assuring equity through policy interventions can provide equal services for people with equal needs and working to reduce known inequalities in health.

Health policy needs to develop a wider participation in the health policy process in order to create health-enhancing environment (physical, political, economic and socio-cultural), recognising health needs of people and looking for solutions which citizens need (Moukhyer, 2005; Abdulraheem, et al, 2012.). Health policy interventions may help in decentralising health system and creating a space for wider participation from communities, groups, professionals and NGOs in creating health-enhancing environment. Similarly, it is the health policy that can introduce institutional arrangements and structures through which people can participate in the health-policy process. Furthermore, participation in the health-policy process can make health programmes more effective, accessible and sustainable through wider participation (Ali, 2000; Howatt et al., 2001).

Besides equity and participation, it is recommended that health policymakers need to realise collaboration in developing health policy and realising policy goals to offer ways, methods and opportunities that can develop collaboration in order to bring many sectors, agencies and people together towards achieving the goal of good health in accordance with HFA (WHO, 1997). The role of health policy is also important in maintaining positive and smooth working relationships among various sectors and actors that collaborate for the purpose of promoting health (Morley, et al, 1983).

4.2 A Brief Overview of PHC Policy in Nigeria

In Nigeria, local governments Areas (LGAs) are established and recognised as the third tier of government responsible for delivering some public services including primary healthcare delivery. These service deliveries are the responsibility of the local governments and they are entitled to statutory allocations from both the federal and state governments for the discharge of these duties. Under the Nigerian concurrent legislative list, the 1999 Constitution allows the provision of a decentralised healthcare system across the three tiers of government that is federal, state and local governments. It is constitutionally-recognised that local government agents have the principal authority and responsibility for PHC delivery.

In the late 1980s, there was a national initiative to overhaul the primary healthcare system through the adoption of a new national health policy in the context of which the federal and state governments issued directives giving local government full jurisdiction over the delivery of primary healthcare services. The national health policy document, revised in 2004, indicates that local governments are expected to be the main implementers of primary healthcare programmes, with the Federal Government being responsible for formulating overall policy and monitoring while state governments are providing logistical support to the LGAs such as personnel training, financial assistance, planning and operations.

At the federal level, the National Primary Health Care Development Agency (NPHCDA) has the mandate to support the provision of primary healthcare through a community health model. The agency is to mobilise financial, human and technological resources for PHCs throughout the country and provide technical support to states and

LGAs. As part of this support, it is to develop PHC standards and guidelines to monitor, supervise and evaluate the delivery of PHC services across the country. NPHCDA, (2001)

At the state level, the ministries of health are responsible for health-policy formulations based on the requirements of the national health policy and ensuring that local governments carry out their responsibility of primary healthcare delivery. The key health players at the state level include the commissioner for health, the permanent secretary for Ministry of Health, directors such as the Director of Public Health, Director of Planning Research and Statistics (DPRS), State Executive Chairman of the Hospital Management Board, and the Executive Director of the SPHCDA (in states where active).

The healthcare delivery at the LGA is headed politically by a supervisory councillor, technically and administratively by a PHC coordinator, and assisted by a deputy-coordinator. The PHC coordinator reports to the supervisory councillor who in turn reports to the LGA chairman (Adeyemo, 2005; Federal Ministry of Health, 2004). The different components of the LGA PHC are manned by personnel of diverse specialties. The LGAs runs primary healthcare delivery in compliance with the principles framework of the National Health Policy. The LGA is divided into various health districts/wards so as to enhance maximum benefit of the principle of decentralisation of the health sector whereby people are not only involved but they also participate, and are mobilised in the PHC processes. At the local government levels, depending on the type of facility, there is usually an officer in charge, nurse, midwife and a number of senior and junior community health extension Workers (CHEWs). Health posts usually have only an officer in charge who is likely to be a CHEW. A junior CHEW is often assigned to the community and is assisted by a number of volunteers like village health workers (VHW). The recruitment and payment of health workers come under the responsibility of State Ministry for Local Government rather than the State Ministry of Health (SMOH).

At the local government level, there is a further decentralised administration in place; this is known as the ward system. Where functional, there is Ward Development Committee (WDC), which has members from smaller committees in the villages. At the local government secretariat, there exists a management committee, which has representatives of committee members from various wards. Smaller committees include

community development committees in villages with representatives at the ward and LG health committee. The village health committee is usually chaired by the village head. This committee serves as a gateway to the community, community health information, and then opinions and grievances about public services are also channelled through this body. Community engagement is a central component of the health policy and all levels of government are required by policy to "devise appropriate mechanisms for involving the communities in the planning and implementation of services on matters affecting their health" (FMOH, 2006).

Based upon the PHC strategy recommendation in the overall national health policy, the Plateau state PHC policy is reviewed to investigate its conformity to such recommendations.

4.3 PHC Policy in Plateau State

Past governments in Plateau State acknowledged the need for formulating a health policy to combat health problems and improve life conditions. The 1992 Plateau State health policy, for example, evolved based on the overall vision of the national health policy, and this can be observed in the statement captured in the policy document, which states that "within the framework of the national health policy, the government of Plateau state evolved this policy document which provides an overall state vision for the Health Sector based on primary health care strategy" (MoH ,Plateau, 1992).

Therefore, it is within the framework of the national health policy that Plateau State thought it necessary to evolve a health policy, considering the health needs of the state and desiring to fulfil the health aspiration of its people. In the 1992 policy declaration, the state and local governments declare that *"Plateau State hereby commit themselves and all the people to intensive action to attain the goal of health for all citizens by the year 2000 and beyond, that is, a level of health that will permit them to lead socially and economically productive lives at the highest possible level"* (PSHP, 1992)

The state government adopted PHC strategy as the key to attaining the goal of the health policy which is a recommendation by the national health policy. The health policy document identifies key areas for the health provision which are expected to improve the

delivery of healthcare services and the overall health status of the population of Plateau State as stated in its goals. The following areas of the policy document are reviewed below to enable the analysis of its conformity to the national health policy.

4.3.1 Fundamental Principles, Goals and Elements of the State Healthcare Policy

The fundamental principle underlying the Plateau State health policy is stated in the policy document that, "this State health policy to achieve health for all the people is based on national and state philosophy of social justice and equity". This philosophy has five objectives:

(a) A free and democratic society.

(b) A just and egalitarian society.

(c) A united, strong and self-reliant state.

(d) A great and dynamic economy.

(e) A land of bright and full opportunities for all citizens.

These principles of social justice, equity and ideals of freedom and opportunity have been affirmed in the Nigerian constitution which has been the recommendation of the national health policy. The state health policy has been formulated in the context of those goals and philosophy. Since health development contributes to and results from socio-economic development, the sectors are to be mutually-supportive and together contribute to the ultimate goals of the state. Health development is to be seen not solely in humanitarian terms but as an essential component of the package of social and economic development as well as being an instrument of social justice and state security.

The policy document defines PHC concept as captured in the Alma Ata Declaration as "... an essential care, based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

The PHC forms an integral part of both the state's health system, it is the first level of contact for individuals, the family and community with the state health system

bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process.

Within the overall fundamental obligations of the Plateau State government and the state's socio-economic development, "the goal of the state health policy was to establish a comprehensive healthcare system based on primary health care that is preventive, curative and rehabilitative to every citizen of the state within available resources so that individuals and communities are assured of good health productivity and social well being" (PSHP, 1992).

The adoption of the primary healthcare approach by Plateau state has a number of implications which are as follows:

The two levels of government at the state (state and local) both have responsibilities for the health of the people which must be fulfilled through the provision of adequate healthcare delivery and other social services.

- The citizens have the right and duty to participate individually and collectively in the planning and implementation of these services; Healthcare must accord high priority in the allocation of the government's resources than previously to meet up with WHO 15% of the budget recommendation to countries adopting the PHC strategy. Health resources must be equitably distributed, giving preference to those at greater risk to their health and the under-served communities as a means of social justice and concerns
- Information on health must be disseminated to all individuals and communities to enable them to have greater responsibility for their health;
- Self-reliance must also be encouraged among individuals, communities and throughout the State;
- Emphasis be placed on preventive and promotive measures; it must be integrated with treatment and rehabilitation in a multidisciplinary and multi-sectoral approach;
- All social and economic sectors are to cooperate which implies that all health practices and technology; both orthodox and traditional, are to be evaluated to determine their efficacy, safety and appropriateness.

PHC Elements elaborated in the State health policy.

The Plateau state government in 1992 adopted the following elements:

(a) Education on prevailing health problems and methods of preventing and controlling them;

(b) Promotion of food supply and proper nutrition;

(c) An adequate supply of portable water and basic sanitation;

(d) Maternal and child healthcare, including family planning. Family Planning here refers to services offered to couples to educate them about family life and to encourage them about family wishes with regard to:

(I) preventing unwanted pregnancies;

(ii) Securing desired pregnancies;

(iii) Spacing of pregnancies; and limiting the size of the family in the interest of the family health and socio-economic status. The methods adopted shall be compatible with the cultural and religious beliefs of the family.

(e) Immunisation against the major infectious diseases;

(f) Prevention and control of locally endemic and epidemic diseases;

(g) Appropriate treatment of common, diseases and injuries;

(h) Provision of essential drugs and supplies;

(i) Promotion of mental and oral health services (Plateau State Health Policy, 1992).

4.3.2 Role of Ministry of Health

The policy document was the creation of the ministry of health in the state as it is the institution saddled with that responsibility by the state government. The roles of the ministry as implementing agency of the government are stated below as contained in the policy document:

(a) The Plateau State Ministry of Health is the directing and coordinating authority on health activities in the State.

(b) Ensuring Political Commitment:

-The State Ministry of Health is to direct activities according to the strategy for health and co-ordinate them on behalf of the government;

-The State Ministry of Health is to tailor initiatives to ensure the commitment of Plateau State Government to the realization of the State health policy; and ensure the support of all organizations, political, religious, communal, social, trade unions and civic leaders and influential non-governmental organizations. The above groups as well as individuals and families are to be involved in technical financial community action for primary health care;

-The State Ministry of Health is to make proposal to the State Government to appropriate mechanism for ensuring the action required in all relevant social and economic sectors, such as inter-ministerial committees and multi-sectoral State Health Committees;

-The Ministry of Health is to advise on the introduction of health reforms and enabling legislation as necessary; for example, to define the right and obligations of people concerning their health as well as those of various categories of health workers and institutions to protect people from environmental hazards; and to permit communities to develop and manage their health and related social programmes and services.

(c) Ensuring Economic Support:

-The State Ministry of Health is to come out with facts and figures, to convince Budget and Planning Department of the Ministry of Finance on need for increasing the allocation to Health. The relevant government agencies shall ensure that Local Governments make adequate budgetary allocation to Primary Health Care, such budgetary allocation should be within the recommendation. of the WHO.

-The State Ministry of Health is to display vigilance in employing or consulting specialised personnel in order to ensure that health needs and protective measures are made integral parts of development projects, such as Tin-Mining and Dams, taking account of cost effectiveness.

(d) Winning over professional groups:

To ensure the support of health professionals in the State, the State Ministry of Health has the mandate to consider ways of involving them in the Health Care delivery, especially Primary Health Care. To this end, the need to hold constant dialogue with

health and health related professional organisations providing them with information, and impressing on them their social responsibilities and how best they can discharge these responsibilities. The State Ministry of Health is to also consider ways of providing tangible incentives.

(e) Establishing a Managerial Process:

The State Ministry of Health is to establish systematic permanent managerial processes for health development.

(f) Public Information and Education:

-Plateau State Ministry of Health is to assume a high active role in disseminating the kind of information that can influence various target audiences. Thus, statements on the aims and potential socio-economic benefits of the State health strategy as well as progress reports on its implementation, is to be disseminated to the public.

-The State Ministry of Health in collaboration with Department of Local Government Affairs is to promote health education activities in all the Local Governments in the State through health personnel, the massmedia and educational institutions of all types, with the aim of enlightening the whole population on good health maintenance on the prevailing health problems in their local government and community and on the most appropriate methods of preventing and controlling them.

(g) Financial and Material Resources:

Successful implementation of the State Health strategy means mobilising all possible human resources. It also depends on mobilizing all possible financial and material resources. This implies first of all, making the most efficient use of existing resources.

(h) Inter-sectoral Action

The Ministry of Health is to play the important role in stimulating and co-coordinating action for health with other social and economic sectors in the state particularly Agriculture, Community Development, Education, Works and Housing, Utility Board, Urban Development Board, Industries and non-governmental agencies.

-The State Ministry of Health is to approach other sectors with a view to motivating them to take action in specific fields.

-The Ministry of Finance and Economic Planning and Ministry of Agriculture is to be approached as appropriate with a view of encouraging production of food-crops.

-The State Utility Board, Housing Corporation, Metropolitan Development Board and the Task Force on Environmental Sanitation is to be approached with respect to the provision of safe drinking water and sanitation.

-Ministry of Finance and Economic Planning is to be approached to ensure that proper attention is given to health aspect of development schemes, such as the prevention of certain parasitic diseases.

-The Ministry of Education and Cultural sectors and Department of Education of Local Government Council, is to be asked to participate in wide ranging health educational activities in communities, schools and other educational training institutions.

-Ministry of Works, Information and Rural Development is to be requested to facilitate the provision of Primary Health Care, through improved communication particularly for the rural populace.

-Access to all media houses in the state through a PRO in the Ministry of Health.

-The Industrial Sector shall be made aware of the measures required to protect the environment from pollution e.g. the Breweries, Detergent and particularly the Training Industries and to prevent occupational diseases and injuries. The State Ministry of Health shall create occupational unit under its Disease Control Department to work hand in hand with the Task Force on Sanitation in enforcing compliance of the industrial sector.

-The State Ministry of Health shall encourage pharmaceutical industries in the State in producing essential drugs and encourage establishment of more of such industries.

(i) Co-ordination within the Health Sector:

-To achieve co-ordination within the health sector, the State Ministry of Health shall pay attention to the following:

-Collaboration between the various health services and institution e.g. Health Services Management Board and the Ministry of Health following agreement on allocation of responsibilities in order to make the most efficient use of resources; Collaboration also with other Governments and Voluntary Institutions, Private practitioners, Women and Youth Organizations active in the health sector;

-Collaboration between the various levels of the health system i.e. between the Primary Health Care, Secondary and Tertiary institutions;

-Collaboration within and among the various categories of health workers following agreement on the division of labour.

(j) Organizing Primary Health Care in Communities: In order to facilitate inter-sectoral collaboration, primary health care shall be organized taking account of administrative boundaries. Communities shall be helped to organize themselves; and responsibility, authority, and appropriate budgets shall be delegated to them. The Ministries of Health shall provide guidelines and practical support as necessary to those communities that organize their own primary health care.

(k) Referral System: Referral is a process by which one health worker shares or transfers responsibility, temporarily or permanently to another health professional.

-Ministry of Health through the Health Services Management Board shall orientate its health personnel in the hospitals to accept direct referral from Local Government Primary Health Care institutions;

-Ministry of Health and Local Government shall develop a system of referral of patients and problems that are identified and refer conditions that require more skilled care, and emergency cases. Referral will be a 2 -way system so that patients and problems are referred to those who sent them accompanied by information on action taken and guidance for further action;

-Ministry of Health shall review transport and communication facilities together with the Department of Local Government Affairs and the Local Government Councils concerned to permit referral systems to function efficiently.

(1) Logistic System:

Ministry of Health and Hospitals' Management Board shall review their logistic system to ensure regular and timely distribution of supplies and equipment, as well as the

availability of transport and its maintenance. Efforts shall be made to purchase vehicles at subsidized rate through International agencies.

(m) Health Manpower:

-The State Ministry of Health, in collaboration with the Federal Ministry of Health, State Ministry of Education, Department of Local Government Affairs, Federal and State Health Institutions within and outside the State shall ensure the education and training of health manpower to perform functions that are relevant to the State's priority health problems along the guidelines.

-The Ministry of Health and other Ministries concerned establishments such as Hospitals Management Board, Department of Local Government Affairs and the Local Government Councils shall take steps to ensure that health workers are socially-motivated and provided with the necessary incentives to serve rural communities.

(n) Health Care Facilities

-Ministry of Health together with Department of Local Government Affairs, shall review the distribution of existing health care facilities run by the State and Local Governments as well as other public, private and voluntary bodies. They shall continually update State Master Plans of requirements for Health Centres, clinics, Cottage Hospitals and General Hospitals. Accessibility to those most in need shall be the foundation of the Master Plan.

-Ministry of Health shall review the functions, staffing, planning, design, equipment, organization and management of health centres, clinics/first referral hospitals i.e. cottage and general hospitals in order to prepare them for their wider function in support of Primary Health Care. Before investing in buildings, the cost of running them shall be carefully considered.

(o) Priority Health Programme:

Ministry of Health shall identify priority health programmes in the light of the essential programme elements of Primary Health Care and the epidemiological situation in the State, and shall ensure that the delivery of these programmes is given top priority.

(p) Priority Health Programmes:

Ministry of Health shall make a systematic assessment of the Health Technology being considered for use in each priority programme with the aim of applying technology that is appropriate for the Local Governments and the State(Plateau State Health Policy, 1992).

From the above description of the responsibilities of the state government through the Ministry of Health to ensure the delivery of healthcare to its citizenry it is expected that PHC policy implementation be on course in the state, therefore the following section gives the analysis of the state health policy document conformity to the national one.

4.3.3 Analysis of the PHC Policy Document

The analysis started with looking for concordance with PHC principles as recommended by the overall national health policy on PHC delivery alongside the comments of the interviewees.

From the review of 1992 Plateau State PHC policy document, the overall policy was found consistent with the government's national health policy vision and directives. The national agenda under the health sector strategy aims at delivery of PHC services through decentralisation to local governments. This means that Plateau state is in conformity with the requirement by the national health policy.

Underpinning the comprehensive PHC strategy required by the overall national health policy, the core principles were focused upon by the state PHC policy and these are first analysed followed by analysis of the key areas before concluding with discussions. These principles of new public health are equity, participation and collaboration (Gupta et al 2003; WHO, 2007).

Equity

The key areas of the policy that intends to address the problems of inadequacies and inequalities seem to address equity, but the problem is that its meaning is restricted. According to PHC strategy, equity refers not only to the provision of material resources on equitable basis but also assuring enough power and status to the people (Conley, 2001, WHO, 1997). Furthermore, PHC strategy advocates social and economic equity as means of promoting health because social, economic, regional and professional inequalities reflect health inequalities (Conley, 2001, WHO, 1997). The SHP 1992 has considered a limited view of equity.

Equity refers to material resources, power, status as well as environment enabling people to achieve goals and services (Campbell, 2007). There are arguments for greater social and economic equity as means of promoting health because social, economic, regional and professional inequalities reflect health inequalities. Equity in health is understood to mean fair share of, and opportunities in, distribution and access to health resources and services. This is especially pertinent, considering the inequitable health systems most countries inherited at independence. Plateau State developed a health policy stating equity as one of the objectives as required by the national health policy but this means a reallocation of limited resources, which leads to taking away resources from the already underfunded services serving the urban elite who are the decision-makers. The equity policy objective is therefore not fully implemented. There are serious inadequate allocations of resources to health sector, especially to the local governments as revealed by the comments of the interviewees in this study. Though Plateau State indicates commitment to equity, this has not been realised and much more needs to be done. There is also evidence that all people living in societies with greater inequality experience poorer health compared to more egalitarian societies (Carol, 2000). This provides a strong argument for advocating greater social and economic equity as a means of promoting health.

Participation

Community participation was seen as a process of involving the community by promoting dialogue with it, and empowering communities to identify their own problems and solving them. Participation of the community in PHC is evidenced in Plateau State health policy through the recommendations made for creation of community health committees, village health committees in health centre or district health committees alongside the selection of community health workers for training. Furthermore, community representatives are recommended for inclusion in health facility or inter-sectoral management structures such as district health boards, district development committees and hospital management boards.

The management committees represent a very important element in the institutional setting of the system with regard to their main role in planning, management

and control of health services. They form an interface between the health system and the population, hence representing and promoting the people's participation and ownership.

A major challenge associated with community participation is the capacity of the community representatives and relevant state structures to support it as revealed by the interviewees. Plateau State has responded by stating that community participation is required in the delivery of PHC services, even though proper guidelines are not emphasised in the document on what is expected of the communities as well as commitment to training and supporting the communities. As a result, community involvement, beyond paying for services and providing labour for work carried out at health facilities, has been one of the most challenging and difficult aspects of PHC implementation as revealed by the findings. Participation, as an important principle of PHC, intends to involve people in the health policy process, recognising their health needs and looking for solutions which citizens need. It makes health programmes more effective. It has been effectively used in fighting against environmental degradation and combating problems of tobacco as well alcohol in many parts of the world (Garg, 1998). Furthermore, participation could address the issues of access and inclusion more effectively as well as make the health programmes more effective, accessible and sustainable. The PHC strategy demands participation to make the health programmes, strategies and services meet the needs of the population more effective. The 1992 health policy has not considered wider participation in its plans, as stated by many interviewees. It is understandable that respondents at local level frequently gave such comments because they experienced a large gap between the policy document intentions and daily practice. The policy has paid attention to the importance of decentralising the existing health system to create space for participation by health organisations, NGOs, professional groups, the media and the community but it is not implemented in practice.

Collaboration

The policy has offered intervention to develop collaboration to engender linkages between ministries, other sectors, groups, organisations, actors, and communities to achieve the comprehensive goals of the PHC but this is not stressed to achieve effective implementation. In the observation of a representative of an NGO, "collaboration among

health sector, media, education department and elected representatives can effectively combat the false myth attached to immunisation and can help the rural people and their children in understanding the importance of immunisation in preventing disease.*"* Yet, collaboration, which is working together with others on shared projects, is essential since many governmental sectors, agencies and people are involved in health-related issues. For example, governmental sectors such as education, environment, water and sanitation, housing, energy, industry and transport affect health directly or indirectly. Collaboration, among all these sectors, actors and stakeholders outside the government, NGOs, communities and their representatives induce more fundamental changes, with an enduring character and a greater potential to prevent disease and promote health.

Pointing Out Key Areas in the PHC Policy

In the key areas, the PHC policy in the state was conceived to reduce the widespread prevalence of communicable diseases by increasing the coverage of immunisation. Indeed, immunisation is important in combating disease but there is also a need to pay attention to other determinants of health, particularly lifestyle, as expressed by the interviewees at all levels, that will reduce HIV and other diseases even at the PHC level.

Another key area is that health hazards, caused by the lack of access to safe drinking water and sanitation, water pollution, urban and industrial pollution and intensive agriculture, are major causes of disease and poor health conditions (WHO, 1997; 1998). This is a key area identified in the policy document, but in practice, poor collaboration among inter-governmental agencies is reported to cause inefficient implementation of that component. Even though the policy stresses collaboration with other government agencies to ensure proper PHC delivery to the people, it is poorly carried out, leading to poor provision of social amenities that enhance the well-being of citizens in practice.

In the policy document, important determinants of health, particularly environment and lifestyle, are briefly mentioned in the policy document; therefore, policy interventions enhancing the implementation of such areas in the policy are not stressed. For example, one of the key areas of the policy intends to reduce the extensive spread of communicable diseases but does not consider the importance of paying attention to

lifestyle in combating disease; also, it does not notice that environmental degradation results in various health hazards. Indeed, the policy does not offer specific intervention to address environmental degradation nor protect the environment, as observed by the interviewees. The policymakers neglected (or paid scant attention to) the important principles of PHC such as equity, participation and collaboration. Unhealthy lifestyle is an important source of many health problems such as HIV/AIDS, cancer, diabetes, cardiovascular diseases, and accidents in the country Nit, (1997), hence the policy needs to stress the importance of healthy lifestyle.

