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FEDERAL GOVERNMENT PROGRAMMES
AND HEALTH STATUS IN NIGERIA
(2004 - 2008)
(A CASE STUDY OF KOGI STATE)

BY

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PG/M.SC/07/42708

DEPARTMENT OF PUBLIC ADMINISTRATION AND LOCAL GOVERNMENT
UNIVERSITY OF NIGERIA, NSUKKA

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CERTIFICATION

AYEGBA O. A. ALHASSAN, a graduate student in the department of Public Administration with the registration number **PG/M.SC/07/42708** has completed the prescribed research work leading to the award of Masters Degree of Science **(M.Sc.)** in Public Administration in Human Resources Management.

This research work is original and it has not been submitted either