Many studies and reports show that many persons infected with communicable diseases such as HIV/AIDS transmit them to other persons through various channels including blood transfusion, use of needles and syringes, and use of inoculation equipment (UNAIDS, 2008). Many studies conclude that paying attention to lifestyles may control accidents because major causes of accidents in the country include traffic rules not, seat belts not being used, and breach of safety measures in vehicles, homes, schools, and workplaces (Murthy and Klugman, 2004).The above evidence shows that there is a need to promote healthy lifestyles in preventing disease and promoting health in accordance with PHC strategy. And this is recognised as a problem by most interviewees for 75% expressed concern that the policy neglected the area (Author's fieldwork, 2012).

Interviewees at all levels stated that besides improving the quality of healthcare services, it is important to pay attention to other determinants of health, particularly lifestyle. This is captured by one of the interviewees in the state, "the policy document states that it intends to reform health sector by following the vision of PHC, however, the focus is not on the delivery of healthcare services by following the disease prevention and health promotion strategy propounded by WHO on PHC; in practice, the biomedical approach is emphasised"

Disease prevention and health-promotion demand availability of an effective human resource for health with an appropriate training on public health and health promotion. Although the policy intends to improve the infrastructure concerning information and quality control, no investments are proposed to build partnerships by working across multidisciplinary boundaries and involving stakeholders from health-related sectors to improve health and life conditions (Plateau State Health Policy, 1992).

Plateau State lacks opportunities for public health training to upgrade the knowledge and skill of the human resource for health in accordance with PHC mission even though training of health personnel is stated as a responsibility of the state ministry of health in the observation of interviewees.

Other key areas that the policy document intended to improve were the existing professional and managerial deficiencies through supervision, by providing appropriate training besides filling vacant positions of doctors, specialists and other paramedics in the public sector hospitals. It is encouraging that policymakers are interested in existing professional deficiencies and intend to remove these. Realisation of such key area will improve the quality of healthcare and strengthen the infrastructure. Although all the planned measures aiming at increasing the quantity and quality of physicians, specialists, paramedics and clinical services are reflections of better functioning of biomedical model, they are not the mission of PHC strategy as pointed out by some health professionals at all levels during interviews. Also, whereas improvement in such areas will enhance the PHC services, it has not been realised as revealed by the interviews (Author's Fieldwork, 2012).

According to a PHC coordinator, "the existing human resource for health is not balanced, because health authorities have not paid particular attention to the rural areas where there is shortage of health workers and poor training of the available workers." The health professionals believed that the PHC strategy demands appropriate training of the health professionals, which must be realised through creating awareness and imparting knowledge of new public health and health promotion (Author's Fieldwork, 2012).

Plateau State experiences an imbalance among healthcare professionals and public health professionals (Plateau State Strategic Plan, 2010). There were 323 nurses/ midwives in 908 PHCs in the state which is 0.3/PHC while the minimum recommended is 4/facility to be able to provide standard services especially to women, their newborns and U-5 children and the health facility ratio of 1.4/1,000 (2/1,000-Nigeria/2.5/1000-WHO benchmark); Plateau state also had 589 doctors and there were 1772 nurses/midwives in public/government secondary facilities in 2009. The Jos University Teaching Hospital (JUTH) accounts for> 70% of the doctors and >25% of the nurses in

the State. This shows A mal-distribution of healthcare givers due to their concentration in the JUTH and Plateau State Specialist Hospital (Plateau State Strategic Plan, 2010).

To support this fact a health professional observes that at the national level also, the country lacks the human resources for health in terms of enough knowledge and skill in accordance with the PHC strategy, "physicians in Nigeria are trained to work in clinical settings and not the broader determinants of health lying outside the biomedical model of health. Consequently such physicians working at state level (as policymakers) cannot offer policy interventions that reflect the mission of PHC."

Another key area of the policy seeks to bridge the basic nutrition gaps in the target population (children, women and vulnerable population groups). Most of the interviewees at all levels indeed believed that nutrition programmes would not only help address the problems of malnutrition but also the problem of inequities in the state.

Another crucial component of the policy was meant to introduce required regulation for quality assurance in private medical sector. Regulation can particularly control unqualified traditional healers and quacks providing low quality healthcare services in the rural areas. However, regulation towards improving the quality of healthcare in public sector should also deal with the geographical imbalance of health services following the equity principle. Such a comprehensive approach is not mentioned in this key issue. Health professionals at all levels and field officers working at local level also commented here that participation and public awareness were important to improve quality in the private sector. A health professional at district level comments on this: "there are rules and regulations, however, in practice; there is no governmental control on the manufacture, sale, distribution, efficacy and quality of drugs particularly in the private sector. Furthermore, practitioners in the private sector particularly quacks (traditional healers) hardly care for the standardised procedures, rules and regulations". A representative of a professional organisation adds: "traditional healers and unqualified practitioners prescribe allopathic medicines and advertise their practices by using the terms such as clinic and hospital. They also openly use the prestigious professional titles such as Dr, Professor, and Professor Dr with their names in advertising their practices" (Author's Fieldwork, 2012).

According to interviewees, especially professionals at district level, there is need to involve other health-related departments, organisations, professionals, media, and communities in health education campaigns but this is lacking in the policy. An elected representative at district level states as follows: " In creating awareness, government needs to introduce public health related programmes upon TV and should provide free TV sets to community centres and youth centres in the rural areas where people can watch healthy TV programmes and films. It can create not only mass awareness but also help in providing a positive recreation to the youth that will certainly keep them away from unhealthy practices such as drug abuse, crime and violence." As mentioned before, this point is not recognised by managers at provincial and district levels due to their positions and attitudes that mostly support governmental view and actions (Author's Fieldwork, 2012).

A strategic focus of the policy intends to improve the availability of drugs, ensure affordability and quality of drugs. Most of the interviewees at all levels believed the said area would certainly help improve the performance of the drug sector in the country. However, to ensure availability, accessibility and quality of drugs, it is necessary to develop wider participation and collaboration with other sectors, professionals as well as communities and their representatives as expressed by the representatives of international organisations, professional organisations and all the actors at the state and district levels.

Another crucial element in the policy states that to build the capacity of the Ministry of Health by creating a research unit in the ministry and establishing Health Management Information System (HMIS) in all the districts. These plans may be seen as important prerequisites for quality control and monitoring developments. They improve the health policy infrastructure. Most of the interviewees were aware of these plans and indeed judged these positively. However, health professionals at provincial and district levels commented that the planned research unit had been envisaged for medical research and not public health. They also believed that the planned expansion of the HMIS narrowly focused on the information related to the incidence of infectious diseases and their clinical treatment based upon biomedicine, and not the public health (Author's Fieldwork, 2012).

4.47 Discussion

With the adoption of the Alma Ata Declaration in 1978, which identified primary healthcare (PHC) as the strategy for health for all, Nigerian government embarked on the task of ensuring that the country's health system is based on the WHO requirement, since member-states are recommended to adopt the PHC strategy in their healthcare system (FMoH, 1988).

A review of Plateau State government's health policy document indicates that the adoption of PHC strategy has been a top priority. The policy document provides an overall state vision for the health sector, based on PHC approach which was required by the national health policy. The national health policy recommends the adoption of the Bamako initiative which encouraged the decentralisation of primary healthcare delivery to the local levels. The Plateau health policy document shows clearly in its stated objectives that PHC service delivery is decentralised to the 17 local government councils in the state. The main goal of the state policy is to deliver basic healthcare from the grassroots by establishing PHC facilities from the village level, making PHC the entry point (first level of contact) into the healthcare system as required by the national health policy. Principles and elements of PHC are stated in the policy document. The principles are equity, community participation, inter-sector collaboration and appropriate technology while eight elements of PHC are stated. The policy philosophy is based on social justice and equity as recommended by the national health policy.

The study discovered that the 1992 Plateau State Health Policy was still the policy document being implemented despite the fact that the Federal Government had revised its 1988 Health Policy in 2004 to match new realities and trends in health situations such as HIV/AIDS which had become a major problem that needed urgent attention. About 56% of the interviewees claimed that they were not aware of availability of updated operational plans which shows that some areas are neglected in health concerns of the people (Author's Fieldwork, 2012).

It was also revealed that important determinants of health, particularly lifestyle and environmental issues that lead to extensive spread of communicable diseases, were not broadly explored in the policy document and paying attention to these areas would

help in combating diseases such as HIV/AIDS and mental illness caused mostly by drug/ substance abuse because of unhealthy lifestyle.

Despite the limitations, the principles of equity, community participation and collaboration addressed in the policy document, most interviewees did not share the view as many of them believed that the policy document emphasised the principles but were not well-implemented if practised at all.

The equity principle was not frequently mentioned by most interviewees, especially PHC coordinators, at the local levels. As one of the key areas mentioned in the policy document, equity intends to address the problems of inadequacies and inequalities, but its meaning is restricted. The policy document considers a limited view of equity and interprets it through the availability of healthcare services on the basis of biomedical model of health rather than PHC. It indicates that this principle is mentioned in the document but it is not extensively covered in the 1992 PHC policy. According to a representative of one of the LGAs chairman, "the deprived and disadvantaged people suffer from higher levels of ill-health and premature death than those in the urban cities who are an advantaged group" (Author's Fieldwork, 2012).

One of the interviewees claimed that there was no collaboration with traditional practitioners who a large number of the rural populace patronised for health needs especially the women using the traditional birth attendants during pregnancy and child birth, whereas collaboration is recommended by the national health policy, especially promoting programmes in such areas as nutrition, environmental sanitation, personal hygiene, family planning and immunisations alongside training to improve their skills to ensure their cooperation in using the referral system, even though inter-sectoral collaboration is weak.

The need to develop a comprehensive health policy has been argued at various international conferences on new public health and health promotion. For example, the Ottawa Charter (1986), passed at the first international conference on health promotion, identifies five essential actions areas of health promotion: to build healthy public policy, create supportive environments, to develop personal skills, strengthen community action, and reorient health services (WHO, 1986). These action areas are mutually-interdependent in preventing disease and promoting health in accordance with Health for

All strategy. However, it is fundamentally a health policy that establishes the basic context that makes the other four possible (de Leeuw, 1989; WHO, 1986). As uncovered in the content analysis and interviews, this interdependency is absent in the state health policy.

In the 1992 health policy, important determinants of health particularly environment and lifestyle were not explored enough in developing policy interventions. For example, one of the key areas of the health policy is to reduce extensive spread of communicable diseases but it does not consider the importance of paying attention to lifestyles in combating disease. Environmental degradation results in various health hazards but the policy neither offers any intervention to address the environmental degradation nor protect the environment, as observed by the interviewees. Similarly, unhealthy lifestyle as a source of many health problems is ignored in the policy document.

The policymakers have only paid scant attention to the important principles of PHC such as equity, participation and collaboration, however clear guidelines are needful for effective implementation. For example, though one of the key areas of the policy document intends to address the problems of equity, its meaning is restricted. According to PHC strategy, equity refers not only to the provision of material resources on equitable basis but also assurance of enough power and status to the people (Conley, 2001; WHO, 1997a;). Furthermore, PHC strategy advocates social and economic equity as means of promoting health because social, economic, regional and professional inequalities reflect health inequalities (Conley, 2001; WHO, 1997).

PHC strategy demands participation in order to make health services meet the needs of the population. The health policy does not consider wider participation in its plans, as stated by many interviewees. It is understandable that respondents at district level frequently gave such comments, because they experienced a large gap between the policy document intentions and daily practice. The policy mentions decentralisation of the existing primary healthcare to create space for participation by health organisations, NGOs, professional groups, the media and the community, however it is not so in practice because community participation especially is limited.

Plateau health policy does not offer intervention strategies in the policy document that can develop collaboration to ensure effective linkages between ministries, other sectors, groups, organisations, actors, and communities to achieve the comprehensive goals of PHC. Although health policy intends to improve the infrastructure concerning information, no investments are proposed to build partnerships by working across multidisciplinary boundaries and involving stakeholders from health-related sectors to improve health and life conditions.

Such a comprehensive health policy, considering all important determinants of health in accordance with PHC, is required to follow a multi-sectoral approach by ensuring wider participation and collaboration with all health-related actors, sectors, NGOs and communities in preventing disease and promoting health. Collaboration between the Ministry of Health and the Ministry of Housing and Works in executing their tenders and assuring the availability of safe water and sanitation is particularly recommended for disease prevention and health promotion.

Equally remarkable, the policy document fails to sufficiently address the area of collaboration and coordination amongst sectors that can enhance the well-being of the citizenry. It is recommended that there should be collaboration between the Ministry of Health and the Ministry of Local Government to build basic health units, rural health centres to be handed over to the Ministry of Health promptly for the purpose of operation at a specified time. The Ministry of Health and the Ministry of Youths and Social Development may jointly address the causes of risky behaviours such as drug abuse. Such collaboration and a wider participation are important for programmes covering disease prevention and health promotion. Participation from communities, their leaders and religious groups is particularly recommended to build awareness, develop healthy lifestyles and protect environment in accordance with the principles of PHC.

Clear understanding of the objectives, procedures and guidelines is central to implementation of policies, those in-charge of executing the policy are expected to know well and understand the objectives and procedures, however in terms of policy objectives, little understanding was observed among the bureaucrats interviewed.

In summary, the content of the Plateau State PHC policy largely mirrors the comprehensive mission of HFA in order to assure quality, prevent disease and promote

health. Even though the policy tends to emphasise curative care and institutional facilities for the delivery of healthcare services, it is recommended that the health authorities in Plateau State should reformulate the state PHC policy. Close attention should be paid to delivery of healthcare services alongside other determinants of health, particularly environment and lifestyle by following the principles of HFA with clear targets, concrete plans and feasible implementation instruments that address the goal of preventive measures. Such a comprehensive health policy considering all-important determinants of health in accordance with HFA needs to follow a multi-sectoral approach by ensuring wider participation and collaboration with all health-related actors, sectors, NGOs and communities in preventing disease and promoting health. Collaboration between the Ministry of Health and the ministries of utilities, housing and works in executing their tenders and assuring the availability of safe water and sanitation is particularly recommended for disease prevention and health promotion.

The collaboration between the Ministry of Health and the Ministry of Local Government should be developed to build basic health units, rural health centres which are expected to be transferred to the Ministry of Health for their functioning within stated time frame immediately. The Ministry of Health and the Ministry of Youths and Women Affairs together may address the causes of risky behaviours such as drug abuse, low quality self-esteem leading to careless lifestyle with multiple sex partners that increases spread of HIV/AIDS and other sexually-communicable diseases. Such collaboration and a wider participation are important for the programmes of disease prevention and health promotion. Participation from communities, their leaders and religious groups is particularly recommended to build awareness, develop healthy lifestyle and protect environment in accordance with the principles of HFA.

CHAPTER FIVE

IMPLEMENTATION ANALYSIS OF PRIMARY HEALTHCARE DELIVERY IN PLATEAU STATE

5.0 Introduction

The preceding chapter reviewed the content of the Plateau State health policy on PHC delivery to ascertain conformity with the national PHC policy alongside discussing the views of the interviewees regarding the content of the policy, thus addressing the first objective of this study. This chapter presents the descriptive and narrative analysis of data derived from the various methods employed regarding the three remaining research objectives. It presents the analysis of findings on the implementation of the PHC policy in Plateau State by dividing the chapter into three sections. Section one presents the PHC facility level survey results that started with the socio-demography of health staff, the characteristics of the facilities, availability of infrastructural facilities, types of services provided and the capacity of providers to offer services in terms of human and financial resources. The second section presents the responses of the households surveyed in respect of their level of satisfaction with the services they received and status of participation in the implementation of the policy. The third section discusses respondents' opinions on issues raised in the interviews in terms of policy implementation.

Part 1: Analysis of Health Facility Survey

5.1 Description of the Facility

Healthcare services are delivered through a tiered package of facilities in Plateau State, broadly classified into tertiary (highly-specialised services provided by the Federal Government), secondary (offering healthcare services at the secondary level in the referral hierarchy) and the primary (providing basic health services of preventive, curative, promotive and rehabilitative as the point of entry into the healthcare systems).

The provision of healthcare at PHC level is largely the responsibility of local governments in Plateau State with the support of state government through the Ministry of Health as stipulated within the overall national health policy (Plateau State Health policy, 1992). The local government records indicate that the local government owns the great majority (80%) of public healthcare facilities in the local governments sampled. Private sector is the other major player, owning 16% of all facilities while state government owned less than 3% of all facilities and Federal Government owned less than 1%. For the purpose of this study, only the public PHC facilities operated under the state and LGs were surveyed.

Plateaus State has a population of 3,383,027 (NPC, 2008) with about 1,000 health facilities distributed in the 17 local government areas. The facilities are owned by public, private and faith-based organisations/missions inclusive of 2 tertiary, 59 secondary and 908 PHC, indicating population per health facility ratio at 1.4/1,000 (2/1000-Nig, 2.5/1000 WHO benchmark). As a whole, Plateau State has 589 doctors and, 1,772 nurses/midwives in the public/government secondary health facilities. The Jos University Teaching Hospital accounts for more than 70% of doctors and more than 25% of nurses in the state. Doctors are rarely found in the public health centres; only about 17% were found to be in the list of physicians in the state ministry of health. The maldistribution of healthcare professionals is due to their concentration in the available two tertiary facilities, namely JUTH and Plateau Specialist Hospital. The healthcare professional ratio (HCP) in the state is 1.4/1,000 population compared to the country's standard (Nigeria 2/1000) as against WHO standard of 2.5/1000. Therefore, there is a huge gap of 0.6-1.1/1000. 300-400 doctors required such that majority of the PHC facilities offering maternal and child health services can be operated by doctors (PSSHDP, 2010)

The Table 5.1 below shows the different types of health facilities available in Plateau State broadly categorised into tertiary, secondary and primary healthcare institutions. The private sector is also a major player in the provision of the healthcare services in the state. The LGs own about 93.7% of the health facilities while the private owns about 4%, the state government owns less than 2.1% of all facilities, and the Federal Government owns less than 1%.

Table 5.1: Classification of Health Facilities in Plateau State (Ownership)

Types of Health Facility	Types of Ownership	Number of Facilities
Tertiary	Federal Government	1
	State Government	1
Secondary	Public	20
	Private/Missions	39
Primary	Local Government	908
Total		969

Source: Ministry of Health Plateau State, 2010.

A total of 36 facilities were sampled, 12 in Barki-Ladi, 16 in Pankshin and 8 in Langtang-North (Table 5.2). 66.6% of the facilities were health posts/ dispensaries, 16.7% were primary health centres and 16.7% were community health centres. Barkin-Ladi LGA facilities were geographically more proximate to referral centres, as well as to a range of private facilities, and this can be attributed to its nearness to the state capital (Jos) where most healthcare facilities, both public and private, are located. For those in Pankshin and Langtang-North, the health-posts in the communities are not necessarily close to referral centres and not much private healthcare facilities are located in these places. Another reason could be that, unlike Barkin-Ladi that is close to the state capital, they are both far from the capital where most hospitals, including teaching and specialist hospitals that offer wider range of healthcare services are located. In Plateau State, health-posts and dispensaries necessarily have to meet a wide range of healthcare needs for the population, regardless of the resources available to them. The profile that emerges

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in this report indicates that Plateau State healthcare facilities succeed in functioning under very difficult circumstances in terms of lack of basic amenities.

Table 5.2 Number of Facilities by Type

Type	Frequency	Percentage
Health post/dispensaries	24	66.6
Primary health centres	6	16.7
Comprehensive health centre	6	16.7
Total	36	100

Source: Author's Field work, (2012)

5.2 Socio-Demographic Characteristics

Analysis of the age distribution of the participants in the survey was illustrated in Figure 1. Majority (42) of the respondents were within the age group of 41-50 years, while only seven per cent were above 50 years. About 27% of the respondents were within the age bracket of 31 and 40 years, while the remaining 20% were those below 31 years, implying that majority of the health workers are still within the age range required to remain in the public service until the retirement age of 65 years. Twenty four (22.2%) were male and 77.8% were female of the total participants, indicating that large majority of the healthcare workers in the local governments in Plateau State are females.

Age of Facility Respondents

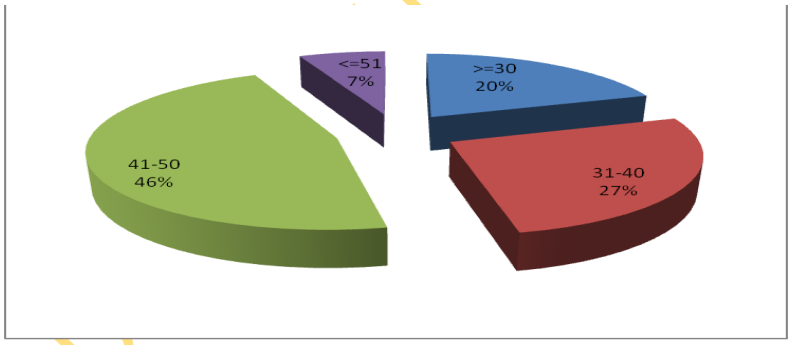


Figure 5.1

Source: Survey Data. (Author's Field work, 2012)

The distribution of educational qualifications of those that took part in the survey is presented in Table 5.3. Out of 108 respondents, 11.1% had primary education, those with secondary education were 5.5% while 5.6% and 11.1% possessed university and other educational qualifications, respectively. More than half (66.7%) of the respondents were certified midwives, hence most of the health workers were trained in the medical line, and it is expected that they should be able to carry out their responsibility professionally.

Table 5.3 Educational Level

Education	Frequency	Percent
Primary	12	11.1
Secondary	6	5.5
School of Midwifery	72	66.7
University	6	5.6
Others	12	11.1
Total	108	100.0

Source: Survey Data. (Author's Field work, 2012)

The distribution of the professional designation of the respondents is illustrated in Figure 5.2 as follows: SCHEWs (12%) and JCHEWs (12%), midwives (6%) and another 6% were environmental health officers (EHOs).

Respondents Designation

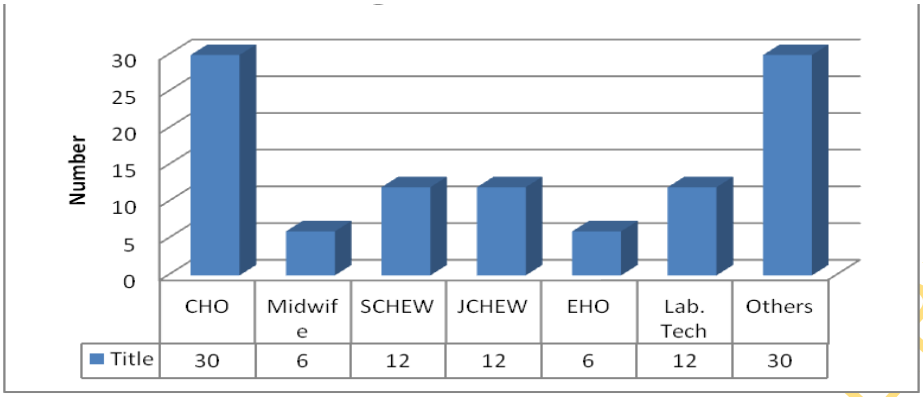


Figure 5. 2

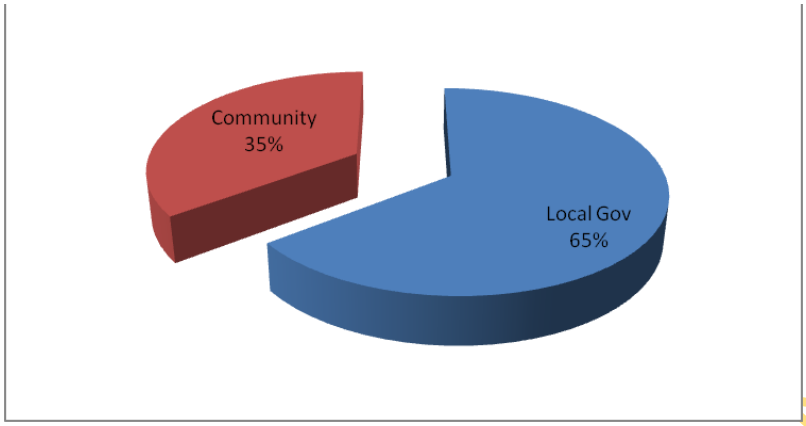
Source: Survey Data. (Author's Field work, 2012)

Characteristics and Conditions of the Facilities

In Plateau State, health posts and dispensaries necessarily have to meet a wider range of healthcare needs of the population, regardless of the resources available to them. The profile that emerges indicates that most of the facilities succeeded in functioning under very difficult circumstances in terms of lack of basic amenities and sufficient funds to the facilities to purchase necessary equipment to provide essential PHC services.

On who provided the building, Figure 5.3, gave a snapshot of the responses of the respondents. About sixty six (61.1%) respondents ascribed it to local government, while 36 (33.3%) claimed that community was responsible for the provision, while 6 (5.6% respondents did not respond to the question.

Figure 5.3: Facility Provider



Source: Survey Data. (Author's Field work, 2012)

Most of the facilities operated by the respondents were under the authority of the local government. Precisely, 89% respondents worked in facilities under the authority of the local government and 11% were in facilities owned by the state government.

Authority under which Facility Operates

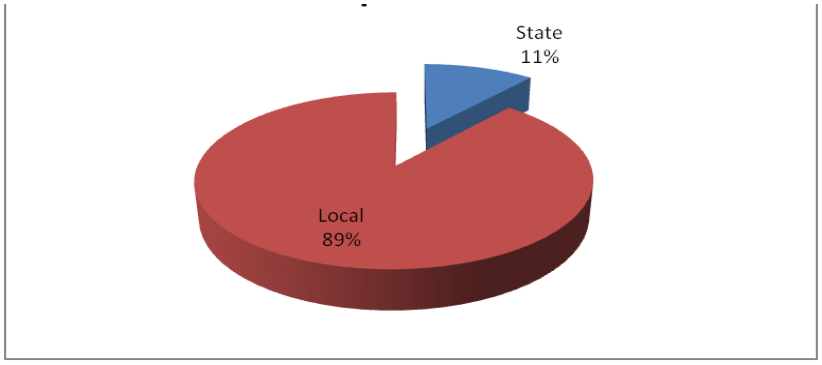


Figure 5.4

Source: Survey Data (Author's Field work, 2012)

Table 5.6 presents the time it would take to get to the nearest referral centre by vehicle. For 5.6% respondents, it would take less than 20 minutes while it was less than 40 minutes for 11.1%. For 16.7%, it would take one hour while it was one-and-a-half hours for 5.6 % of the respondents. About 44.4% respondents stated that it would take two hours and 11.2% said it was about two-and-half hours.

Table 5.4 Time to Get to Referral Centre by Vehicle

Minutes	**Frequency**	**Percentage**
Less than 20 mins	6	5.6
Less than45 mins	12	11.1
1 hour	18	16.7
Less than1.30mins	6	5.6
2 hours	48	44.4
2.30min	18	11.2

Source: Survey Data. (Author's Field work, 2012)

Concerning the principal decision-maker in the supply of drugs and equipment for the health facilities, (5.6%) respondents agreed that state government was responsible, (72.2%) believed that local government was in charge while (5.6%) were of the opinion that community was in-charge. Table 5.5 contains responses of the respondents to the question on the principal decision-maker. The Chi-Square result implies that there was a significant difference between the outcomes.

Table 5.5 Principal Decision-Maker

Decision maker	Frequency	Percentage	Chi-Square
State Government	6	5.6	115.2***
LGA	78	72.2	
Community	6	5.6	
Missing Response	18	16.7	

Note: ***denotes significance of probability value at 1% level.
**denotes significance of probability value at 5% level.
Source: Survey Data. (Author's Field work, 2012)

On the conditions of facility as presented in Table 5.6, only 59% of the facilities had functional working toilets for patients in Langtang-North LGA while Pankshin LGA had 70% which was far higher than Barkin-Ladi LGA with 50% facilities surveyed. Over 30% each of the facilities had leaking roof, the highest being Pankshin (36%), as well, Pankshin had the highest broken doors (58%) and cracked floors (53%), giving the facilities bad appearance (facility maintenance appears to be poor). For clean surroundings of the environment and neatness, 54% of PHC facilities observed were classified as ''clean'' in Barkin-Ladi, 18% were ''dirty'', and 59% in Pankshin were rated clean while Langtang-North had 44% clean environment but substantial proportion of the facilities were in bad state of repair even though clean.

Table 5.6 Percentage of Condition of Facilities, by LGA

Condition	Barkin-Ladi	Pankshin	Langtang-N
Dirty	18	14	30.6
Very dirty	10	9	16
Clean	54	59	44
very clean	18	13	9.4
Cleanliness unspecified	-	5	-
Total	100	100	100
Leaking roof	35	36	29
Broken doors/windows	43	58	46
Cracked floor	51	63	60
Working toilet for patients	50	71	59

Source: Survey Data. (Author's Field work, 2012)

Type and Quality of Services Provided

Table 5.7 shows the types of services offered by the healthcare facilities. All respondents asserted that immunisation, antenatal/post-natal consultations and normal delivery care, diagnosis and management of minor illness, dispensing of routine medications, public health education and referrals were part of the services rendered.

Table 5.7 Types of Services Provided by Health Facilities

Services provided	Percentage
Antenatal care/ Post-natal services	76.9%
Normal delivery	64%
Immunisation	89%
Treatment of minor ailments	85.1%
Health education	52.1%
Family planning	56%
Laboratory services	20.9%

Source: Survey Data. (Author's Field work, 2012)

On the quality of equipment and materials available in the facilities, respondents' views are presented in Table 5.8. The survey made enquiry about steadiness of drug supply to healthcare facilities. However, it is hard to conclude on the findings as 50% agreed that drug supply was steady while the remaining half disagreed.

As regards the adequacy of the healthcare facilities in terms of size, utilities and furnishing, 55.6% of respondents were pleased with the existing facilities whereas 44.4% considered that the existing infrastructure was not adequate in terms of size, utilities and furnishing. The coefficient of Chi-square, however revealed a non-significant difference between the two responses, thus it is hard to conclude that there is difference between them.

Table 5.8 Quality of Equipment in the Healthcare Facilities

Items	Yes	%	No	%	Total	Chi-Square
Does this facility have a steady supply of drugs	54	72.2	78	27.8	108	21.33**
Adequacy in terms of size, utilities and furnishing	60	55.6	48	44.4	108	1.33

Note: **denotes significance of probability value at 5% level.

Source: Survey Data. (Author's Field work, 2012)

On the availability of supplies, Table 5.9 shows that majority of the respondents were of the view that supplies to the facilities were not delivered on time. The difference between the two classes was significant as indicated by the coefficient of the estimated Chi-square, which was significant at 1% level of significance. It could be concluded that majority of the respondents agreed that delivery of supplies to the primary healthcare facilities was not timely.

Similarly, majority (72%) of the respondents perceived that essential supplies for the proper functioning of the healthcare facilities were not usually available. This was strongly supported by the value of the coefficient of chi-square, which implied significant difference between those that agreed and those that disagreed on this assertion.

Table 5.9 Availability of Essential Supply

Items	Yes	%	No	%	Total	Chi-Square
Facility receive essential supplies on time	36	33.3	72	66.7	108	1.33
Facility usually have availability of essential supplies	30	27.8	78	72.2	108	1.33

Note: **denotes significance of probability value at 5% level.

Source: Survey Data. (Author's Field work, 2012)

Availability of Amenities in Facility

In terms of PHC facilities connected to electricity, 75% stated that they had working electricity connection even though supply was not constant; notably too, only 15% of health- posts were not connected. Majority, 102 (94%) of the health workers said that in the case of emergency, there was no standby vehicle to convey patients to the nearest referral centre and relations had to make private arrangements to transfer the patient to the referred facility and, in some cases, the health workers use their personal vehicles but the relations had to fuel the car. The remaining 6 respondents were silent on this. Also, there was average of one bed per health-post and 4-6 beds per CPHC. Two-thirds of CPHCs had functioning fridges/ freezers, compared with one-third of the few in health-posts. These are presented in Table 5.10.

Table 5.10: Availability of Infrastructural Amenities

	Available	Not Available
Electricity	75%	15%
Emergency vehicle	6%	94%
Bed	80%	20%
Fridge/Freezer	55%	45%

Source: Survey Data. (Author's Field work, 2012)

On the main sources of water supply in the facilities, 23.1% respondents said that it was borehole, 42.6% mentioned well, 6% cited pipe-borne supply, 22.6% got water from river/stream, 6% relied on rainfall, all indicating poor supply of water by the government to the LGAs in Plateau State. This distribution is captured in Table 5.11.

Table 5.1:11 Percentage Distribution of Facility Main Source of Water, by LGA

	Barkin-Ladi	Pankshin	Langtang-North
Piped water	7	16	19
Borehole	23	34	34
Well	53	37	45
Rain collection	13	2	-
River/Stream	1	2	-
Other	2	9	-
Unspecified	-	-	2
Total	100	100	100

Source: Survey Data. (Author's Field work, 2012)

PHC Staff Condition and Incentives

The survey evidence on how the health workers get to work reveals that 55(50.9%) walked, 28 (25.9%) rode motorcycle while 17 (15.7%) went by car. Figure 5.5 shows how the health workers get to work.

Transport Medium

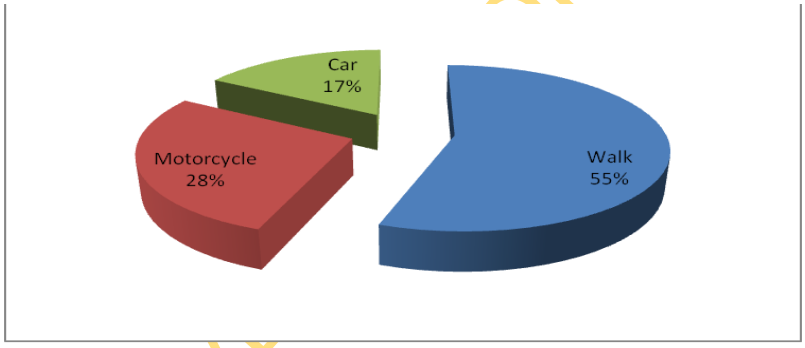


Figure 5.5:

Source: Survey Data. (Author's Field work, 2012)

Table 5:12 Time it takes to get to Work

Minutes	Frequency	Per cent
10.00	18	16.7
20.00	36	33.3
25.00	6	5.6
30.00	24	22.2
45.00	6	5.6
60.00	18	16.7
Total	108	100.0

Source: Survey Data. (Author's Field work, 2012)

About 16.7% used ten minutes to move from their house to the workplace, 33.3% spent twenty minutes; for 22.2%, it was thirty minutes, 16.7% expended up to 60 minutes to get to the workplace from their abode while 5.6% used 25 minutes, and 5.6% travelled for 45 minutes from table 5.12.

Human Resource and Development of Workers

On the availability of health workers at the facilities on call seven days per week, 24 hours per day, 46% affirmed that health workers such as nurses, midwives, clinical officers or medical officers (at least one of them) would be at the health facilities on call seven days per week, 24 hours per day. With reference to adequate number of skilled health workers, it was 57% and 14% indicated they had undergone training in the last 24 months.

Table 5.13 Manpower and Capacity

Availability of required number of health workers	46%
Availability of adequate number of skilled health workers	57%
Respondents who have undergone in-service training within the last 24 months	14%

Source: Survey Data. (Author's Field work, 2012)

Table 5.14: Last 12 months Salary being paid

Nos. of Months Paid	Frequency	Percentage
Three	12	11.1
Five	6	5.6
Six	24	22.2
Eight	48	44.4
Nine	6	5.6
Twelve	6	5.6
Missing Response	6	5.6

Source: Survey Data. (Author's Field work, 2012)

Furthermore on salary, Table 5.15 presents the responses of the respondents and the Chi-Square coefficients to show whether or not the differences between the frequencies of the responses were statistically different. 96 respondents out of 108 bluntly refuted having fringe benefits on schooling for children, while others were quiet on this. Similarly, about 24 (22.2%) respondents denied augmenting their salaries while others did not reveal their intentions on this. This was also true of 18 (16.6%) respondents and 12 (11.1%) respondents that declined augmenting their salaries from selling medicine and other sources, respectively. Other enquiries on salary, as regards adequacy of compensation for work, obtaining salary as and when due; medical, food, housing and health fringe benefits, and augmenting salaries from home services were strongly refuted by the respondents and their claims were strongly statistically significant. On the other

hand, the survey reveals that majority of the respondents augment their salaries from petty trade and practise of agricultural activities. The difference between those that augmented their salaries from home services (6 respondents) and those that did not (12 respondents) was not statistically significant.

Table 5.15 On Salary, Benefits, Supplementing Salaries

Items	Yes	%	No	%	Total	Chi-Square
receive adequate salary compensation for the work you do	12	12.5	84	77.8	96	54.00***
Get your salary as and when due	6	5.6	102	94.4	108	85.33***
Healthcare fringe benefits	36	35.3	66	64.7	102	8.82***
Medicine fringe benefits	12	12.5	84	77.8	96	54.0***
Schooling for children fringe benefits			96	88.9	96	
Housing fringe benefits	24	25.0	72	75.0	96	24.0***
Food items fringe benefits	6	6.3	90	93.8	96	73.5***
Supplement your salary through other means?	24	22.2	72	66.7	96	24.0***
Augment salary from agriculture	36	85.7	6	14.3	66	21.43***
Augment salary from petty trade	36	66.7	18	16.7	54	6.0**
Augment salary from private clinic			24	100	24	
Augment salary from home services	6	33.3	12	66.7	18	2.00
Augment salary from selling medicines			18	100	18	
Augment salary from other sources			12	100	12	

Note: ***denotes significance of probability value at 1% level.

**denotes significance of probability value at 5% level.

Source: Survey Data. (Author's Field work, 2012)

On job description of the respondents, 83.3% agreed that they had clearer job description, 84% affirmed that they experienced supervision frequently, and 72.2% consented that they had explicit standard for performance. The significant tests carried out to affirm if the differential between the alternative responses was significant implied

that majority of the respondents had clear job description, experienced supervision frequently and that the facilities had explicit standard for performance. All the respondents ascertained that there were clearer reporting structures. However, 72.2% of the respondents did not agree with the assertion that they attended to patients that did not relate to their area of specialisation, and 27 .8 % of the respondents agreed with the assertion.

Table 5.16 Job of the Respondents

Items	Yes	%	No	%	Total	Chi-Square
Clearer job description	90	83.3	18	16.7	108	48.00***
Explicit standard for performance	78	72.2	30	27.8	108	21.33***
Clear reporting structure	108	100				
See patients not related to your work	30	27.8	78	72.2	108	21.33***
Receive supervision frequently?	84	77.8	24	22.2	108	33.33***

Note: ***denotes significance of probability value at 1% level.
**denotes significance of probability value at 5% level.
Source: Survey Data. (Author's Field work, 2012)

Finance of PHC Facility

The survey shows that the LGA is the main source of financing PHC service delivery at the facility level. Staff salaries, facility building construction and maintenance, supply of drugs, equipment and other medical commodities, are all predominantly provided by local government administrations in Plateau State. However, community-based organisations and facility staff are indicated by facilities as other sources of drugs (18% of facility respondents) and medical supplies (25%). With regard to building maintenance, 55% of respondents indicated that community-based organisations were the main suppliers in the last 12 months whereas 45% indicated the LGA as the main supplier.

Table 5.17: Facility Resources Supply

Main Supplier of Drugs to the PHC facility	
Federal Government	2
State Government	10
Local Government	68
Community Development Committee	13
Facility Funds	6
NGO/Donor/Individuals	1
Main Supplier of other Medical Commodities to PHC Facility	
Federal Government	0%
State Government	5.7%
Local Government	79.3%
Community Development Committee	2%
Facility Funds	2%
Staff Personal Funds	8%
NGO/Donor/Individuals	%
Main Supplier of Equipment and Maintenance in Facility	
Federal Government	0%
State Government	1.4%
Local Government	81.5%
Community Development Committee	0%
Facility Funds	2.1%
Staff Personal Funds	2.1%
NGO/Donor/Individuals	5%

Table 5.17 continued

Main Supplier of Facility Building Maintenance in the Last Year

Federal Government	0%
State Government	3.2%
Local Government	60.8%
Community Development Committee	30.2%
Facility Funds	1.4%
Staff Personal Funds	3%
NGO/Donor/Individuals	1.4%
Staff Salary Payment	
Federal Government	0.9%
State Government	1,1%
Local Government	98%
Community Development Committee	0%
NGO/Donor/Individuals/Other	0%

Values in the columns indicate the percentage of facility respondents that responded "yes" for the agency.

Source: Survey Data. (Author's Field work, 2012)

In Plateau State, staff salaries are exclusively provided by local government. Hence, financing of day-to-day facility functioning is largely provided by local governments. However, the national health policy provides general guidelines to all three tiers of government to prioritise resource allocation in favour of preventive health services and primary healthcare, which is the cornerstone of the national programme. In this spirit of prioritisation, the federal and state governments are expected to provide logistical and financial assistance to the LGAs primarily for programmes of national importance such as the national programme of immunisation, or controlling the spread of HIV/ AIDS. The federal budget has included programmes of construction of PHC facilities in local governments.

Local government expenditure responsibilities are financed largely through statutory allocations from the Federation Account, with LGAs regularly receiving about 20 per cent of total federal resources in the divisible pool. Since oil revenues are part of the Federation Account, LGAs receive substantial revenues on account of this statutory allocation. LGAs are also entitled to a share of federally-collected VAT revenues (outside of the Federation Account). In addition, LGAs are supposed to receive statutory allocations from state government revenues, but the rules relating to this are less strict and not always enforced. Local governments in Plateau are overwhelmingly dependent on statutory allocations from the Federation Account for their revenue, and receive almost nothing from the state government; to be precise, <6% of the state budget was allocated to the health sector in the past decade. Public delivery of primary health services in the state revealed through the survey that public resources do not appear to be reaching their intended destinations. Evidence suggests large-scale outflow in public resources in Plateau State; indeed, it is reported that there is a great discrepancy between original budget allocations and what is actually released for use in implementation of policy at the facility levels. Although staff salaries account for 80% of health expenditures and 20% of total LGA revenues, on average, the survey of facility staff in Plateau revealed that 49% of the public healthcare workers had not been paid salaries for more than seven months in the past year.

The survey attempted to collect budgetary data on health expenditures of local governments, and this was a difficult exercise because budget documents from local government were not released to the researcher. During the field testing of the survey instruments, it was observed that numbers on total health expenditures were either not easy to find. Although the survey asked several questions relating to fees charged at facilities for their services, the responses were often inconsistent across questions and the data therefore hard to interpret. About 43% of the facilities surveyed said no fee was charged. Yet, some of these facilities that claimed not to charge fees for their services responded with non-zero values for average charges for services, and “yes” to the question of whether they charged standard prices for treatment. Hardly was any facility (less than 5%) observed to have permanent displays of user charges. 60% of respondents indicated that the facilities did not charge standard prices for treatment. The states and

LGAs are not performing their respective responsibilities in managing and allocating resources; neither did there appear to be a formal financial management system in place nor a policy on financial resource generation. Poor financial resource allocation for PHC services were reported by the health workers, especially in priority areas, and those resulted in defective basic infrastructure and logistic support as well as inadequate service provision. It is evident that poor funding, bad management practices and infrastructural decay is the bane of efficient PHC delivery in the state. The poor funding may be traceable to the poor budgeting practice/culture and mismanagement due to poor accountability. It is obvious from the results that the budgeting system is seriously flawed, primarily due to the fact that even the programme planners and managers do not have a reasonable estimation of how much it will cost to provide appropriate services per facility. There was a downward trend in allocation to health systems in Plateau State till 2008 and 2009 when an upward review was made although total state budget had risen significantly in the same period as shown in Table 5.18 below.

Table 5.18: Available Funds for Plateau State Health Delivery Systems

Year	Total State Budget	Percentage of Health Allocation
1999	3.6 billion	6.3%
2000	7.8 billion	8.8%
2001	14.4 billion	8.6 %
2002	15.43 billion	8.3 %
2003	16.76 billion	2.5 %
2004	20.48 billion	1.6 %
2005	29.18 billion	1.2 %
2006	31.87 billion	1.5 %
2007	35.42 billion	2.20 %
2008	63.016billion	5.5 %
2009	79.51billion	7.8 %

Source: PSHSP, 2010.

Evidence suggests that there is a general problem of accountability at the local government level in the use of public resources transferred from higher tiers of government and about which local citizens may, therefore, not be well-informed. The state PHC coordinator, in his opinion on the challenges of PHC delivery in the state, complained that LGAs lacked sufficient funds, and this constituted problem to health facilities. He further lamented the total neglect at the LGA level and linked the poor quality of services to this neglect: The financing of day-to-day facility functioning is largely provided by local governments. However, the national health policy provides general guidelines to all three tiers of government to prioritise resource allocation in favour of preventive health services and primary healthcare, which is the cornerstone of the national programme. In this spirit of prioritisation, the federal and state governments are expected to provide logistical and financial assistance to the LGAs, primarily for programmes of national importance such as the national programme of immunisation, or

controlling the spread of HIV/ AIDS. The federal budget in recent years included programmes of construction of PHC facilities in local governments. However, there are no established rules or policies for the provision of financial assistance from the higher tiers of government, and it is not clear how well any assistance that is forthcoming is coordinated with LGA budgets and plans for PHC services. He suggested that "governments should allocate more funds from general tax revenue to aim at achieving a health sector share of budget of 15% as per Abuja Declaration." The funds made available need to be allocated efficiently and utilised accountably especially in procurement goods and services**.**

Some interviewees reported that the actual staff costs per facility in each LGA could be covered by allocations received; however there were cases of unpaid salaries hence, the non-payment of salaries cannot be explained by lack of resources available to local governments.

The analysis also shows that the greater the extent of non-payment of salaries, the higher the likelihood of facility staff behaving as private providers —with more services provided outside the facility through home visits, and essential drugs being privately provided, either funded by staff own resources or expropriated from facility stocks. This evidence suggests that there is a general problem of accountability at the local government level in the use of public resources transferred from higher tiers of government and about which local citizens may not be well-informed since they are not the tax-payers.

Community Participation

On health community management committee (HCMC), 96% of the respondents agreed that there was HCMC for their facilities, while only 12 respondents did not agree that their facilities had HCMC. About 62% of 96 respondents attended most of the meetings with the HCMC, but 37.5% of 96 respondents participated in such meetings. In terms of HCMC having input in establishing budget in the facility, about 68.8% vehemently disagreed while 31.3% consented with it. Majority of the respondents did not agree that the HCMC actions impacted on discipline of the staff, drugs provision, repairs of equipment and resolving administrative issues. Furthermore, majority disagreed that

activities of the HCMC, when visiting the facilities, include checking register, checking stock cards and checking users' receipts. There was a tie in responses to the question on whether the activities of the HCMC when visiting the facilities include discussing medical issues. However, majority (58.3%) concurred that activities of the HCMC when on visit include checking of equipment and 53.3% agreed that the activities include discussing administrative issues, although the differential between the responses were not significant.

Table 5.19 Health Community Management Committee (HCMC)

Items	Yes	%	No	%	Total	Chi-Square
Any HCMC in your facility?	96	88.9	12	11.1	108	65.33***
Do you attend most of the meetings?	60	62.5	36	37.5	96	6.0**
Does the HCMC have input into establishing Budget in the facility?	30	31.3	66	68.8	96	13.5***
Action by the HCMC in the past years_ Disciplinary recommendation for staff	12	13.3	78	86.7	90	48.4***
Action by the HCMC in the past years_ Provide drugs	12	16.7	60	55.6	72	32.0***
Action by the HCMC in the past years_ Fixed user charges	12	16.7	60	83.3	72	32.0***
Action by the HCMC in the past years_ Carried out repairs on equipment	24	26.7	66	73.3	90	19.6***
Action by the HCMC in the past years_ Resolved administrative issues	12	15.4	66	84.6	78	37.39***
Activities of the HCMC when visit_ Check register	6	9.1	60	90.9	66	44.18***
Activities of the HCMC when visit_ Check stock cards	12	20.0	48	80.0	60	21.6***
Activities of the HCMC when visit_ Check user receipts	12	20.0	48	80.0	60	21.6***
Activities of the HCMC when visit_ Discuss medical issues	36	50.0	36	50.0	72	1.00
Activities of the HCMC when visit_ Discuss administrative issues	48	53.3	42	46.7	90	0.4
Activities of the HCMC when visit_ Check equipments	42	58.3	30	41.7	72	2.0

Note: ***denotes significance of probability value at 1% level.

**denotes significance of probability value at 5% level.

Source: Survey Data. (Author's Field work, 2012)

PART 2: HOUSEHOLD SURVEY RESULTS

5.3 Analysis of Beneficiary's Survey

In all, 1, 200 questionnaires were administered. However, only 903 questionnaires were retrieved at the end of the exercise. This connotes 75% response rate. Out of 903 participants in the survey, 501 respondents, representing 55.5%, were female, while the remaining 402 (44.5%) were male. For ease of appreciation, the ages of the respondents were grouped into four, namely those below 26 (<=25), those between 26 and 49 (26-49), those within 50 and 74 (50-74) and those above s74 (>=75). Table 1 below shows the age distribution and the corresponding percentage distribution of the respondents.

Table 5.2.1: Age (grouped)

	Frequency	Percentage	Chi-Square
<=25	372	41.2	465.28***
26-49	399	44.2	
50-74	102	11.3	
>=75	30	3.3	
Total	903	100.0	

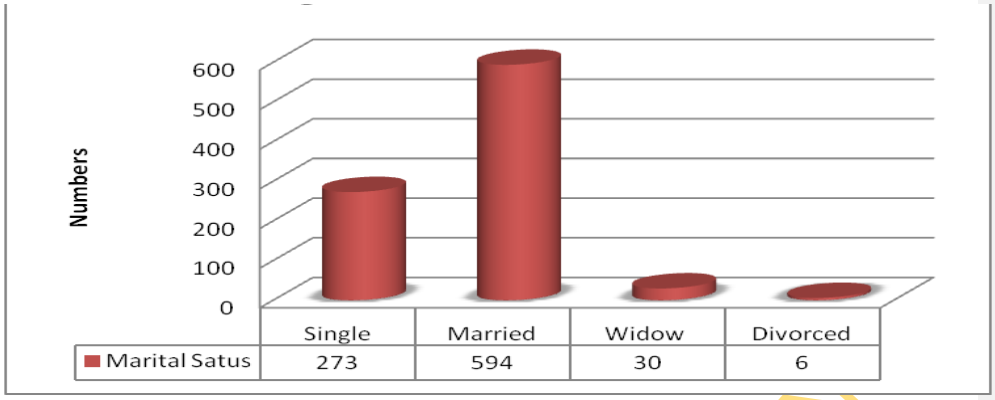
Note: ***denotes significance of probability value at 1% level.

Source: Survey Data. (Author's Field work, 2012)

Majority of the respondents (44.2%) were within the age group 26-49. This was followed by those below 26 years old, which accounted for 372 respondents. 11.3% of the participants were within the age group 50-74 while the remaining 3.3% were above 74 years old. From this age distribution, majority of the participants were in their active years. In addition to this, the Chi-Square result of the age distribution, which is greater than the critical value of the 0.05 significance level (3.84), shows that there were significant differences in the age distribution of the respondents.

It is also clear from the distribution of the marital status, as presented in Figure 1, that 594 (65.8%) of the respondents were married, 273 (30.2%) were single 30 (3.3%) and 6 (0.7%) were widowed and divorced respectively.

FIGURE 5.2.1 Marital Status



Source: Survey Data. (Author's Field work, 2012)

On level of education, 891 of the total participants declared their educational status as illustrated in Table 5.2.2. They are 17.8%, 20.9%, and 45.5% for primary, secondary, and tertiary levels respectively. The remaining 15.8% did not have any formal education. The inference from the foregoing is that majority of the participants were learned.

Table 5.2.2 Educational Level

		Frequency	Percentage
Valid	Primary	159	17.6
	Secondary	405	44.9
	Tertiary	186	20.6
	None	141	15.6
	Total	891	98.7
Missing	System	12	1.3
Total		903	100.0

Source: Survey Data. (Author's Field work, 2012)

The participants agreed that they were active users of health facilities. As captured in Table 5.2.3, all responded to the question on where they received treatment, with 86.4% patronising government hospitals and clinics while 7% used private hospital. Only 6.6% of the total respondents went to medicine stores/ chemists to receive treatment for self and their family when ill.

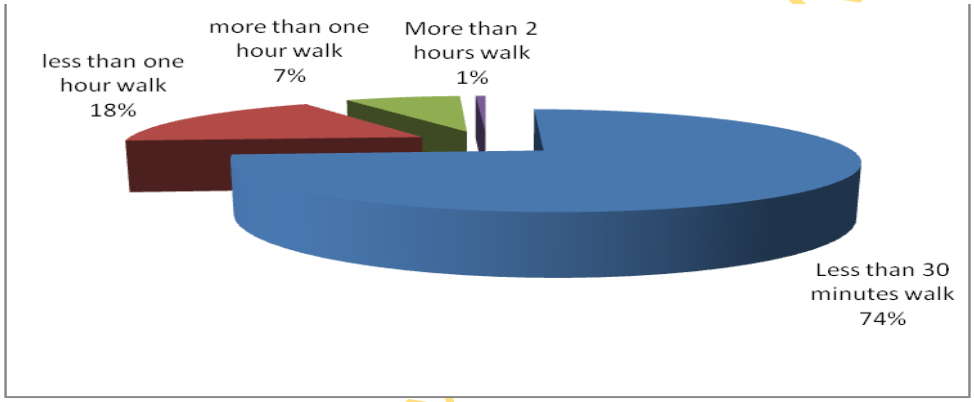
Table 5.2. 3 Where Family Go to Receive Treatment when ill

		Frequency	Per cent	Valid cent	Per	Cumulative Per cent
Valid	Government hospital/ clinic	780	86.4	86.4		86.4
	Medicine store/chemist	60	6.6	6.6		93.0
	Private hospital	63	7.0	7.0		100.0
	Total	903	100.0	100.0		

Source: Survey Data. (Author's Field work, 2012)

Those residing within a distance of 30-minute walk to the nearest public primary health facility were 666. Another 162 required less than an hour of walking and 69 walked more than an hour from their abode to the nearest public primary health facility. Yet another set of 6 respondents, representing 1.0% of the total had to walk for more than two hours from their residence to the nearest public primary health facility. The distribution of the respondents on the distance between residence and nearest public primary health facility is depicted in Figure 5.2.2

Figure 5.2.2: Nearness to Health Facility



Source: Survey Data. (Author's Field work, 2012)

More than three-quarters of the participants utilised primary healthcare centres. The rest of the respondents did not utilise the primary healthcare centres in their community. The reasons advanced for not patronising the primary healthcare centres in their community ranged from poorly-equipped facilities, non-availability of doctors, unfriendly staff and expensive services.

Table 5.2.4: Reason(s) for Not Patronising Health Facility

	Frequency	**Percentage**
Facility is not well-equipped	63	42.9
There is no doctor to attend to patient	51	34.7
Staff is not friendly	18	12.2
The services are too expensive	15	10.2
Total	147	100.0

Source: Survey Data. (Author's Field work, 2012)

The frequency of utilisation among those that used the health facilities ranged between 1 and 30 within the last 12 months. The utilisation rate was further categorised into five groups as found in Table 5.2.5. A preponderance of the respondents, 56.85%, used the primary healthcare facilities 1-5 times in the last 12 months. 17.9%, 4.0% and 0.7% of the primary healthcare facilities used it for 6-10 times, 11-19 times and 20-29 times respectively in the last 12 months. Only 0.3% of the respondents used the primary healthcare facilities more than 29 times in the last 12 months.

Table 5.2.5: Rate of Health Facilities Utilisation in the Last 12 Months

Utilisation Rate	Frequency	Percentage
1-5 times	513	56.8
6-10 times	162	17.9
11-19 times	36	4.0
20-29 times	6	0.7
>=30 times	3	0.3
Missing Response	183	20.3

Source: Survey Data. (Author's Field work, 2012)

Respondents were requested to comment on their level of satisfaction with the quality of care received pertaining to each of the following type of cares:

- Drug supply
- Availability of medical and nursing staff
- Attitude of the healthcare workers
- Availability of diagnostic services
- Information on disease prevention and care
- Availability of drugs
- Waiting time
- Availability of supplies for service delivery

Table 5.2.6 presents the responses to the above listed points.

An overwhelming majority of 528 respondents (58.5%) indicated that they were not "satisfied" with the drug supply at the primary healthcare facilities. 21.3% rated the drug supply as "fair", and 13.3% were "satisfied". Of the total, 4.7% were "very satisfied" with the supply of drugs.

In response to the question on availability of medical and nursing staff at the primary healthcare facilities, 45.8% were "not satisfied" whereas 26.9% were "satisfied". Another 21.6% considered the availability "fair" while 4.3% were "very satisfied".

On the attitude of the healthcare workers, 60 respondents (16.6% of the total respondents) were "satisfied" and 19.6% of the respondents considered the attitude of the healthcare workers in the primary healthcare facilities "fair". However, 66.4% and 6.6% of the respondents were "not satisfied" and "very satisfied" respectively.

As regards the availability of diagnostic services, 20.9% of the respondents were "satisfied" while 29.9% of the participants considered the availability of diagnostic services "fair". On the other spectrum, 41.9% indicated the availability as not satisfying. The remaining 5.3% of the participants considered the availability of diagnostic services in the primary healthcare facilities as very satisfactory.

Acquisition of relevant information on disease prevention and care from the primary healthcare facilities was also considered. Those who were "satisfied" amounted to 120 participants while those that rated the information on disease prevention and care

from the primary healthcare facilities as “fair” were 19.9%. Furthermore, 501 respondents were “not satisfied” , and 48 people (5.3%) were “very satisfied”.

Of the respondents, 324, representing 35.9% of them indicated that they were “not satisfied” with the availability of drugs in the primary healthcare facilities. 27.9% rated the availability of drugs in the primary healthcare facilities as “fair” while 28.2% were “satisfied” . Notably also,, 10.6% were “very satisfied”,.

A quantum (50.2%) of the respondents) was “satisfied” with the waiting time at the primary healthcare facilities. On the contrary, 19.9% of the respondents were “not satisfied”. To 27.5% , the waiting time was “fair” while 5.6% of the respondents were “very satisfied” .

On the availability of supplies for service delivery, 270 respondents (29.9%) were “not satisfied”, but27.2% considered it “fair”. Also, 35.6% and 6.6% of the respondents were “satisfied” and “very satisfied” respectively.

Table 5.2.6 Level of Satisfaction with Facility

Level of Satisfaction	Frequency	Percentage
Satisfied	120	13.3
Fair	192	21.3
Not satisfied	528	58.5
Very satisfied	42	4.7
Missing Response	21	2.3

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Availability of Medical and Nursing Staff

Level of satisfaction	Frequency	Percentage
Satisfied	243	26.9
Fair	195	21.6
Not satisfied	414	45.8
Very satisfied	39	4.3
Missing Response	12	1.3

Attitude of Healthcare Workers

Level of satisfaction	Frequency	Percentage
Satisfied	60	6.6
Fair	177	19.6
Not satisfied	600	66.4
Very satisfied	60	6.6
Missing Response	6	0.7

Availability of Diagnostic Services

Level of satisfaction	Frequency	Percentage
Satisfied	189	20.9
Fair	270	29.0
Not satisfied	378	41.9
Very satisfied	48	5.3
Missing Response	18	2.0

Table 5.2.6 continued

Information on Disease Prevention and Care

Level of satisfaction	Frequency	Percentage
Satisfied	114	12.6
Fair	180	19.9
Not satisfied	501	55.5
Very satisfied	96	10.6
Missing Response	12	1.3

Availability of Drugs

Level of Satisfaction	Frequency	Percentage
Satisfied	255	28.2
Fair	252	27.9
Not satisfied	324	35.9
Very satisfied	57	6.3
Missing Response	15	1.7

Waiting Time

Level of satisfaction	Frequency	Percentage
Not satisfied	180	19.9
Fair	204	22.6
Satisfied	453	50.2
Very satisfied	51	5.6
Missing Response	15	1.7

Table 5.2.6 continued

Availability of Supplies for Service Delivery

Level of satisfaction	Frequency	Percentage
Satisfied	270	29.9
Fair	246	27.2
Not satisfied	318	35.2
Very satisfied	60	6.6
Missing Response	9	1.0

Source: Survey Data. (Author's Field work, 2012)

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On the types of services offered by the healthcare facilities, respondents' views are presented in Table 5.2.7, 873 (97.0%) of 900 agreed that immunisation was part of the services offered by healthcare facilities in their locality. The Chi-square coefficient of 795.24 suggests significant difference between those affirming immunisation as part of the services offered by the healthcare facilities and those refuting it, thus it could be concluded that immunisation was part of the services offered by the healthcare facilities in the area. Similarly, 91.0% of respondents ascertained antenatal/post-natal consultations and normal delivery care as one of the types of services offered by the health facilities while 9% disagreed. Furthermore, those who agreed that STD services, diagnosis and management of minor illness, dispensing of routine medications, public health education and referrals were offered by the health care facilities were 55.8%, 90.6%, 87.0%, 79.9% and 94.9, respectively; however, those who refuted it were 44.2%, 9.4%, 13.0%, 20.1% and 5.1% respectively. The coefficients of the Chi-Square revealed that there were significant differences between the responses for each category of items listed under services offered by the healthcare facilities.

Table 5.2.7 Services Offered by Healthcare Facilities

Items	Yes	%	No	%	Total	Chi-Square
Immunisation	873	97.0	27	3.0	900	795.24***
Antenatal/Post-natal consultations and normal delivery care	816	91.0	81	9.0	897	602.26***
STD services	474	55.8	375	44.2	849	11.54**
Diagnosis and management of minor illness	810	90.6	84	9.4	894	479.34***
Dispensing of routine medications	762	87.0	114	13.0	876	318.97***
Public health education	714	79.9	180	20.1	894	318.97***
Referrals	834	94.9	45	5.1	879	708.22***

Note: ***denotes significance of probability value at 1% level.

**denotes significance of probability value at 5% level.

Source: Survey Data. (Author's Field work, 2012)

Education on health problems and the methods for controlling and preventing them addresses the broad determinants of disease and ill-health in the state, with the aim of promoting health. According to 7% of the interviewees from the LGAs, PHC facilities gave health education to the people, 20% had information, education and communication; 67% had health promotion; 2% had information, education and communication and health education; 1% had information, 5% education and communication and social mobilisation, and 2% had no specific approach.

Immunisation against Major Infectious Diseases: Immunisation programme is one of the most successful programmes of the health sector of Plateau State which is also a model of collaboration between government and NGOs. Unlike many other programmes, the study found the documentation of this programme in all the LGAs and State MoH

(even though that was the only area where one secured some information when needed since the Federal Government frequently demands such information for usage mostly by international organisations including WHO) averagely satisfactory. The EPI target and achievement chart was conspicuously placed in some of the LGAs offices of PHC coordinators. Expanded Programme on Immunisation (EPI) is carried out both by the federal and state governments. The state and LGs announce in the community where and when the vaccination programme will take place.

Most of the people know about the immunisation programme and are interested in getting their children vaccinated. This remarkable coverage of vaccination and the information regarding its benefits can be attributed to the television and radio advertisements and field visits by the health officials. This is a good development in a state located in the northern part of Nigeria where it is known to be problematic as illiteracy and probably religious factor prevent most families from allowing their children to be immunised. This could be because Plateau State is located in the middle part of Nigeria and proximately closer to the southern parts of the country.

There is little effort at specifically targeting preventive measures for endemic diseases. Health education emerged as the most important preventive approach from the interviews. Diarrhoea is a common disease however the prevalence reduced significantly in recent years due to health education of mothers as claimed by some of the people interviewed. No specific preventive activity was deployed against locally endemic diseases in the LGAs studied. However, there were preventive programmes in the PHCs, designed through top-down approach by the FGN, for example de-worming programme. Every PHC is instructed to maintain Disease Profile which is supplied by the FMoH. The list of diseases in the profile often does not contain certain diseases which may be prevalent in that particular area. No epidemiological survey has been conducted to formally identify locally endemic diseases in order to devise appropriate prevention and control strategy.

There is poor functioning referral linkage in Plateau State. Officially, PHC is the first point where people referred from the health-post/clinics and dispensaries report. District hospitals are the second line of referral where patients referred from the PHC are supposed to be admitted. Medical college hospitals (teaching hospitals) and specialised

hospitals constitute the final stage of referral. But this pathway is seldom maintained as most of the people visit the health facilities according to their will and nearness. In order to prevent congesting the higher level with simple ailments, patients must follow a particular referral line-up. But to convince people to maintain proper referral line-up, quality service must be ensured at every referral stage. Lack of equipment and medicine is also a major hindrance to quality service. Therefore, there is always a tendency for the patients to overtake one level and seek care from the upper level if the patient can afford it. As a consequence, the upper referral levels such as district hospitals and teaching and specialist hospitals face tremendous pressure from patients who could easily be treated in PHC centres. It affects the quality of service delivered at that referral level as well. Finally, the patients become deprived of good service from both the PHC level and the higher level (Author's Field work, 2012)

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In Langtang-North especially, referral from the lower level is not satisfactory as lamented by the health supervisory councillor. There were no functioning ambulances services in the public PHCs, thus making private arrangement the recourse of patients' relations, with patients constrained to work out their own solution. But in Duk PHC (Pankshin LGA), the scenario is very pathetic. The Health management committee member who was interviewed on behalf of the chairman of the committee confessed, "Yes, there is no ambulance for sure, but even if there is one where is the road here in this desolate place to run the ambulance?" Moreover, the roads are too narrow for any ambulance to take patient to any referral. Therefore, patients usually travel to the health centre by *Keke Napep* (tricycle)or motorcycle.

Patients are not likely to overtake one level and seek service from the higher one if quality service is ensured at every level because, travelling itself costs a lot of money, and much more is the cost of treatment at higher level.

The respondents were also quizzed about the types of social amenities provided by government to improve standard of living in the community. In Table 5.2.10 which present the distribution of the respondents, 59.8% of the respondents stated that government provided borehole/deep well to improve standard of living in the community. On the provision of schools as social amenity to improve standard of living, 22.6% of the

respondents were impressed by the government effort. Also, 9.6% declared that government involvement in the provision of good road had improved the standard of the living of the people in the community. Provision of electricity by the government was commended by 51 respondents, representing 5.6% of the total respondents, as social amenity that had improved the standard of living of the people in the community (Author's Field work, 2012)

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Table 5.2.8 Social Amenities Provided By Government to Improve Standard of Living in the Community

	Frequency	Percentage
Pipe/Borehole/well	540	59.8
Good road	87	9.
Electricity	51	5.6
Schools	204	22.6
Missing Response	21	2.3

Source: Survey Data. (Author's Field work, 2012)

Although adequate supply of safe water and basic sanitation constitute one of the components of PHC, respondents did not observe formal responsibility of the health sector in this regard. Providing safe water and basic sanitation is the sole responsibility of the state government through the Ministry of Water Board. Government health personnel are supposed to be involved in water supply to various communities as the policy document requires coordination between various government institutions responsible for sanitation, water supply, food and nutrition to the people, but this coordination was not effective, leading to poor provision of these essential services that enhance the well-being of the people and improve their health status as citizen. However, it appears that there is lack of clear guidelines for any form of inter-sectoral collaboration and, even in the policy document; there is no clear job description in this regard. In general, their responsibilities are limited principally to providing health education concerning water

and sanitation and occasional inspection of sanitary latrines during diarrheal disease outbreaks.

There is an impressive range of sanitary inspection conducted in Plateau as 69% of interviewees in LGAs reported having undertaken food vendor certification in the past year, and all conducted the prescribed forms of sanitary inspection of public water sources, markets, house-to-house inspection, and inspection of food businesses. An obvious issue in sanitary inspection is that of corruption as workers extort the people for money and get compromised while on inspection duty However. These can be avoided or minimised if effective anti-corruption measures are put in place. It is notable also that extortion or bribery may not be easily accomplished in the open where it can be witnessed by the public.

Community Participation

The survey asked the respondents if they were aware of the existence of the community health management committee and Table5.2.9 present the distribution of the responses. 52.5% of the respondents affirmed this assertion while 47.5% agreed with the assertion. The Chi-square coefficient of 2.243 was not statistically significant. This implied that there was no statistical significant difference between the set of respondents that agreed and the one that disagreed with the existence of community health management committee.

Table 5.2.9 Community Health Management Committee

	Frequency	Percentage	Chi-Square
Yes	474	52.5	2.243
No	429	47.5	
Total	903	100.0	

Source: Survey Data. (Author's Field work, 2012)

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The respondents were also asked if they considered the community management committee effective in improving the quality of care in their health centres. 58.4% of the respondents disagreed while 41.6% agreed that the community management committee

was effective in improving the quality of care in their health centres. Table 5.2.10 show the distribution of the responses. The Chi-square coefficient of 18.17 was statistically significant. This implies that there was statistical significant difference between the respondents who agreed and those who disagreed that the community management committee was effective in improving the quality of care in their health centres. The conclusion from this is that community management committee was effective in improving the quality of care in their health centres

Table 5.2.10 Effect of Community Management Committee

	Frequency	Percentage	Chi-Square
No	375	58.4	18.17***
Yes	267	41.6	
Total	642	100.0	

Note: ***denotes significance of probability value at 1% level.

Source: Survey Data. (Author's Field work, 2012)

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Table 5.2.11 illustrates the distribution of the respondents to the question posed to ascertain their awareness of any community-initiated programme. Less than average (42%) of the respondents testified to awareness of the existence of community-initiated health programmes. On the contrary, 58.0% of the respondents claimed that they were not aware of any community-initiated health programme. The Chi-square result suggests a significant statistical difference between the two response categories. What can be drawn from the forgoing is that majority of the respondents were not aware of any community-initiated health programme.

Table 5.2.11: Community-initiated health programme

	Frequency	Percentage	Chi-Square
Yes	378	42.0	23.04***
No	522	58.0	
Total	900	100.0	

Note: ***denotes significance of probability value at 1% level.

Source: Survey Data. (Author's Field work, 2012)

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The distribution of respondents' views on if they have input into the community health management committee is illustrated in Table 12. Majority of the respondents (59.0%) declined their involvement in the community health management committee, while the remaining 41.0% affirmed their involvement in the community health management committee. The Chi-square coefficient was statistically significant, suggesting that majority of the participants did not have any input into the community health management committee.

Table 5.2.12 Input into the community health management committee

	Frequency	Percentage	Chi-Square
Yes	363	41.0	28.57***
No	522	59.0	
Total	885	100.0	

Note: ***denotes significance of probability value at 1% level.

Source: Survey Data. (Author's Field work, 2012)

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The national health policy in Nigeria emphasises active community engagement in the provision of PHC services in the spirit of the Bamako Initiative of 1987, where various nations adopted resolutions for promoting sustainable primary healthcare through community participation in financing, maintenance, and monitoring of services. Community participation was institutionalised in Nigeria through the creation of

development committees at the level of the district —district development committee (DDC) and the village development committees (VDC), with explicit guidelines for their respective duties and responsibilities (Monica, 2003).

Community participation is seen as a process of involving the community by promoting dialogue with, and empowering communities to identify their own problems and solve them. Participation of the community in PHC was evidenced in Plateau State through the formation of community health committees, village health committees and health centre or area health committees as well as selection of community health workers for training. Furthermore, community representatives were included in health facility or inter-sectoral management structures such as district health boards, district development committees and hospital management boards.

The management committees represent a very important element in the institutional setting of the system with regard to their main role in planning, management and control of health services. They form an interface between the health system and the population and, hence, represent and promote the people's participation and ownership. Unfortunately in the study area, for example, as was the case reported in Barkin-Ladi, less than 20% of these committees were found to be operational even though the PHC coordinator gave a positive view of communities being actively involved in health matters of their communities, but this view was not in agreement with the views of the few health management committee members interviewed who are of the opinion that their involvement is minimal and non-existent in some communities. A major challenge reported by a high number of those interviewed on community participation was the capacity of the community representatives as well as and relevant local structures to support committees.

Another problem highlighted in community participation is associated with the way the members of the committee were chosen, which was often based on criteria other than consideration of the required expertise. More often than not, the chairperson of the committee is the political leader who may not even be staying in the locality. Some interviewees stated the need to emphasise guidelines on the details of community involvement,

It was discovered that despite the structures claimed by the LGs health officials being in place to manage the work of CHWs, their operation is hampered by the weak managerial capacities of the community and the high illiteracy rates. Whilst the role of community health workers in achieving greater and quicker service coverage is claimed to be recognised, the village health worker programmes in many communities studied have disintegrated. The concept of traditional birth attendants (TBA) still exists but is not widely promoted, given the new emphasis on the need for skilled attendants. Besides, the role of the traditional health practitioners, who are providing a lot of services to the community, does not seem to be well-integrated into national health systems as respondents revealed. One of the directors in MoH stated that although ensuring qualified personnel-assisted deliveries is one of the pillars of the Safe Motherhood Initiative, the contribution of unassisted deliveries to maternal mortality remains significant in the state. The promotion of the traditional birth attendants programmes was launched in the 1970s, supposedly as a transitory measure. However, qualified personnel to assist deliveries are limited, and often concentrated in big cities. Studies have shown limited capacity to detect signs that predict unwanted outcomes of pregnancy by traditional birth attendants. It was also noticed that the antenatal care provided was not of adequate quality. Subsequently, it is not surprising to notice enormous disparities in the maternal mortality rates between the urban and rural populations in the state (Author's Field work, 2012).

In Langtang-North LGA, the chairman of the community health committees in the local government states, "there is no consideration for PHC delivery at all." In fact, in terms of a particular ward, he said that they appeared neglected and uncared for. The situation did not seem limited to health services but covered the general welfare of the community as he declares, the ward "has no water so (health workers) have to struggle going to houses to get water when a woman in labour comes to the health centre." On community engagement, he explained that the people refused to engage because they did not have confidence in the staff. This was primarily because the community had previously complained about the incompetence of the Ward Head but nothing was done because of his connection with one of the state commissioners (Author's Field work, 2012).

PRESENTATION OF HYPOTHESIS

This section presents the hypothesis as tested in the study. The first hypothesis states that: The quality of service is a function of the type of service provided.

Simple linear regression with the formula is

$y = a + bx_1 ... x_n + e$

On the hypothesis

1. Quality of services is a function of the type of service provided.
2. Quality of service is a function of community participation.

y = Quality of service

a = Intercept

x_i = type of health service rendered

Going by the equation (1), the result of the regression shows that R= 0.049, where r^2 =0.002 $r^2 \times 100$ = 0.2, this implies that only 0.2% of the variation in the quality of services rendered are accounted for by the types of services provided. Therefore, The result (F=1.839) is not significant at 0.0.5% confidence level. Therefore, the null is rejected. The meaning is that the type of healthcare facilities does not necessarily determine the quality of services. The respondents may have alternative means of attending to their healthcare demand which may be trado-medical healthcare system.

Table 5.2.13

The result of the Regression , ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	33.318	1	33.318	1.839	.175[b]
	Residual	13715.812	757	18.119		
	Total	13749.130	758			

a. Dependent Variable: Quality of service rendered.

b. Predictors: (Constant), Types of services rendered.

The second hypothesis states that quality of service is a function of community participation. By simple linear regression formula, equation for hypothesis (2) goes thus:

y = Quality of service

a = Intercept

x_i = Community participation

Going by the equation (2), the result of the regression shows that R= 0.201, where r^2 = 0.040 of the variation in the community participation. Therefore, the result (F=34.742) is not significant at 0.00% confidence level. Therefore, the null is rejected. The implication of the result is that community participation was not given a place of priority in the healthcare delivery; thereby affecting impact of the policy on the people since they were not involved from formulation through implementation, accordingly the policy is bound to be ineffective. This result also supports the report earlier presented in this work.

Table 5.2.14

Result of the Regression , ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	33.318	1	33.318	1.839	.175[b]
	Residual	13715.812	757	18.119		
	Total	13749.130	758			

a. Dependent Variable: Quality of service rendered.

b. Predictors: (Constant), types of services rendered.

PART 3: Interview Schedule

5.4 Synopsis of Responses of the Stakeholders/Actors Involved with Health Policy in PHC Delivery in Plateau State

This section presents the qualitative data findings from the interviews with some of the stakeholders/actors involved in the implementation of the health policy at various levels of governance. Building on the previous sections, this section shows the centrality of actors and their ideas in determining effective implementation. The previous section provided the quantitative analysis of the PHC facilities and household perception as well as involvement in the policy, it served as a background to understand how stakeholders/actors have had an impact on policy implementation. The interviewees were requested to state their views on the challenges of implementing PHC policy.

In Plateau State, the health sector is decentralised; therefore, service delivery arrangements involve federal, state and local government coordination and provisioning. The aim of this section is to explain how relationships derived from the existing service delivery arrangements (decentralisation to the LG) influenced the effective implementation of policies in the case of Plateau State. It addresses the questions of how services are provided to the population and how the orientation of the political leadership in the state influence the delivery of services, in this case, the PHC services delivery, as well as getting the status of community participation in service delivery.

Type of Delivery Method: Decentralisation

The interviewer asked respondents at both the LGA and state levels who were the principal decision-maker for the PHC facilities in their LGAs especially in the areas of construction, facility expansion, acquiring new equipment, drugs and medical supplies, facility revenues from treatment and consultation and staff, and transferring staff between facilities. An overwhelming majority of LGA respondents indicated the LGA as the principal decision-maker for most of the areas of facility-level provision of PHC services. Of the three LGAs, all PHC coordinators interviewed listed the LGA as the principal decision-maker for all of the areas surveyed. At the facility-level, respondents similarly indicated the LGA as the principal decision-maker for most service provision decisions at

the facility level, as compared to the other two tiers of government —the state and the Federal Government.

Managerial practices by the Implementing Agencies

Good management is often cited as one of the key factors for ensuring successful policy implementation in the new public management (NPM) literature (Kaufman, 1991 McLaughlin et al, 2001). Managerial practices observed through the interviews conducted for this analysis are performance monitoring, incentive mechanisms, staff understanding of policy objectives and procedures, and training of staff.

It was discovered that, managerial practices were unacceptably weak. Public health systems or institutions in Plateau State seems not yet influenced by the new public management (NPM) trend that has dominated public administration in other countries like the United Kingdom. A clear understanding of the policy objectives, procedures and guidelines is central to implementation. It is the starting point of good management practices. Those in charge of carrying out the policy have to know well besides understanding policy objectives and procedures. However, little understanding of the PHC policy was observed even amongst street-level bureaucrats interviewed in both the state Ministry of Health and at the LG level who were supposed to ensure that implementers achieved the policy aims and objectives as intended when the policy was formulated, by either direct or indirect supervision of healthcare delivery in the state.

In the interview, it was discovered that political leaders, bureaucrats who are policymakers and traditional medical practitioners also had a poor understanding of the policy content as well as the procedures to put the policy into practice. Those concerned with implementation of the policy have to be familiar with, and understand, the policy objectives and procedures. But the interview clearly revealed great ignorance exhibited by some directors, politicians and some medical practitioners that were confronted with question on how far the policy document had addressed the procedures of implementing the PHC policy it was equally evident that some had a poor understanding of the content of the policy. Those who attempted to show knowledge of the policy content revealed that the document needed to be reviewed to clarify issues on collaboration with inter-governmental agencies to ensure effective implementation. One of the interviewee expressed it as follows: “there was no implementation strategy to rely on, so each

department had to find their own way…" Policy implementation guidelines and norms need to be frequently upgraded to match emerging challenges.

No performance monitoring or incentive mechanisms were found within implementing agencies in Plateau State. Performance monitoring involves ongoing reviews with personnel where their performance is compared against predetermined standards and goals. Incentives act as rewards to encourage desired behaviour of staff. Good management also requires having clear objectives and procedures which should be well-understood by staff.

The commissioner, his permanent secretary, and some top management officials of the Ministry of Health opined that the greatest challenges to the health sector were multifarious. In the first place, they were unanimous on the need to rebuild effective service delivery system through training and retraining of existing PHC staff to handle increasingly-complex intricacies of the enormous health problems of the people. Training ensures personnel are better prepared when delivering healthcare services and the survey result agrees with this, as it was observed across LGs that staff training, which improves policy implementation, was poor and lacking in some cases. They further claimed that problems associated with inadequate utilisation of PHC facilities at the local levels, especially the remote areas, arose from the ill-equipping of the PHC facilities attributable to insufficient funding from the federal and state governments, resulting in poor service delivery. This needs to be tackled in order to enhance quality provision of healthcare services.

The management officials were also of the view that the absence of legal and constitutional backing for health in the concurrent list in Nigerian constitution encourages poor coordination of health policies between the federal, states, and local governments including relationship with the private sector and donors. A former Commissioner of Health confirms this, and emphasises the need for the amendment of the current constitution to clarify the vague reference to state and local government responsibilities on healthcare: "unfortunately, the issues of health are just mentioned in passing just about three times in the Nigeria 1999 constitution he further stated that the national health policy adopted by the government in 2004 lays out the roles and functions of each tier of government in health care. While the federal government is assigned the responsibility of

overall policy formulation, coordination, and adherence to internationally recognized standards, the state government with the active participation of local governments is responsible for actually delivering primary health care services, however, neither the National Health Policy nor the Constitution of 1999 makes clear prescriptions about the delineation of responsibilities and authorities between the states and local governments" (Author's Field work, 2012).

During an interview with the Health Commissioner, he added that resources were grossly inadequate especially human capacity at the PHC levels in the state. He blamed it on a series of deficiencies linked to the lack of political will or support from the politicians at the helm of affairs. He further stated that inadequacy of the management capacity of the implementing agency (Ministry of Health) to ensure very effective implementation of the policy in PHC delivery was also due to unavailability of updated policy framework to meet emerging health challenges, tracing the lack of updated framework to lack of seriousness from the part of the political leadership which refused to pay attention to proposals presented to them by his ministry to meet up with the emerging challenges not addressed and budgeted for in the health policy. He illustrated with health information systems that are supposed to indicate problems of implementation of the policy and even the current state health policy is the document enacted in 1990 and adopted in 1992. He said that data quality was poor with regard to the dissemination and use of information, adding however that "unreliable data is still better than no data."

A senior official with the Department of Planning Research and Statistics in the Ministry of Health in the state submits that a pervasive culture of absence of data resulted in the lack of support for PHC in the state. He however pointed out that the policymakers, ironically, wanted information but were not prepared to support the process. When he was asked how the data were used for planning, he laughed and then said, "Only when the federal government wants data then everyone runs around looking for data."

Also, on several visits to one of the PHC offices located in a LG secretariat among the local governments studied, it was discovered that the information officer was always not available although information on disease control and the health status of the people was sought by the researcher. When questioned about this, one of the officers

made a few calls and reported back, saying, "he is at home, there is no work so there is nothing to do here."

Proceeding on to the monitoring and evaluation office in another local government secretariat, it was discovered again that the monitoring and evaluation officer was absent from work – and in fact had been absent from work for weeks because she regarded her appointment in that post was "a political disciplinary action." The State Health Management Information System Officer gave four reasons why public servants may not turn up for work as:" 1) The government does not provide the necessary things to keep people in office; 2) qualified staff may be subject of vindictive action by political agents and therefore posted to a remote area and, they in turn, may decide to stay away from work; 3) If your staff does not come to work and you report them, nothing will happen. They can also decide to inform a top official in another ministry and then you can even be posted out of your station on no basis, rather than you are disturbing people to come to work; 4) And even if you want to work and so identify training workshops to help you and your staff, there's no funding."

When a senior official in the Ministry of Health was asked whether there was a State Health Management Information System policy in place, he noted that the state was not without its weaknesses: "Our problem is that for a while we have not given much importance to monitoring, we just assume that monitoring is a waste of time. So we don't have any specific policy intervention." Picking up on the issue of donor activities in the state and how this impacts data integration, the Permanent Secretary argued that human resources in the health sector in the state and indeed throughout the country was being "overstretched by the WHO." (Author's Field work, 2012)

Political Leadership Context

History has shown that no nation grew and enjoyed steady development in virtually all spheres of its national life without properly-oriented good and selfless political leadership. This is largely because qualitative growth and development have always been outcome of good governance (Michael, 2012). The character of leaders more than anything else, determines the character of the society. Where leaders are genuinely constructive and developmental in their approach to socio-economic and political

organisation of the state, society will surely have better legacies to show for it. It is the character of the leadership class or state elite that largely, and more than any other factor, determines the character and quality of society.

Commenting on the experience of the Plateau State political leadership, one of the interviewees, a director with the Plateau State Ministry of Health said that the trouble with Nigeria is simply and squarely a failure of leadership. Consequently, when the political leadership class of a country espouses corruption, it becomes difficult for it to act positively to the benefit of the state and its citizens. This is the condition of the Nigerian state since independence. The political leadership class, in its quest to secure or retain power, suppress opposition, and divert public funds for personal use. They thus, sacrificed positive leadership for corruption.

Stakeholders admitted the existence of corruption in the sector, and that situations were actually created for corruption to thrive. As an expression of the sorry state of corruption in the sector, an official declares, "As a Christian association, we don't want to get corrupt, but one has to be corrupt in order to be able to do what you want to do. Either you accept to be corrupt or you don't get what you want''.

5.54 Implications of Findings

Policy implementation studies have been concerned with why policy objectives and expected outcomes are sometimes not met. The overall objective of this research was to examine the implementation of Plateau State PHC policy in service delivery by focusing on some factors that have received little attention in literature and account for can also influence the success or failure of policy implementation: type of delivery arrangement (operations), actors such as political leadership and bureaucrats interest, and commitment and extent of community participation in the implementation of the policy. Data were collected using both quantitative and qualitative research techniques, employing research tools such as survey questionnaire, in-depth interview, observation and document analysis.

Type of Service Delivery Arrangement: Decentralisation

Policy implementation studies have been concerned with why policy objectives and expected outcomes are sometimes not met. Federal administrations, like Nigeria, pose a challenge for country-wide policy implementation since, in the first instance, each state has to agree and enact its policy to be in conformity with the national policy. Furthermore, translating a policy into action can be potentially more difficult if it has to move downwards from the Federal Government to states and local governments. In such cases, the coordination and division of responsibilities has to be carefully described and assigned. This situation reflects what Pressman and Wildavsky first depict as the implementation problem: How great expectations in Washington are dashed in Oakland Pressman and Wildavsky, (1973).

The PHC policy is an example of federal policy intended for adoption in local settings. The risk of decentralised service delivery is that it may create conflicts between the different levels of governments. In decentralised systems such as the PHC provision in Plateau State, the relationship between local and federal governments is crucial for policy implementation. Whether there is decentralisation of healthcare provisioning or not, individuals and their interest matter in the way implementation is carried out. The individuals holding key positions determine this relationship. They have the power to enable or constrain certain policies. The interviewees complained of conflictual relationship that constrains policy implementation between federal and local governments. These conflicts arise from the ambiguity or lack of clarity in sharing of responsibilities by the 1999 Constitution especially on decentralisation to local governments, implying that the provisions of some public goods are concurrently shared between the federal and state governments.

In 1976, local government authorities (LGAs) were established and recognised as the third tier of government, responsible for participating in the delivery of most local public services along with state governments and entitled to statutory revenue allocations from both the federal and state governments for the discharge of their responsibilities. In the late 1980s, there was a national initiative to overhaul the PHC system by adopting a new national health policy, in the context of which the federal and state governments

issued directives by giving LGAs full responsibility over the delivery of PHC services (Adeniyi, et al 2003).

The current national health policy document, revised in 2004, indicates that local governments are expected to be the main implementers of PHC policies with the Federal Government responsible for formulating overall policy and for monitoring and evaluation and state governments for providing logistical support to the LGAs in terms of personnel training, financial assistance, planning and operations. It is stated thus: "With the general guidance, support and technical supervision of State Health Ministries, under the aegis of Ministries of Local Government, Local Government Councils shall design and implement strategies to discharge the responsibilities assigned to them under the Constitution, and to meet the health needs of the local community" (NHP, 2004). Still, the current constitution of Nigeria is ambiguous with regard to the authority and autonomy of local governments in providing basic services, such as PHC services, for which they have been assigned responsibility through sectoral directives.

The Fourth Schedule of the constitution lists the functions of LGAs as follows:
The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters: (a) the provision and maintenance of primary, adult and vocational education; (b) the development of agriculture and natural resources, other than the exploitation of minerals; (c) the provision and maintenance of health services; and (d) such other functions as may be conferred on a local government council by the House of Assembly of the State.

Against the backdrop of the constitution, state governments have principal responsibilities for basic services such as primary health and primary education, with the extent of participation of LGAs in the execution of these responsibilities determined by individual state governments.

Nigeria is one of the few countries in the developing world that has constitutionally decentralised revenue allocation and expenditure responsibilities to locally-elected governments. In many developing countries, even when locally-elected governments exist, there are neither regular nor systematic channels of resource transfer nor well-defined responsibilities for service delivery. In comparison, local governments in Nigeria receive large and substantial funds to perform their functions, given their share

in the federation's oil revenues, and are generally identified as the responsible government agency for primary social services. This might lead to an expectation that public delivery of services in Nigeria would benefit from the institutional arrangement of decentralisation to local governments. Yet, the survey evidence generated from this study reveals enormous problems of accountability at local governments.

PHC Operations

Generally, health services of preventive, curative, promotive and rehabilitative nature are meant to be provided at the PHC level which is the point of entry to the healthcare system. These services are provided by the LGA with the support of the state and federal governments. These basic service provisions in Plateau State are adjudged unsatisfactory. PHC facilities are inadequately distributed and poorly-maintained particularly at the lowest rank of the PHC facilities known as the health-post or dispensaries mostly located at village level. A poor state of infrastructure (buildings, equipment, materials and supplies) and inequitable distribution of available facilities is the norm in many places as found by the study. In some communities, people have to travel for some distance to access healthcare and referral centres are not easily-reached as emergency vehicles are not provided in the facilities.

The demographic profile seems to suggest that the literacy level is close to 65%, however quite a number of respondents claiming to have attained primary-level education still had difficulty understanding and completing the questionnaires, and had to be assisted. Although farming is the main occupation of the majority, this is limited to subsistence farming, and not large-scale mechanised farming.

The fact that at least 80% of community members would most likely visit a health facility annually demonstrates a clear need for good basic health services to be provided within the community. The frequency of hospital visits provides a good indicator for inventory planning for service provision. It follows that once the catchment population of the facilities is known; there should be provision of monthly inventory to serve at least 20% of the population. It is interesting to note that although 45.2% of the respondents claimed that government hospitals were their first port of call on suspecting an illness, in terms of real patronage and frequency, the traditional and private hospitals are most

patronised and the PHCs least patronised. This is indicative of low utilisation of the PHCs due to poor service provision. Although it very obvious that the most important need for community health services is for the management of ill-health (malaria and dysentery being the most important), these services are not readily available. Rather, only the funded vertical programmes (immunisation, antenatal care and family planning) are the most readily available services, hence the perception of 'inadequate health service delivery by the community.

It is therefore desirable for the level of funding of health programme interventions to be proportional to the needs of the generality of the population served. This buttresses the point made by Meier, (2003), on the dangers of promoting selective PHC over comprehensive PHC in most developing countries, According to them, this is contrary to vision of the 1978 Alma Ata declaration and has led to poor outcomes of the PHC implementation. The outcome of this study justifies this assertion, as the evidence from the perception of the communities surveyed indicates that the PHC system as currently implemented has very limited functionality. It is noteworthy that ''access to essential drugs'' remains the key indicator identified by the community for evaluating the performance of the PHC. However, there is no list of essential drugs and neither are the drugs available.

The facility, household surveys and qualitative interviews carried out found out how the principles of PHC were implemented. These principles included condition of education concerning prevailing health problems and the methods of prevention and controlling them, promotion of food supply and proper nutrition, supply of safe water and basic sanitation, maternal and child healthcare including family planning, immunisation against major infectious diseases, prevention and control of locally-endemic diseases, treatment of common diseases and injuries as well as provision of essential drugs. Only in terms of immunisation were the findings satisfactory.

The supply of safe water and basic sanitation is not the responsibility of the health facilities but the local and state government ministries of water resources and ministry of environment, who are suppose to be in collaboration with the ministry of health and finance to provide these services to the people. Plateau health policy has not offered any concrete terms and clear conditions to ensure collaboration between ministries, other

sectors, groups, organisations, actors, and communities to achieve the comprehensive goals of the PHC. The absence of a well-documented and articulated plan in the supposed roles and responsibility by each sector is lacking, resulting in the poor coordination, integration of service provision and supervision in the state. This lack of collaboration leads to resource mismanagement, professional agitations, confusion, frustration and consequently inefficiency. The need for the health sector to play a leading role in health besides coordinating and establishing synergic relations with other sectors that have an impact on health was seen as one of the major contributions that can enhance the achievement of the PHC strategies for health development. This is necessary because there were no institutional mechanisms to guarantee that health objectives were prioritised and made an integral part of policies and programmes with other sectors. Some respondents noted that envisaged inter-sectoral collaboration had remained non-functional partly due to lack of funds as well as lack of clarity of roles and responsibilities.

In general, opinion among stakeholders reveals that Plateau State has established some health councils and PHC committees at the state and local levels to promote interactions amongst government agencies however the collaboration exists on ad hoc basis rather than in a formal sense with clearly-designated structures and well-defined motives. As a result, there seems to be a lack of general understanding among the different stakeholders on their roles in PHC. WHO (2003a) evaluation reports cite the important constraints on inter-sectoral collaboration in health as including (i) lack of a permanent multi-sectoral collaboration in the field, (ii) close organisational structures and the specialised nature of public health services, (iii) low financial resources, (iv) underestimation by healthcare authorities of the potential of other sectors in addressing health problems (v) increasing social and economic difficulties (vi) frequent political instabilities and (vii) differing donor expectations and requirements.

Availability of skilled/qualified healthcare workers and training level of facility staff have been identified as key quality determinant of PHC service delivery. The result of this study indicates a gap in the skill level of health workers manning majority of the facilities. The distribution of health personnel is inequitable and inadequate in the rural areas especially in the hard-to-reach areas. The service provider's client relations are also

poor, with poor incentives and poor compensation for health workers. David, (2014) stressed that the perceptions of facility staff commitment to the community has effects on community beliefs about healthcare, including levels of distrust in the healthcare system. Considerable evidence across many disciplines has demonstrated that trust is associated with higher functioning of organizational units and societal entities, largely by reducing "transaction costs" and strengthening social support. Senior Community Health Extension Worker (S/CHEW), which is the designation of the appropriately-trained personnel to manage referral level PHCs, were available in only 30.7% of the facilities. This has serious implications for staffing practices and norms, in terms of the quality of service delivery and the attendant customer satisfaction. Indeed, this factor came out clearly in the community survey wherein the community members expressed lack of adequately-trained personnel as an important quality concern.

Health systems are challenged to entice urban-educated doctors and nurses to work in poor areas. Poor areas are more likely to have lower-paid health providers who may miss work often or have little motivation or incentive to provide good care as a result of being engaged in other activities to supplement salaries. In addition, some health providers openly discriminate against individuals from certain economic classes or ethnic groups. The "social distance" between service providers and their clients can be large; leaving clients feeling scorned or neglected Dercon, (1996). Nurses in Plateau State are often portrayed as angry and rude towards the poor. This problem is due to the poor nature of some districts and these results in negative consequences for people making use of health services.

Although the national health policy identifies 10 minimum package of essential services that should be provided at all levels within the PHC system, it was obvious that the lower level facilities have neither the capacity nor the skilled personnel required to provide all the services required. The study proposes that the organisation and/or categorisation of the different levels of PHC should be according to the number of service components they have the capacity to provide (NHP, 2004).

Identification and prioritisation of the respective packages should be driven by the objective to achieve equity in health and well-being outcomes, as proposed by Sachs, (2001). From the study's findings, majority of the facilities investigated have the capacity

to provide satisfactorily, to a large extent, only two (immunisation and ante/post-natal care) out of the 10 components and other services provided are not done as satisfactorily as the two mentioned earlier. This situation is not unconnected to the funding status of the respective programmes. Immunisation is the best-acclaimed programme of health sector which reduced child mortality considerably. This buttresses the observation by Sachs, (2001) that current international donor-driven disease-control initiatives (HIV/ADDS, TB and Malaria) should avoid the mistakes of mass campaigns of past decades, which set programme targets driven by international agenda such that achievements were at the cost of adverse negative impact on sustainable health-system development.

The quality of service is poor and largely unaffordable by majority of people. Squabbles between nurses, community health workers, and environmental officers are a contributory factor to low quality of care. Sensitive health issues are now being relegated to low cadre of staff with very little experience. Protocols for standard management of common childhood illnesses at the PHC level are inadequate. Poor client satisfaction has, over the years, led to loss of confidence in the public healthcare delivery system.

Traditional health practitioners are devoid of standardised practice and may constitute danger in their mode of practice sometimes. In Langtang Local Government and Lipchok district area, in-depth interview with the TBAs reveals the deplorable condition under which they deliver services to clients and most people in the rural areas seek medical attention from traditional medical practitioners due to poverty and inability to pay charges in modern health facilities (Author's Field work, 2012).

The laboratories were not functional, where available at all, in most PHC facilities surveyed. PHC laboratories, where available, were found to have very low workload, and the accuracy of their results and the quality of the small range of tests performed are questionable. There was no quality control of laboratory tests in primary facilities because they lacked appropriate professional supervision.

The survey also shed some light on the referral system, which again relates to a number of issues such as service delivery, accessibility and equity in service utilisation. The study found that there is no functional integrity in the referral system. Service delivery and utilisation are inequitably distributed among the population across their

gender and income quintiles. Richer people in the local governments can access the health centres more quickly than the poor since they can afford the services of private healthcare providers. Also, long travel time, less contact time due to shortage of health worker, lack of responsiveness by the service providers, scarcity of medicine and equipment, unavailability of proper HRH and lack of trust provoke the people to overtake the lower referral level and succumb to distant health facilities notwithstanding higher cost. Furthermore, if critical patients are referred to higher health facility, it becomes difficult due to unavailability of appropriate referral facility in place. (Author's Field work, 2012).

Continuity of care, in addition to comprehensiveness of care, warrants commitment of the service providers, availability and proper management of services, effective HMIS, internal and external monitoring, progressive prepayment health-financing mechanism, transparency, accountability and responsiveness towards patients' needs. Taking these indivisible issues into account, proper referral mechanism should be integrated into the PHC delivery.

Financial Resources

Most countries in Africa are currently facing an array of healthcare financing and management problems. Increasingly, countries have been found to rely on direct out-of-pocket payments as a means of paying for healthcare goods and services in the their regions (an average of 36.7% of total health spending in 2000 ranging from a high of 73% of total health spending in Nigeria to zero in Algeria, WHO, 2005). Although such alternative financing and cost-recovery schemes have been implemented in many African countries, their effect on promoting equity and accessibility of PHC is still limited.

Health financing strategy has major implications for the provision of primary health in Plateau State. Indeed, because it was found lacking by the study, it is essential for the state to develop a comprehensive health-financing strategies including computation of the cost of implementing the state health policy and strategic plans and provision of the essential services, and the financing sources and mechanisms that will be employed to fund them.

Local government expenditure responsibilities are financed largely through statutory allocations from the Federation Account, with LGAs regularly receiving about

20 per cent of total federal resources in the divisible pool. Since oil revenues are part of the Federation Account, LGAs receive substantial revenues on account of this statutory allocation. LGAs are also entitled to a share of federally-collected VAT revenues (outside of the Federation Account). In addition, LGAs are supposed to receive statutory allocations from state government revenues, but the rules related to this are less strict and not always enforced. Total LGA revenues in the country amounted on average to over 5 per cent of GDP between 1990 and 1999, and over 10 per cent of GDP after the oil price increase in 1999 (IDB, 2004). LGAs also have recourse to significant own tax bases, although studies have shown that these have not been explored maximally, and that internally-generated revenues are a small proportion of total LGA revenues (IDB, 2004). .

Plateau State largely depends on Federal Government for statutory allocation which is reported as insufficient. In the opinion of the majority (82%) of the interviewees, internally-generated revenue is poor even though it is claimed by the state government that revenue generation has marginally improved both at the state and local government levels since the present governor (2011 -2015)Jonah David Jang came into power in 2007 but this claim can only be commendable if public services are visibly improved, meaning that the improved generation of revenue is being properly channelled for the betterment of the people (Plateau State Strategic plan, 2010).

A critical factor inhibiting effective implementation of PHC policy in the state is that the agencies or institutions saddled with the responsibility of implementing policy do not possess the requisite resources in terms of human (manpower) and financial resources to effectively implement them. On the issue of inadequate resources, for instance, government, sometimes, does not budget adequately to enable the public bureaucracy properly implement formulated policies (Ikelegbe, 2006). Indeed, to effectively implement policies, the implementing agency needs resources in adequate and timely manner, however such not being the case in Plateau State explains, in part, the failure of certain public policies to achieve desired goals. Federal Government claims to give out sufficient fund but the corrupt activities within state and local governments do not allow for its judicious use to effectively execute policy programmes. In any case, insufficiency of financial resources has resulted in situations where laws could not be enforced, services were not provided and reasonable regulation not developed and applied.

Findings revealed a gross underfunding of the health sector in the last decade at state and local government levels, with less than or slightly above, 6% of the state budget and 1% of the local government budget allocated to health respectively over the years. At these levels, health financing ≤6% in the last 5-10 years, much less than the minimum allocation of 15% set by the Abuja declaration and the WHO (Plateau State Strategic plan, 2010).

Local government (LG) is the most critical level of government as far as primary healthcare delivery is concerned, yet it is deemed the weakest arm of government especially in terms of capacity. There is a strong perception that it is a setting where corruption is rife, jobs are given to unqualified and, most likely, disinterested candidates because of their connections. The LG chairman is a key stakeholder in the process because his office determines budget allocation. For example, a chairman may prefer to build markets rather than invest in health because the latter is deemed intangible.

Historically, there is a wide spread lack of appreciation for the need to ensure that PHCs are adequately provided and equipped. However, beyond the continuance of a defective legacy practice, a director in the Ministry of Health, using investment in PHC as an illustration, expressed the inefficiency of a policy that purports to promote the PHC system but invests more in secondary and tertiary health institutions. The subtext is that the actors in influential policy positions are maintaining the status quo through their passiveness in order to protect their interests. For instance, ideological preferences and political gains stand to benefit more from tangible prestigious projects like building tertiary and specialist hospitals. There is a weak implementation of the PHC policy even though the government claims considering health a top priority. PHC delivery to communities is usually challenging because they are often isolated without adequate roads, accommodation, electricity, and other social amenities. Consequently, attracting experienced and qualified health workers to run the PHC facilities in the rural areas is a problem. The quality of care provided at rural communities is often very poor and the situation is further compounded by the breakdown of supervision arrangements because some of these communities are hard to reach (Author's Field work, 2012).

Human Resources

On the issue of inadequate human resources, the PHC facilities do not have adequate staff in terms of proposed requirement by the national and international standards and more importantly in terms of specific areas of professional competence and expertise. There were 327 nurses/midwives in 908 PHCs across the LGs in the state, a ratio of 0.3/PHC against the minimum 4/facility national standard. Healthcare professional ratio was 1.4/1000 population compared to national standard of 2/1000, and World Health Organisation standard of 2.5/1000. This is counterproductive as the capabilities of government bureaucracy in terms of expertise and skill determines, to a large extent, policy implementation success or failure therefore the fact that there is an increase in the demand for primary care service is a great concern on the shortage of man power. It is noteworthy to mention that not only in Plateau State is the demand for increase in primary health care but even in developed countries like the United State of America as observed by Allison, (2015) who stated that the demand for primary care services is increasing on multiple fronts as underserved communities face increasing clinician workforce shortages. Where abilities exist, policies could be confidently formulated with reasonable assurance of their effective implementation. It is worthy of note that the inadequacy of personnel, particularly as it relates to expertise and skilled manpower such as in the health sector, results in part, from the personnel recruitment policies into the Plateau State PHC facility which are essentially based on non-bureaucratic criteria such as the state of origin or ethnic group against objectively-measurable criteria like qualification and professional competence (Mahler, 1980 and Lerche, 2008).

Political Context

Health policy process does not take place in a political vacuum but is embedded in a political and administrative context (Navarro, 2000). According to international organisations, governments should be stewards of their national resources, maintaining and improving them for the benefit of their populations (WHO, 2000). In health, this means government's continuous and permanent responsibility for the careful management of the citizens' health and well-being (WHO, 2005). By acknowledging the importance of political context, the 1992 Plateau State Health Policy states that good

governance is one of the key features of the policy and government considers good governance as the basis of health sector plan to achieve quality of healthcare (SHP, 1992).

However, as the analysis showed, in practice governments could neither offer good governance nor a favourable policy context that can assure an effective health policy process. Consequently, health policy in PHC delivery lacks sustainability and the health sector suffers from resource constraints which could be attributed to the lack of political will of the ruling class.

The orientation of the political leadership of the country since independence is responsible for entrenching corruption in Nigeria and, by extension, had impeded meaningful socio-economic development. It is incontrovertible that corruption is the bane of Nigeria's development. Accordingly, the phenomenon has ravaged the country and destroyed most of cherished national values. Unfortunately, the political class saddled with the responsibility of directing the affairs of the country, has been a major culprit in perpetrating this act. Regrettably since independence, the surviving legacy of the political leadership, civilian and military, in the country is institutionalisation of corruption in all agencies of the public service, which, like a deadly virus, has infested the private sector of the country.

It is a paradox that Nigeria, the world's eighth largest exporter of crude oil, a country endowed with many resources, still has more than 70 per cent of its population living below the poverty line as a result of corruption and economic mismanagement (Okafor, 2008). Pathetically, most interviewees described the Nigerian political leadership class as self-serving at the expense of national interests. Consequently, corruption has become the hallmark of the leadership in managing the wealth of the public at national, state and local levels.

1.1 A constraining factor in effective policy implementation in Plateau State is undue political leadership influence on the public bureaucracy. Usually, in Plateau State and indeed Nigeria, the political leaders formulate policies as well control and direct the implementation activities of the policy. This is not proper as such control and directive are mostly motivated by selfish personal or political interests. Indeed, the implementers cannot effectively implement policies and

meaningfully contribute to national development if it is controlled and directed by political authorities. This is more so in extreme cases in the state, as revealed by some of the interviewees, though they were implementers they were not allowed to take decisions or actions on basic routine administrative matters without consultation and the consent of relevant political authorities. By this, much time and energy are wasted while prompt action is required for effective implementation of policy. Given this, therefore, Ikelegbe, (2006) posit that the extent to which politics influence the implementation activities will continue to determine and shape the extent to which policies can be properly and effectively implemented by the public bureaucracy which can also happen in Plateau State. It is very disturbing that political influence on policy implementers is becoming tighter as promotion to headship positions in some public institutions is based on political patronage or loyalty and not on the basis of relevant or cognate experience and seniority. Bureaucrats promoted under such circumstance are obliged to subject their official decisions and actions, substantially, to the wishes, preferences, control and endorsement of their political masters. .

In all, political power in Plateau State has alternated between the civilian and the military since independence and neither has fare better in terms of corruption ratings. Politically, the thinking of the leadership class was based on politics for material gain in terms of making money and affluent living. The military rulers were not better nor different from the civilians leaders; apart from the mismanagement of the economy, the military regimes are also enmeshed in corruption. Frequent changes in governance remove the political energy needed for effective implementation of the project as expressed by a former commissioner of health in the state: "it is impossible to work and plan under uncertain political situation, particularly when health commissioners are changed frequently and every new commissioner asks for changes in health plans" (Author's Field work, 2012). Citing himself as an example, he served for two years as commissioner and had started executing some plans towards significantly improving PHC service delivery, but they were aborted by his successor.

About 90% of those interviewed overwhelmingly accused the political leaders of seeking how to further their own financial interest at the expense of service provision.

Other issues were lack of political will, poor leadership and governance, poor health human resources resulting in inefficient service delivery in the state. (Author's Field work, 2012)

Due to the self-serving nature of the political leaders, they lacked the commitment to offer good governance. By orientation, the political leadership remains elitist and exploitative, thus the welfare of the people is excluded from their calculations. It was also stated by majority of the interviewees that political instability, resulting in frequent changes in government, threatens accountability due to policy somersault or abandonment of programmes started in earlier tenure. In the context of this study, frequent change of health commissioners and PHC coordinators is a relevant factor.

Like most developing countries, Nigeria is still grappling with the dilemma of corruption that has largely retarded social development, undermined economic growth, discouraged foreign investments and reduced the resources available for infrastructural development, public service, and poverty-reduction programmes. Much more disturbing, the scourge of corruption leaves the poor perpetually disproportionately under-privileged, even as it render the development of democracy and the building of a society of opportunity more problematic (Okeke, 2001). Thus, by diverting assets from their intended use, corruption can be said to be the single most important factor responsible for the failure of governance and lack of sustainable socio-economic development in Nigeria.

Failure of the political leadership class in managing the affairs and wealth of the state has inevitably brought severe hardship to the poor masses. Nigeria's post-independence political bureaucratic and military elite have pillaged the nation's wealth with impunity, thereby denying the citizens access to economic prosperity and quality living condition.

Governmental expenditure is a noticeable consequence of corruption on the political and economic well-being of Nigerians, the government at all levels spends relatively more on large and hard-to-manage projects, such as airports or stadiums, to make room for fraud because execution of such project makes fraud easy rather than embarking on projects such as building health facilities that will enhance the well-being of the ordinary people. Indeed, it is difficult to think of any social ill in the country that is not associated with the embezzlement and misappropriation of public funds, particularly

as a direct or indirect consequence of the corruption perpetrated by the callous political leadership since independence.

As a result of corruption in Plateau State, the healthcare delivery system and other social amenities are poorly provided. Government spending has been considerably reduced towards these vital social sectors of the economy and others of equal importance, which are supposed to be of high priority to government. To this end, the results of these effects have been catastrophic as different forms of malpractices and corrupt practices have degraded the state healthcare development. More so, corruption in the health sector has also allowed counterfeit and adulterated drugs to find easy passage into the country as a whole and not just the state with little or no resistance until 1999 when Professor Dora Akunyili took over the leadership of the National Agency for Food and Drug Administration and Control (NAFDAC).

Numerous charges of corruption and misuse of public authority against civil servants working in health ministries and health managers were frequently made by the interviewees. Factors responsible for corruption mentioned in health sector included: weak judicial system, lack of accountability, low salary, and non-recognition of performance and lack of motivation particularly among health workers working in rural areas (Bourke et al, 2004; Britt et al, 2008; Gulliford, 2004).

Corruption in the health sector significantly affects health policy implementation and health outcomes in various ways such as purchase of outdated or expired medicines, acceptance of bribes and kickbacks for purchasing low-quality medical equipment and technologies, stealing of public equipment and medicines meant for poor patients (Babura, . 2003). There are repeated complaints of bribery, misuse of resources (including ambulances), and sale of public equipment in government hospitals (Whitehead, 1999, Asuzu, 2004). As a result, the health sector loses its scarce resources and health policy implementation is distorted. There are complaints of doctors, nurses and other health professionals being absent from PHC facilities in the rural areas. Corruption has eroded the capacity of the health sector to ensure that other public policies and the activities of the other sectors are aligned to health development in the state.

Corruption reduces the resources available for health, lowers the quality, equity and effectiveness of healthcare services; decreases the volume and increases the cost of

provided services. Also, it discourages people to use and pay for health services and ultimately has a corrosive impact on the population's level of health. Nigeria's corruption perception index in 2009 was 3.9 out of a total of 10, showing that corruption remains a major problem in Nigeria and much of its anti-corruption stance is mere rhetoric (World Bank, 2010)

Despite its substantial natural and human resources, Nigeria remains desperately poor due to bad management of its wealth by successive corrupt governments. Perhaps the most tragic effect of corruption on Nigeria has been the failure of the country to attain economic potentials.

For healthcare systems, in spite of better economic performance and reasonable economic growth, the country allocates minimal resources to health development. International organisations have commented that Nigeria falls in that category of countries where economic advances are being made but resources or policy deficiencies are blocking progress towards achieving several health and welfare goals (UNDP, 2004; Word Bank, 2004).

Such an unfavourable economic context of particularly-low governmental expenditures on health has led to severe resource constraints on the health sector. As a consequence, health policy implementation is difficult and health projects suffer from delays in preparation and successful implementation. The resource constraints also increase the dependency of the Ministry of Health on donors in implementing international health strategies and programmes.

Economic and socio-cultural factors influence health policy process in various ways in Plateau State. The state has low public health expenditures. This has led to resource constraints on health sector and results in health policy implementation failures. Corruption leads to low quality in the human resources for health, low quality of drugs and medicines and health services, and ultimately to implementation failures in health policies and programmes.

The survey attempted to collect budgetary data on health expenditures of local governments, but it was a difficult exercise. During the field testing of the survey instruments, it was observed that numbers on total health expenditures were either not easy to find or simply not available in LGA budget documents, and the responses on

questions relating to finance were often inconsistent and the data therefore hard to interpret.

Silent corruption prevails at the MoH, where staff is believed to be plying their own business during official business hours. Mega corruption is also believed to be occurring but on a limited scale, and difficult to uncover because expenditure reports are not in line with the budget headings. Moreover, data in the sector is not good enough to offer leads to corrupt practices.

Economy and Social Trajectory

Economic and socio-cultural factors affect the health policy environment, and influence the socio-political behaviour of the people and the flow of resources for health development. Nigeria has experienced high levels of economic growth since 2005 while oil revenue increased. Between 2005 and 2006, Nigeria repaid $12 billion to the Paris Club to achieve debt cancellation of $18 billion. But its economy remains largely a mono-mineral economy with oil accounting for about 20% of GDP and 80% of foreign earnings. Nigeria's Gross Domestic Product (GDP) at 1990 constant basic price was about N888 billion with the economy averaging a growth rate of 5.6% over 1999-2007 and 6.7% over 2005-2012. The GDP per capita (at constant 2010 $US) as at 2012 was 1,071.52, with average growth rate of 4.2% in 2006-2012 (National Bureau of Statistics, 2013).

The economy has been experiencing structural changes in terms of contribution of sectors to the GDP. The contribution of agriculture which constitutes 64.1% of the GDP in 1960 experienced a decline to 42.2% in 2007 and 39.2% in 2012. Industry (which comprises crude oil and gas, and manufacturing) contribution to the GDP which was about 15.3% in 1970 rose to 30.4% in 2004, and afterwards has been on a decline to 23.4% in 2007 and 18.3% in 2012.

The wholesale and retail sector has recorded marginal increase in terms of relative contribution, from 13.9% in 1981 to 16.2% in 2007 and 19.95% in 2012. The observed increase in the contribution of wholesale and retail sector to the Gross Domestic Product in recent years is attributable to the rise in the domestic investment by foreign retail

outlets such as Shoprite and, Woolworth evident in the increasing construction of shopping malls in the major cities.

The services sector, which houses the advancing telecommunications sector, trends an increasing proportion of 9.8% in 1981 to 16.2% in 2007, and 20.3% in 2012. This can be explained by the developmental reforms in the financial sector and telecommunications industry. The transformation in the telecommunications service sub-sector has led to increases in the number of telephone lines, subscribers and service providers, and also created massive employment within the country. The World Development Indicator shows that the mobile cellular subscription per 100 people is about 67-68 in 2012.

Though the trend analysis above shows the structural change in the dependence of the economy on one sector, the economy can still be said to be agrarian and primary in nature, as major proportion of its domestic product is from agriculture. The dependence of the economy on the oil sector cannot also be overemphasised as oil revenue accounted for 26.2 per cent of GDP, 89.8 per cent of foreign exchange receipts and 83.0 per cent of government revenue in the period 2003-2007. The crude oil and gas proportion of exports was about 96.8% in 2007 and oil revenue accounted for 75.3% of federally-collected revenue in 2012 (National Bureau of Statistics, 2008, Nigerian National Planning Commission 2004, CBN, 2012).

The above analysis shows an economy that has been experiencing growth over the last decade. However, the distribution of these increasing income and resources has been a source of concern to policymakers, given the exacerbating poverty level in the country. The resource allocation across its tiers of government has been a source of recurring debate, and has been a major issue of controversy. In March 2004, the Federal Government issued a modification that increased states' share of the Federation Account to 26.7% and reduced Federal Government's share to 52.7%, which currently serves as the threshold (Federal Republic of Nigeria, 2009, Social Statistics Abstract in Nigeria).

Community Perception and Participation

Community participation is desirable to connect primary healthcare services and their users, and drive improvements in service quality and ensure accountability, but evidence of effective models is limited. The involvement of the community is minimal at critical points in the decision-making process and because communities are not well-informed on matters affecting their health, they are often unable to make rational choices. The community survey was able to measure the status of the peoples' participation and estimated the level of involvement in the implementation PHC policy for service efficiency. The instruments used were sensitive enough to uncover specific relevant problems which, if addressed, will contribute to the optimisation of outcomes of the PHC service provision. It was able to uncover the community needs and expectations in the terms of PHC service delivery, and baseline parameters, which can subsequently be monitored following appropriate interventions.

In Plateau State, community participation was seen as a process of involving the community by promoting dialogue with, and empowering, communities to identify their own problems and solve them. Participation of the community in PHC was evidenced in Plateau State through the formation of community health committees and village health committees, and the selection of community health workers for training. Furthermore, community representatives were included in health facility or inter-sectoral management structures such as district health boards, district development committees and hospital management boards.

The management committees represent a very important element in the institutional setting of the system with regard to their main role in planning, management and control of health services. They form an interface between the health system and the population, and hence represent and promote the people's participation and ownership. Unfortunately, less than 50% of these committees were found to be operational. This problem may be associated with the way in which the members of the committee were chosen, which was often based on criteria other than consideration of the required expertise. More often than not, the chairperson of the committee is the political leader who may not even be resident in the locality.

A major challenge with community participation has been the capacity of the community representatives and relevant state structures to support it. Notably, Plateau State has developed guidelines on what was expected of the communities and committed to train and support the communities in its health policy. Nonetheless, community involvement, beyond paying for services and providing labour for work carried out at health facilities, has been one of the most challenging and difficult aspects of PHC implementation (Ferman, 1990).

Community health workers (CHWs) have contributed significantly to programme effectiveness in many community-based programmes. Despite the structures in place to manage the work of CHWs, their operation has been hampered by the weak managerial capacities of the community and high illiteracy rates. Although community participation has been argued as the core of PHC policies, it has largely remained problematic, calling for more review and definition. The concept of traditional birth attendants (TBA) still exists but it is not widely promoted, given the new emphasis on the need for skilled attendants.

Besides, the role of the traditional health practitioners, who are providing a lot of services to the community, is not well-integrated into state health systems. Although ensuring qualified personnel-assisted deliveries is one of the pillars of the Safe Motherhood Initiative, the contribution of unassisted deliveries to maternal mortality still remains significant.

The promotion of the traditional birth attendants programmes was launched in the 1970s, supposedly as a transitory measure. However, qualified personnel to assist deliveries are limited and, often concentrated in big cities. Studies have shown limited capacity to detect signs that predict unwanted outcomes of pregnancy by traditional birth attendants. It was also noticed that the antenatal care provided was not of adequate quality. Subsequently, it is not surprising to notice enormous disparities in the maternal mortality rates between the urban and rural populations. Some communities are significantly dependent on community health workers (CHWs) and traditional birth attendants to assist childbirth, especially in rural areas.

In revisiting community participation, David et al (1998) highlight three main difficulties in terms of the conceptualisation and evaluation of community participation.

These are (i) the great variety of health indicators using community participation as a strategy, (ii) the complexity of community participation and (iii) what community participation itself is understood to mean. The same authors recommend the need to develop community structures that take into account the needs, resources, social structures and values of the community.

CHAPTER SIX

Summary, Conclusion and Recommendations

6.1 Summary

The study attempted investigating the implementation of PHC policy in Plateau State. In doing this, the study has tried to examine the policy document conformity to the requirement by the national health policy on PHC delivery, inquired into how the policy is implemented by examining the type of delivery method in place (decentralisation to LGAs) and the actual provisions of the PHC services at the public health facilities, the effects of political leadership interest and commitments to the implementation of the policy as well as level of community participation or involvement in the implementation.

This chapter present~~s~~ed the summary of major findings of the research in a way to indicate that the objectives of the study were fulfilled. It provided answers to the research questions raised in the beginning of the research and concluded by highlighting the major contributions of the study to existing body of knowledge. This study is composed of six chapters. Chapter one presents a brief general introduction of the study and Chapter two reviewed literature and gave the theoretical framework, chapter three presented the methodology, chapter four ~~analysed~~presented the PHC policy in Plateau State to examine the extent of its conformity to the national policy, and chapter five presented the data gathered from fieldwork while chapter six contains the summary, conclusion and recommendations of the study.

With the adoption of the Alma-Ata Declaration in 1978, which identified primary healthcare (PHC) as the strategy for health for all, Nigeria embarked on the quest to ensure that the country's health system is based on the WHO requirement of its member states to adopt the PHC strategy in their healthcare system. Introducing the primary healthcare (PHC) strategy in the nation's health system constituted a turning point in the history of healthcare policy. PHC is defined in the national health policy as "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at

every stage of development in the spirit of self-reliance and self determination" (NHP, 2004).

PHC is expected to form an integral part of the country's health system. It is the entry point into the health systems in the state, making it the first level of contact by individuals, the family and community with the national health system with the purpose of bringing healthcare as close as possible to where people work and live. PHC comprises eight elements: (i) education concerning prevailing health problems and the methods of preventing and controlling them, (ii) promotion of food supply and proper nutrition, (iii) adequate supply of safe water and basic sanitation, (iv) maternal and child healthcare, including family planning, (v) immunisation against major infectious diseases, (vi) prevention and control of locally-endemic diseases, (vii) appropriate treatment of common diseases and injuries, and (viii) provision of essential drugs.

The principles of the PHC, which were adopted by the Federal Government in the National Health Policy, closely matched what was and has since been advocated in human development such as social justice, equity, human rights, universal access to services, giving priority to the most vulnerable and underprivileged, and community involvement. At Alma Ata, it was recognised that the promotion and protection of the health of the people are essential to sustained economic and social development and contributes to better quality of life and world peace.

The review of Plateau State Health Policy revealed the states' commitment in the PHC process as evidenced in the development of health policy documents and development plans reflecting its conformity to Federal Government directives. The review indicates that the adoption of PHC strategy has been given priority. The national health policy adopted the Bamako initiative which aimed at revitalising healthcare at the local level. The policy document also, when reviewed alongside the national health policy on PHC, showed clearly in its objectives that PHC strategy recommended by the national health policy has been adopted and PHC service delivery has been decentralised to the local government administrations (LGAs) in the state. The main goal of the state policy was to position basic healthcare services very close to the grassroots by establishing PHC facilities at the village level, making primary healthcare to be the entry

point (first level of contact) for the state healthcare system as required by the national health policy.

The review found that, in the Plateau State PHC policy document, elements of PHC strategy had been well-articulated in the policy. The five principles and the eight elements of PHC were addressed, although the extent to which the PHC policy encompassed equity, community participation, inter-sectoral collaboration and affordability is still questionable. Five principles and eight elements of PHC were stated as required by the national policy on PHC delivery. The five principles, namely universal access, equity, community participation; inter-sector collaboration and appropriate technology were also stated in the policy document. Although all the three sampled LGAs in the state were of the view that they were committed to PHC implementation, the effectiveness of the process was not strongly felt due to a combination of factors. These factors included lack of clear implementation procedures, absence of definite terms of inter-governmental collaborations, weak structures, inadequate attention to PHC principles, insufficient resource allocation as well as lack of political will. Periodic monitoring and evaluation of PHC activities in most of the LGAs is either lacking or done irregularly.

The interview revealed that some areas were not adequately reflected in the policy document and the policy document had not been re-enacted or reviewed to address such issues; indeed, the 1992 policy document is what is still being implemented in Plateau State even after the National Health Policy was reviewed in 2004. The principles of equity, participation and collaboration are addressed in the policy document, yet most interviewees did not share such a view as many of them believed that the policy document paid scant attention to the important principles recommended by the national health policy. Also, it was revealed from the review of the content of the policy that important determinants of health, particularly lifestyle, have not been explored in developing policy interventions though the policy intends to reduce widespread of communicable diseases. The importance of paying attention to lifestyles in combating drug abuse that is, causing a major havoc among the youths in the state and diseases such as HIV/AIDS due to unhealthy lifestyle is missing in the policy document. Substance abuse such as what is generally referred as *goskolo* popular among the youth's calls for

quick action as the damage such abuse is causing is greatly alarming. These are the salient issues in the policy document.

The PHC strategy demands community participation in order to make the health programmes, strategies and services to meet the needs of the population more effective as well as development policies more sustained. It was revealed that the policy document does not consider wider participation in its plans, as stated by many interviewees. It is understandable that respondents at district level frequently gave such comments because they experience a large gap between the policy document intentions and daily practice.

Despite the attempt and commitment shown in the policy document, in it's over 20 years of implementation, not much has been achieved. PHC is still challenged by complex scenarios in the state, such as the emergence and re-emergence of both communicable and non communicable diseases, especially the high prevalence rate of HIV/AIDS and declining national economic performance since the state largely depends on fiscal transfer for its socio-economic developments. Moreover, the social situation has continued to deteriorate with increased disparities in access to basic social services among the urban and rural population in the state. In addition, crisis in some localities in the state is already showing the signs of food shortage as most people are being displaced from their farms and locality especially in Barkin-Ladi LGA, and this crisis are causing diversions of considerable resources that could be used for developments in the state to address emergencies caused by the crisis, exhausting the resources originally earmarked for social development including PHC delivery.

In summary the content of Plateau health policy does mirror in many respects the comprehensive mission of national health policy in order to assure quality, prevent disease and promote health but more is required by reviewing the policy document to address some areas needing urgent attention and, more critically, the area of lifestyle which influences the health of people. It is recommended that the health authorities in Plateau reformulate the state health policy by paying attention not only to delivery of healthcare services but also other determinants of health, particularly lifestyle by following the principles of PHC with clear targets, concrete plans and feasible implementation instruments.

The adoption of the PHC strategy meant that attention should be given to the principles of universal access, equity, community participation, appropriate technology and inter-sectoral coordination as important considerations in developing health systems. Although Plateau State developed guidelines for the implementation of PHC policy, this study revealed discrepancy between policy formulation and implementation.

To assess the processes of implementation of the PHC policy in Plateau State, the study investigated the method of delivery of the services to the people and the actual provision of the services. Evidence from the study showed that local governments assume responsibility for services provided by the PHC facilities in their localities as stated by the health policy document. By decentralising PHC service provision to the local governments in Plateau State, access to healthcare by the people is made a major objective in implementing the policy; decentralisation promotes bottom-up approaches and contributes to mobilisation of additional resources for PHC.

The study revealed that Plateau State developed a three- level hierarchical healthcare system. The structure comprises the Ministry of Health as the tutelage structure, teaching hospitals owned by the Federal Government, specialist hospitals owned by the state government, and district health centres/post owned by the local governments. The Ministry of Health acts as the intermediary between all the levels and has the responsibility of overseeing the implementation of the policy.

The study also discovered that strict interpretation of the constitution of Nigeria in respect of sharing of responsibilities between the three tiers of government implies that state governments that have the principal responsibility regarding primary health services and primary education, with the extent of participation of the local government in the execution of these responsibilities determined by each state government. The constitutional existence of state-level discretion may lead to disparity across state governments or local governments, to the extent to which responsibility for PHC services is effectively decentralised. In the face of such constitutional ambiguity, the study examined the extent of decentralisation of PHC services to the local government.

The survey revealed that an overwhelming majority of the healthcare delivery facilities are PHC facilities which are the direct responsibility of LGs and more than half of the respondents indicated local governments as the principal providers as well as

decision-makers for PHC service provision, while state and federal were infrequently indicated as principal providers.

The study found out that local governments are the main sources of financing of PHC delivery in Plateau State: staff salaries, facility built, maintenance, supply of drugs, equipment and other medical commodities; as well, the local governments are largely dependent on statutory allocations from the federation account for their revenue and receive almost nothing from the state government. Bulk of the health expenditures are allocated to staff salaries (80%). The state allocated <6% of the state budget to health in the last 10 years while the LGA councils allocated about 1% of their total budget to health, much less than the minimum allocation of 15% set by the Abuja declaration in the national health policy.

Inter-sectoral collaboration, denoting coordination and synergic relations with other sectors that have impact on health (sectors such as planning, rural development, finance and development planning), are lacking even though advocated in the policy document. 45% of the policymakers and executives interviewed gave positive response on inter-sectoral collaboration but 55% indicated a low level of interaction among the collaborating agencies as envisaged collaboration remained non-functional. Reasons given for this included lack of funds, non-clarity of roles and non-specification of responsibilities.

For services provided, survey reveals that about 78% of the facilities are health-posts in the communities with less density of referrals. These health-posts meet a much wider range of healthcare needs of the population served, but the amenities in them were poor as most facilities had limited supply of water and electricity, making workers function in difficult conditions. Most of the facilities provided services including antenatal, post-natal, treatment of common ailments like malaria, diarrhoea and immunisations are provided through the regular health services on routine basis as well as through the national immunisation drive. Even though majority of the facilities observed were clean, they needed repair; also, household survey responses indicated poor quality of services.

Many of the facilities reported shortage of basic equipment and drugs and health staff were reported to be selling drugs privately while health workers claimed shortage of finance in the purchase of drugs in the facilities.

On preventable disease healthcare, it is evident that public health surveillance are poor in the local government as only 38% of the PHC facilities indicated records of tracer and noticeable diseases.

The study reveals that about 92% of the all the staff was employed by the LGA, and medical doctors rarely visited the PHC facilities. Health workers claimed they supplemented their income and agriculture was the common way; 10% confessed to selling of drugs, most claimed they did not receive any kind of benefits. Remarkably, data indicate nurse and midwives and other health workers were undertaking all the deliveries and immunisations, as well as antenatal, family planning and minor treatments of ailments alongside giving outpatient care and health education.

The study revealed lower access to healthcare facilities in some localities where people had to travel long distances to access healthcare. This condition leads the people in rural areas to seek and get healthcare from chemists and quack health-shop owners and traditional healers who are not licensed by the state government. Service delivery is expected to be in an integrated manner in all facilities ranging from ante-natal care, treatment of common ailments to disease control, immunisation and other forms of preventive care.

Contextual factors such as power politics among the various sectors, actors and stakeholders, corruption and wealth distribution (economic) significantly influenced the implementation process of the health policy in the state. The study found out that political instability resulting in frequent changes in government threatened accountability, while low priority was given to welfare sector by the politicians via allocating minimal resources to the health sector. The analysis reveals that due to frequent changes in government, the new political leadership also changed the executive cabinet ushering in new policymakers and implementers including commissioners of health and LGA PHC coordinators that usually abandoned ongoing health plans inherited from prior administration as eras differed in terms of preferred projects and implementation.

Health-related issues and environment protection are not attractive to most political leaders and this is evident in the way they allocate minimal financial resources to health sector. Some respondents stated that "Plateau State has improved in its revenue collection and therefore improved financial resources yet very little percentage is allocated to the health sector". Many respondents requested the government of Plateau to pay more attention to good health in its political agenda by increasing health expenditures, as this led to resource constrains especially at the local government areas levels.

Lack of accountability is revealed in the health sector as affecting implementation and corruption is seen in the misuse of limited resources by the political leaders. As a result of these, the scarce resources allocated to the health sector distort the implementation process as disclosed by the survey results.

In conclusion, the misuse of public authority, lack of accountability, low salaries, non-recognition of performance, and lack of motivation of health workers working in rural areas are problems that hinder effective implementation from the contextual factors identified. Government is expected to be stewards of their state resources by maintaining and improving the life of its populace, government should take good responsibility of taking care of its citizens' health and well-being (WHO, 2005). The importance of political context in health policy states that good leadership and government is a basic requirement of the government to achieve quality care. However, analysis show that, in practice, governments do not show favourable policy context that can ensure effective implementation of the PHC service delivery, making the health of the people to suffer.

Following the assumption that community participation in this process may contribute to better services, this study examined the avenues available for communities to get involved in policy implementation. Therefore, it provided an analysis of community involvement in the implementation of the primary healthcare service delivery in favour of beneficiaries by examining those actions that communities carry out to participate in their health issues and how they hold service providers to account.

The study focused on available channels through which they can contribute to a more effective policy implementation and found out that community participation in primary healthcare service delivery has been institutionalised in Plateau State through the

creation of village development committees and district health committees. Unfortunately, the study reveals that most of the committees in the communities studied are weak operationally and can be concluded as dormant in most cases. This problem, as revealed by the study, is because members of the committees consist of the respected people in the communities, being local political leaders or prominent people in the communities who are neither always around nor staying in the locality and, so, hardly participate in the affairs concerning the health of the people and operations of the PHC facilities. The major challenge in respect of community participation is the capacity of the representatives to support the health system in their communities. These health community organisations are particularly active only in the areas of building maintenance and acquiring drugs, medical supplies, and equipment in the facilities. There is comparatively little community involvement in setting charges for drugs, as envisioned by the national health policy and almost negligible in disciplining staff, which is overwhelmingly indicated as the responsibility of local governments. It may therefore be that despite community participation in Plateau and active engagement in some areas of service delivery by communities in the state, participation is lacking in the key areas critical to improving service delivery in the facilities. The study undertook some analysis of the effect of community participation in Plateau on various performance indicators at the facility level productivity of staff (as measured by number of patients seen for various conditions per staff in the facility), record-keeping for public health surveillance, cleanliness and general maintenance of the facility, and availability of essential drugs and equipment.

Lack of collective community participation in accountability activities was found. The PHC does not show strong societal accountability. Societal accountability is defined as "community action aimed at overseeing political authorities... a non-electoral, yet vertical mechanism of control that rests on the actions of a multiple array of community associations and movements and on the media, actions that aim at exposing governmental wrongdoing, bringing new issues onto the public agenda…" (Peruzzotti and Smulovitz 2002). However, in the case of Plateau, no relevant collective actions were found from groups of healthcare service users. The Plateau case shows that, even though mechanisms for holding service deliverers to account are in place, communities may not participate

for various reasons, such as lack of time and lack of interest or absence of community cohesion.

Community involvement observed in the health sector can draw on different mechanisms for influencing policy and service delivery. However, their real impact on health policy is limited. Most community-participation mechanisms do not have any binding power on service deliverers and they are only able to implement changes.

A striking feature of lack of accountability of public delivery of primary health services by the communities in Plateau reveals through the survey is that public resources do not appear to be reaching their intended destinations. There is evidence of large-scale leakage in public resources in Plateau, away from original budget allocations. Although staff salaries account for 80% of health expenditures and 20% of total LGA revenues, on average, the survey of facility staff in Plateau revealed that 48% of them had not been paid their salaries for more than eight months in the past year. Using the interview data, it was found that even when budget allocations were sufficient to cover estimated actual costs, the staff survey showed non-payment of salaries for several months in the year during the survey. The non-payment of salaries was blamed on lack of resources by local governments.

The analysis also showed that the greater the extent of non-payment of salaries, the higher the likelihood of facility staff behaving like private providers —with more services provided outside the facility through home visits and essential drugs being privately provided, either funded by staff own resources or expropriated from facility stocks.

This evidence suggests that there is a general problem of accountability at the local government level in the use of public resources that are transferred from higher tiers of government and about which; therefore, local citizens may not be well-informed.

It was concluded that community participation and service-provider accountability hindered the implementation of health policies' effectiveness. Community participation and accountability of service providers were found to be weak. A more active participation may enhance policy implementation.

6.2 Conclusion

The overall objective of every government is to bring about a qualitative improvement in the standard of living of its citizens especially their well-being as well as promote growth and development generally. Realising these noble goals entails formulation and effective implementation. Implementation of well-designed public policies may not be attained as projected by policymakers, hence it may not yield expected outcomes, or result in poor service delivery because of ineffective policy implementation. Although reasons for poor delivery of services vary, having a deeper understanding of the implementation process may provide answers as to why implemented policies are not producing expected results.

This study aimed to better understand the implementation of primary health policy in Plateau State by having a deeper knowledge of factors that can influence effective delivery of healthcare to the people. It is possible to enhance the factors that contribute to more effective implementation and reduce the influence of those that constrain it and, in this way, delivery of public services can also be improved.

It is concluded that the Plateau State PHC policy posed challenges in its implementation. The PHC service delivery needed the collaboration between federal, state and local health authorities to bring about its implementation. This was found to weak and therefore need more strengthening to enhance effective implementation of the policy for improved healthcare delivery to the people of Plateau State.

Given the number of years that Plateau state PHC policy has been formulated and implemented, the people are supposed to have witnessed tremendous improvement in the level of their health status which would have permitted them to lead socially and economically productive lives at the highest possible level. However, the reverse is the case and this underscores the conclusion that there has not been effective implementation of the policy in Plateau State. In essence, the study identified a wide gap between the development goals of the PHC policy at the formulation stage and the realisation of the goals on implementation. To close this gap, there is the need to enhance the extent to which the local governments can effectively implement the policy. And to realise this enhancement, the recommended measures need to be considered in the course of policy implementation activities of the healthcare systems in the state.

There are myriads of policy initiatives and health programmes in Plateau State, but it is now expedient to realise the actual role of policy in driving implementation. To achieve better health outcomes, emphasis must be given to effective implementation of policy with motivation, conviction, high commitment and accountability at micro and macro levels in the state. Efforts are required to create awareness among the public about their right to demand better policy implementation.

This study noted a knowledge and accessibility gap between policy implementers and policy documents. Implementers confessed that they had neither seen the policy nor know about its contents despite being responsible for making annual action plans according to policy. This holds significant implication for policy advocacy intervention. It is not only desirable to promote policy among its actors; also decision-making should be guided by it. This study tends to be clear that political as well as local-level leadership and commitment are crucial to stimulating policy implementation. More ways must be found to motivate policymakers to be more effectively committed to policy implementation. It is evident that PHC policy formulation and implementation have been a highly complex issue. PHC strategy implementation requires fulfilment of the five principles of equity, community participation, universal access, appropriate technology and inter-sectoral collaboration. Remarkably, PHC introduces a management challenge of combining central policy direction with significant degree of decentralisation.

A review of the Plateau State government's health policy document indicates that adoption of PHC strategy is a high priority. The National Health Policy recommends the adoption of the Bamako Initiative, aimed at encouraging the decentralisation of primary healthcare delivery to the local levels. The Plateau State Health Policy document shows clearly in its stated objectives that PHC service delivery is decentralised to the 17 local government councils in the state. The main goal of the state policy was to deliver basic healthcare from the grassroots by establishing PHC facilities from the village level, making PHC the entry point (first level of contact) into the healthcare system as required by the national health policy. Principles and elements of PHC are stated in the policy document. The principles are universal access, equity, community participation, inter-sector collaboration and appropriate technology while eight elements of PHC were stated.

The policy philosophy was based on social justice and equity as recommended by the national health policy yet discrepancy was noticed in the implementation.

The study concludes that the 1992 Plateau State Health Policy is the current policy document being implemented despite the fact that the Federal Government revised its 1988 health policy in 2004 to suit new realities in health situations such as HIV/AIDS which became a major problem that needed urgent attention. It is also concluded that although the content of Plateau health policy, to some extent, consents to the comprehensive mission of National Health Policy in order to assure quality, prevent disease and promote health, it needs to be reformulated since it was enacted in 1992 whereas the Federal Government has reviewed the 1988 health policy in 2004 This will enable the state to ensure that all areas are properly addressed and attention is paid not only to delivery of healthcare services but also other determinants of health, particularly lifestyle, by following the principles of PHC with clear targets, concrete plans and feasible implementation instruments.

Decentralisation to the district levels, currently being implemented through health sector reforms, is envisaged to promote bottom-up approaches and contribute to the mobilisation of additional resources for PHC. In addition, multi-sectoral collaboration has been largely neglected in the planning and implementation of programmes.

The study concluded that historical and structural legacies such as the underlying political economy resulted in weak structures that constrained policy implementation. Alongside that is ethical degeneracy, undermining formal procedure of governance by both the political leadership and street-level bureaucrats seeking short-term individual benefit at the cost of long-term public welfare. It also concluded that there is misuse of public authority by the political leaders who lack the political will to implement policies effectively to the benefit of the people. Lack of accountability mechanisms, underfunding of the health sector, non-recognition of performance and lack of motivation of health workers operating in rural areas are problems that hinder effective implementation from the political contextual factors identified.

Financial resources have not expanded to cope with the increasing demand for healthcare. Total health spending remained critically low with a meagre 1% of the budget at local government level allocated to health system in the state, below the minimum

figure recommended by the Commission for Macroeconomics and Health Report of 2001 for the provision of essential healthcare package. It is clear that unless massive resources are mobilised from internal and external sources, the poor performance of the health systems will continue and the achievement of the millennium development goals will be threatened.

The problem of shortage of human resources for health services has become a significant factor in the performance of health systems in the state. There has been a high attrition rate of health workers as a result of death or migration in search of better remuneration and terms of service, thus further reducing the capacity of health systems to deliver healthcare to the population.

Although in Plateau State, the implementation of PHC has involved community health workers, it is concluded that the human resource policy in the state has not taken community health workers into account in terms of organisation, management, integration in the health system as well as consideration of proper procedures for selection, career development, motivation and remuneration, and supervision. They are not yet seen as partners; hence their involvement in healthcare delivery is not adequately promoted. The health policy document has not defined clear policy or mechanisms and procedures for collaboration with the private sector in health services delivery, in general and in the application of PHC in particular. The involvement of the private sector and all community interest groups in PHC suffers mainly from lack of coordination, integration, regular follow-up and evaluation.

Health committees exist at the level of each health facility in districts in the state. Nevertheless, determination of their membership, internal structures, and relationships with health services and staff motivation pose a number of problems. It is also concluded that periodic monitoring and evaluation of PHC is either lacking or erratic; hand in hand with that, the extent to which Plateau State has progressed in implementation of the PHC policy has largely remained unknown. This has limited critical review in this area. Reliable data on health services is scanty and, often, there are no comprehensive and functional health information systems in place. The problem is compounded by shortage of appropriately-trained personnel to handle and interpret data.

6.3 Recommendations

Based on the findings by this study, recommendations are made as follows:

1. Reformulation of Healthcare Policy: The health authorities in Plateau State need to reformulate or update their Healthcare Policy by paying attention not only to delivery of healthcare services but also other determinants of health, particularly environment and lifestyle, with clear targets, concrete plans and feasible implementation instruments. A comprehensive health policy that considers all important determinants of health in accordance with Primary Health Care strategy, and that will follow a multi-sectoral approach by ensuring equity, wider participation and collaboration with all health-related actors, sectors and communities in preventing disease and promoting health.
2. Need for inter-sectoral collaboration: There is need to promote more inter-sectoral collaboration and coordination with the different stakeholders involved in PHC implementation and, especially, at the local level where PHC implementation is advocated. For the attainment of better inter-sectoral collaboration, the necessary interactions of the health system with other systems such as the ministries for Water Resources, Agriculture, Youths and Women Affairs and Local Government Affairs should be clearly defined in the policy documents as roles and responsibilities of collaborating ministries be clearly be stated, and appropriate mechanisms for inter-sectoral collaboration should be clearly defined. It is further recommended that the state government pay improved attention to the health policy context and treat the health sector as important as other sectors such as security, mining, agriculture and commerce in allocating human as well as financial resources.
3. Improved financing of PHC for improved service delivery: Financing policies and strategies should aim at improving equity in order to improve service delivery coverage for the poor by strengthening financial management skills, including competencies in budgeting, planning, accounting, auditing, monitoring and evaluation at local levels, and then implementing financial decentralisation in order to promote transparency and accountability. It is highly recommended that the local government as well as all the other tiers of

government increase their allocation to the health sector. Local governments on the other hand should be more pro-active in the area of internally-generated revenue to reduce their large dependence on the statutory allocations from the federation account in financing health programmes.

4. Notably, Plateau State needs to increase health expenditure in its state and local government budgets. Resource allocation to PHC should be reviewed and sustainable financing of PHC should be sought to fulfil the country's pledge to allocate at least 15% of the nation's budget to health and greater efforts should be made in the state to increase efficiency in the utilisation of the meagre resources available. Also required is institutionalisation of state and local health accounts within health management information systems for better tracking of health expenditures and to increase the efficiency of the public healthcare sectors through efficiency analysis, capacity strengthening, rational priority setting, needs-based resource allocation alongside health system organisational and management reforms to curb wastage of resources, among others.
5. Enhancing Human Resource Management: In relation to human resources for health, recommendation is made for more recruitment, training and re-training of all cadres of PHC healthcare workers to ensure staff motivation and retention for the coverage and quality of healthcare delivery in the state.

   Equally recommended is pursuit of comprehensive policies and plans for health workforce advancement within the context of state health policy and plans that are adequate for supervision, monitoring and evaluation of programmes with vigour after the provision of required manpower.
6. Change in Leadership Orientation and Service Attitude: Poor leadership and political instability have been identified as causes of unsuccessful implementation of government policy and programmes on healthcare delivery in the state. Therefore, it is recommended that good leadership and political stability are desirable to provide enabling environment for the implementation of the PHC programmes. This will invariably reduce the problem of abandoned projects in the health sector. There is need for focused, responsible

and purposeful political leadership at the head in various government tiers (Federal Government, state government and local governments) and the emergence of honest and dedicated political representatives and bureaucratic leadership at the top and heads of public bureaucracies. It is expected that the democratisation process in Nigeria will aid and hasten the coming into existence of such visionary and purposeful leaderships that will be more inclined to developing appropriate policies to address problems and such policies that can be effectively implemented.

7. Enthroning Good Governance: Priority should be given by every political leadership to improve living conditions of the people beyond the present poverty level, so as to enhance better healthy living. There is the need for maintenance of minimum health standard, adequate potable water supply, environmental sanitation and food supply for the sustenance of good health condition. To this end, intensive and effective health education of the public on preventive measures and promotion of healthy lifestyles must be reinforced.
8. Ensuring a new quality control system: To set up a new quality control system that can effectively control purchase and use of low quality medicines and medical equipment by increasing the number of drug inspectors, ensure their regular visits to the drug market and pharmaceutical industry, control bribery in the health sectors as well as control absenteeism of doctors, nurses and other health professionals from their duties, it is important to improve the system of complaints by providing special numbers and telephone facilities to the beneficiaries for making their complaints.
9. Strengthening Community Management Structures: Strengthening of coordination and collaboration with available community participation mechanisms such as the Village Health Committee, District Health committee, Management Health Committees and Civil Society Organisations particularly NGOs, in community health development and future efforts should address challenges such as effective involvement of the community in health-planning and decision-making through these established linkages between health

facilities and community structures. In addition issues of health like security is the concern of everybody it is required to be strengthened in areas such as problem identification, priority setting, data collection and analysis, evaluation, and planning.

10. Improving the integrated service delivery models at all levels of the referral system regardless of the organisation and nature of the services (promotive, preventive, curative and rehabilitative) so as to enhance the economic efficiency and equity of health service delivery is recommended.
11. Accountability Mechanism: Mechanisms used by the communities to participate such as the health committees should be allow them impose sanctions to hold service providers to account. Service providers should be held responsible for their (in) actions. Accountability mechanisms could be more effective if they sanction wrongdoings instead of only pointing them out or suggesting better practices.

Contribution to Knowledge

In the first place, studies related to health issues have been left largely in the confines of Medical Professionals such as doctors, nurses and other clinically-oriented health workers, but the growing realisation that socio-economic and political environments have implications for healthcare calls for research on healthcare from other fields aside the medical field, therefore this study on health policy has added to the few literature that can be found from other fields, much especially that the study focused on policy which is majorly the concern of Public Administration a branch of Political Science.

Secondly, studies on Healthcare Policy have extensively focused at both the International and National levels with a shape neglect of the sub-national levels of the State and Local levels therefore this study investigated the implementation of Primary Health Policy at the local government level in Plateau State, being a study at the sub-national level. Notably also, most studies on Health Policy on Plateau State have been carried out by donor agencies with specific focus on their areas of interest for example on Family Planning and Sexually Transmitted Diseases.

Thirdly, public policy studies available on healthcare delivery mostly focus on the formulation process of policies or the overall outcomes of the policies without examining the implementation stage, hence it should be realised that policy issues do not end with the formulation of the policy; indeed, it is only the beginning of policy-to-action continuum and such studies lack completeness. This is particularly so when it is realised that there could be a wide gulf between policy planning and actualisation as a result of many interacting and intervening variables.

Fourthly, this study empirically tested the influence of specific factors on the implementation of primary healthcare delivery in Plateau State. While many of the factors identified are recognised in the literature, authors do not make empirical association between them and primary healthcare policy implementation. In addition, the survey by the study has generated a wealth of data that can form the basis of evidence-based policy formulation and implementation in strategic planning processes for efficient performance of PHCs in Plateau State. The study has been able to provide insights into the operational mechanism of the PHC at the health facility management level. More important is the fact that it has provided useful recommendations to enhance health delivery to the people.

In addition to the general knowledge, the survey of the primary health facilities has also generated evidence on public health service delivery, in terms of facility infrastructure, availability of essential supplies and equipment, and types and quality of services provided by PHC facilities in the state.

Finally, very little research exists on Plateau State especially about health policy implementation. This thesis therefore contributes to the literature on primary healthcare systems and health policy in Plateau State and, simultaneously, provides lessons to other states.

Further Study

The involvement of private and NGOs in primary healthcare delivery can contribute to the development of any nation, state or local levels, therefore research can be conducted into their involvement in the delivery of primary healthcare in Plateau

State. Given the lack of extensive studies about their role and participation in the overall health system in Plateau State, more and information on them would be very useful.

Research is also needed to examine the perceptions of policy actors in a context where policies are owned and successful in achieving goals. This will help to understand how policies can be more effectively implemented as well as how policy acceptance and commitment can be achieved.

Furthermore, traditional healthcare givers and how they meet the health needs of the people can be investigated since they are patronised by many rural dwellers as revealed by this study. This will inform the government on the policy direction to be adopted to regulate the activities of traditional healthcare providers as the present policy merely mentions their importance without awarding them a role Indeed, research in this area will be rewarding.

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APPENDIX
HEALTH FACILITY STAFF QUESTIONNAIRE

Good day,
My name is …….
I am a student of University of Ibadan. Please I would like you to answer some questions to help me assess primary health care services in your community. This questionnaire is specifically for academic research purposes as such, information provided will be treated with utmost confidentiality. Thanking you most sincerely in anticipation of your kind cooperation.

Thank You.

STAFF QUESTIONNAIRE: Please tick or answer as appropriate.

SECTION A: SOCIO-DEMOGRAPHIC CHARASTARISTICS OF STAFF

1. Sex: Male ( ) Female ( )
2. Age: _____ (please specify)
3. Marital status: (a) Single ( ) (b) Married ( ) (c) Widowed ( ) (d) Divorced ( )
4. Educational Level: (a) Primary ( ) (b) Secondary ( ) (c) Teacher training ( ) (d) School of midwifery Nursing/Health Technology ( ) (e) University ( ) (f) None ( ) (g) Other (please specify)_____
5. What is your Professional designation or title?
   a. Medical officer ( ) (b) Community Health Officer ( )
   c. Nurse ( ) d. Nurse/midwife ( ) e. SCHEW ( )
   f. JCHEW ( ) g. Environmental (Public) Health Officer ( )
   h. Laboratory Technician ( ) (i) Other (specify) _____

SECTION B: BASIC CHARACTERISTICS OF HEALTH FACILITY

6. What type of facility do you operate?
   (a) Health post or dispensary ( )
   (b) Primary health centre/maternity ( )
   (c) General Hospital ( )

7. Under what authority is this facility operated?

(a) Federal Government _____( )

(b) State Government _____( )

(c) Local Government _____( )

(d) Community ( )

8. How long does it take to reach the referral centre by vehicle?

Hrs _____ Mins. _____

9. Who provided this building?

(a) Federal government ( ) (b) state government ( )

(c) Local Government Area ( ) (d) NGO ( ) (e) community ( )

10. Who is the principal decision-maker for this facility?

		Yes	No
(a)	Federal Government		
(b)	State government		
(c)	LGA		
(d)	Community		
(e)	Facility head		
(f)	Non Governmental organizations(NGO)		
g)	No idea		

SECTION C TYPES OF SERVICES PROVIDED

11. Which primary health care services are presently provided in this facility?

		Yes	No
(a)	Immunisation		
(b)	Antenatal/Normal delivery services and postnatal care		
(c)	Diagnosis and management of minor illness: malaria, Diarrhoea, STDs		
(d)	Dispensing of routine drugs		
(e)	Public health education		
(f)	Referrals		

SECTION D AVAILABILITY OF DRUG SUPPLY IN THE FACILITY

12. Does this facility have a steady supply of drugs?

Yes ( ) No ( )

13. Are supplies usually received on time?

Yes ( ) No ( )

14. In case of emergency, does this facility have a standby vehicle for transportation to a referral centre? Yes ( ) No ( )

SECTION E AVAILABILITY OF INFRASTRUCTURAL FACILITY

15. Does this facility have electricity connection?

    Yes ( ) No ( )

16. In case of power failure do you have private electricity, e.g generator

    Yes ( ) No ( )

17. What is the main source of water?.

    (a) Piped water ( ) (b) borehole ( ) (c) well ( ) (d) rain ( ) (e) River/stream ( ) (f) Other (specify) _____

18. Is this facility adequate in terms of size, utilities and furnishing?

    Yes ( ) No ( )

19. Are supplies usually received on time?

    Yes ( ) No ( )

20. Are essential supplies usually available?

    Yes ( ) No ( )

SECTION F FACILITY RESOURCES: MANPOWER AND FINANCE

21. Does this health facility have the required number of health workers?

    Yes ( )No ( )

22. Are all the available health workers in this facility adequately skilled?

    Yes ( )No ( )

23. Is there a nurse, midwife, clinical officer, or Medical Officer at this facility on call seven days per week, 24 hours per day?

    Yes ( ) No ( )

24. Are you adequately motivated to do your job?

    Yes ( ) No ( )

25. Are you satisfied with the kind of responsibility you have been assigned with?

    Yes ( )No ( )

26. How do you usually get to work?

    (a) walk (b) bicycle (c) motorcycle (d) car (e) other (please specify)

    _____

27. How long those it take you to get to work?

Hrs _____ Mins. _____

28. Did your training as a health worker prepare you for the duties you perform currently?

Yes ( ) No ( )

29. Do you receive any training and retraining on the job?

Yes ( )No ( )

30. Did you receive any special training in the last 12 months?

Yes ( ) No ( )

31. Who pays your salary?

		Yes	No
(a)	Federal government		
(b)	State		
(c)	L.G.A		
(d)	Community		
(e)	NGOs/donors		
(f)	Private sector		
(g)	Others (specify)		

32. Do you receive adequate salary compensation for the work you do?

Yes ( ) No ( )

33. In the last 12 months, how many months have you been paid your salary? ( )

34. Do you get your salary as at when due? Yes ( ) No ( )

35. Do you receive any of the following fringe benefits for working.

		Yes	No
(a)	Health care		
(b)	Medicines		
(c)	Schooling for children		
(d)	Housing		
(e)	Food items		

36. Do you supplement or augment your salary through other means?

Yes ( ) No ( )

37. If yes, please select those that apply from the categories below.

		Yes	No
(a)	Agricultural work		
(b)	Commercial/petty trade		
(c)	Work in private clinic for facility		
(d)	Provide health care in your home and homes of patients		
(e)	Sell medicines		
(f)	Other (please specify)		

SECTION G SUPERVISION OF FACILITY STAFF

38. Do you have clearly stated job description? Yes ( ) No ( )

39. Are there explicit standard for performance? Yes ( ) No ( )

40. Is there a clear reporting structure? Yes ( ) No ( )

41. Who do you report to? _____

42. As part of your job, how many patients do you see outside the facility per week _____

43. Do you see patients not related to your work? Yes ( ) No ( )

44. Do you receive supervision frequently and regularly? Yes ( ) No ( )

44. When do you expect to see your supervisor again? _____

45. Are all the health workers on duty present? Yes ( ) No ( )

46. If no, what are the reasons for the absence of staff?

Work related ( ) Not work related (

SECTION H COMMUNITY COLLABORATION WITH FACILITY

47. Is there a health community management committee that sees to the activities of this facility? Yes ( )No ( )

48. If yes, how often does the Health community management committee meet to discuss facility operations?

a. At least once per month ( ) (b) Few times a year ( )

c. Once per year ( ) (d) Once every two years ( )

e. very rarely or never ( )

49. Do you attend most of the meetings? Yes ( ) No ( )

50. Does the Health Community Management Committee have input into establishing budgets in this facility. Yes ( ) No ( )

51. Has the Health Community Management Committee taken any of the following actions in the past year? Yes ( ) No ( )

		Yes	No
(a)	Made disciplinary recommendations regarding staff		
(b)	Provided drugs		
(c)	Fixed user charges		
(d)	Carried out repairs on equipment/facility		
(e)	Resolved administrative issues		

52. If a member of the Health Community Management Committee does visit the facility, what does the person usually do?

		Yes	No
(a)	Check register		
(b)	Check stock cards		
(c)	Check user receipts		
(d)	Discuss medical issues		
(e)	Discuss administrative issues		
(f)	Check equipments		
(g)	Other (specify) _____		

HOUSEHOLD QUESTIONNAIRE

Good day sir/ma,

My name is ……..

I am a student of University of Ibadan. Please I will like you to fill this Questionnaire to help me assess Primary Health Care Services in your community.

The questionnaire is specifically for academic research; information provided will be treated as confidential and used for research purposes only.

Thank you.

HOUSEHOLD QUESTIONNAIRE

Please tick or answer as appropriate. Section A: Personal identification and characteristics of respondent.

Name of respondent (optional)……

(1) Sex of your child (youngest)

(a) Male ( ) (b) Female ( )

(2) Age of the child:

(3) (a) Less than 6 months ( ) (b) 6---11 months ( ) (c) 1—2years (d) 3-5years ( ) (e) Don't know ( )

Marital Status:

(a) Single ( ) (b) Married ( ) (c) Widowed ( ) (d) Divorced ( )

(4) Educational Level:

(a) Primary ( ) (b) Secondary ( ) (c) Tertiary ( ) (d)None ( )

SECTION B:

(5) Where do you and your family go to receive treatment when you are ill?

(a) Government hospital/clinic ( ) (b) Medicine store/chemist ( )

(c) Private hospital ( ) (d) Traditional helper ( ) (e) Others (please specify)……

(6) Do you have primary healthcare centre in your community?

Yes ( ) No ( )

(7) If yes, Who owns the PHC facility ?

(a) government ( ) (b) private/NGO ( ) (c) Community ( )

(8) How close is the nearest primary health facility to your house?

(a) Less than 30 minutes walk ( ) (b) less than one hour walk ( )

(c) more than one hour walk ( ) (d) more than two hours walk ( )

(e) three hours and above ( )

(9) Do you or your child use this PHC? Yes ( ) No ( )

(10) If the answer to the above question is no, please specify reason(s) for not patronizing this health facility?

(a) Facility is not well equipped ( ) (b) there is no doctor to attend to patient ( ) (c) staff is not friendly ( ) (d) the services are too expensive ( ) (e) others (please specify) ……..

(11) If the answer is yes how many times did you or any member of your household visit the health facility in the last 12 months ……

(12) Please comment on your satisfaction with the quality of care you receive at this PHC facility. (Tick one box per row).

Type of care	Not satisfied	Fair	Satisfied	Very satisfied
Drugs supply				
Availability of medical and nursing staff				
Attitude of the health care workers				
Availability of diagnostic services				
Information on disease prevention and care				
Availability of drugs				
Waiting times				
Availability of supplies for service delivery				

(13)What services does the health facility offer?

Types of care	Yes	No
Immunization		
Antenatal/postnatal consultations and normal delivery care		
STD Services		
Diagnosis and management of minor illness e.g malaria,Diarrhoea		
Dispensing of routine medications		
Public health education		
Referrals		

(14)What is the source of your households' drinking water?

(a) Borehole ( ) (b) well ( ) (c) Tap water ( )

(15)What other social amenities do you have in your community? (a) good roads ( ) (b) electricity ( ) (c) schools ( ) (d) storage facilities ( ) (f) other(s) specify ……..…….

(16) How do you usually dispose off refuse? (a) open dumping ( ) (b) controlled dumping ( ) (c) incinerating plant ( )

(17) What kind toilet does your household have access to?

(a) Bush hole ( ) (b) Latrine ( ) (c) flush Toilet ( )

(18) Do you have a community health management committee?

(a) Yes ( ) (b) No ( )

(19) If so, do you think the community management committee is effective in improving the quality of care in your health centre?

(a) Yes ( ) (b) No ( )

(20) Are you aware of any community initiated health program?

(a) Yes ( ) (b) No ( )

(21) Do you have any input into the community health management committee?

(a) Yes ( ) (b) No ( )

INTERVIEW SCHEDULE FOR ACTORS AND STAKEHOLDERS ON PHC POLICY IN PLATEAU STATE

1. Could you please tell us about yourself, your educational background and career?
2. Can you reflect on your work as the Stakeholder/actor of this PHC strategy in the state?
3. Is there any particular issue that you want to share regarding PHC delivery in this state?
4. What has been the basic Health Policies of the Plateau State Ministry of Health?
5. What factors facilitate implementation of health programmes in the State?
6. What factors disrupt implementation of health programmes in the State?
7. What are the major financing strategies for the health system in Plateau State?
8. What is the level of health development assistance to the State from donor agencies?
9. What would you suggest as management measures that need to be adopted for strengthening the coordination of primary health care services?
10. Do you ever get the opportunity to set local policies and priorities, plans autonomously in response to local preferences and needs?
11. Does local government have any program of disseminating information regarding health and health care service to the people?
12. Do you have any say about the budget of the PHC?
13. Do you know whether the people are included and participate in forums where issues related their health and health care are discussed?
14. What do you think Plateau State should do to in order to improve its performance?

SEPTEMBER, 2015.

CERTIFICATION PAGE

I certify that this work was carried out by Gloria Samdi PULDU in the Department of Political Science, University of Ibadan.

.....

SUPERVISOR
Emmanuel Remi AIYEDE
BA, MSc, PhD (IBADAN)
Department of Political Science
University of Ibadan,
Ibadan, Nigeria

DEDICATION

This thesis is dedicated to my husband, Emmanuel Musa Samdi, my children Mimi, Mama and Kwama, and to the loving memories of my late sister Grace and most honourably my late father and hero, Hon. Godwin Puldu Bwidal.

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For all those lives, I give all praise to the Lord,
Who Himself took me out of my mother's womb
And brought me this way in His mercy and now in
Him I live; I move and have my being.
To God be the glory.

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ABSTRACT

Healthcare policy initiatives have often failed to achieve the set goal of providing access to basic health services in Nigeria. Although implementation studies have sought to explain healthcare policy at both the international and national levels, few studies have focused at the sub-national level of the states and local governments (LGs). Also, the few studies on Plateau State healthcare delivery have been done largely by donor agencies with limited focus on political economy of healthcare policy and primary healthcare (PHC) delivery. This study, therefore, examined the implementation of PHC policy in Plateau State from a political economy perspective, from 1990 to 2010.

Political Economy provided the theoretical basis. The study adopted survey and case study research designs. Using a two-stage random sampling method, 903 households from 12 health districts drawn proportionately, covering rural and urban populations of the state, responded to copies of a user-based questionnaire. The questionnaire focused on socio-demographic characteristics (age, sex and education), healthcare financing, provision and utilisation of health services and management variables. Thirty key informant interviews were conducted with key government officials, past and current commissioners for health, LGs' chairmen and traditional birth attendants. Secondary data were sourced on policy achievement indicators from the Plateau State Health Strategic Plan 2010, National Bureau of Statistics: Annual Abstract of Statistics and Statistical fact sheet. Fund, human resources, health facility ratio, quality of service, under-5 mortality, community participation/stakeholder frameworks, and political/bureaucratic commitment were variables used for the analysis. Quantitative data were analysed, using descriptive and regression statistics at $p<0.5$ level of significance and qualitative data were content analysed.

Respondents' age was 43.1 ± 13.3 years and 55.5% were females while those with secondary and post-secondary education constituted 70.5% and 17.6% had primary education. There was no significant difference in the type of services rendered and the quality of services provided (F value = 33.318). Majority of respondents (80%) indicated poor quality services. The health sector was poorly funded with an average budget of 6% and 1% per annum at the state and LG levels respectively. High cost of medical services forced the rural populace to patronise quack chemists and traditional healers. There were 327 nurses/midwives in 908 PHCs across the LGs in the state, a ratio of 0.3/PHC against the minimum 4/facility national standard. Healthcare professional ratio was 1.4/1,000 population compared to national standard of 2/1,000, and World Health Organisation standard of 2.5/1000. Under-5 mortality was at an average of 2.6%. Poor community participation resulted from lack of clearly-stated roles and responsibilities and lack of clear guidelines for collaboration among stakeholders. Decentralised healthcare givers were not empowered to take decisions that can enhance their performance. Poor attitude to work, corruption and ineffective accountability weighed heavily on implementation.

The objectives of the primary healthcare policy were not fully achieved due to poor implementation. Policy action deviated from policy intention because of lack of commitment, limited fund and unclear guidelines for collaboration and participation and therefore resulting in performance and interaction deficits among stakeholders.

Keywords: Primary healthcare policy**,** Under-5 mortality, Community participation,

Plateau State Health facility ratio.

Word count: 494

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BHSS	Basic Health Services Scheme
CDC	Community Development Committee
DFID	Department for International Development
DPRS	Director of Planning Research and Statistics
FMOH	Federal Ministry of Health
HFA	Health for All
HIV	Human immunodeficiency virus
IDI	In-Depth Interview

JCHEW	Junior Community Health Extension Worker
JUTH	Jos University Teaching Hospital
LGA	Local Government Area
MDGs	Millennium Development Goals
NBS	National Bureau of Statistics
NDHS	Nigeria Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organisation
NPHCDA	National Primary Health Care Development Agency
NPHCDA	National Primary Health Care Development Agency
NPHCS	Nigerian Primary Health Care System
NSHDP	National Strategic Health Development Plan
PLSHSP	Plateau State Health Strategic Plan
PSHDP	Plateau State Health Development Plan
SCHEW	Senior Community Health Extension Worker
SEEDS	State Economic Empowerment and Development Strategy
SHP	State Health Policy
SMOH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
VHD	Village Health Committee
VHW	Village Health Workers
WDC	Ward Development Committee
WHO	World Health Organisation

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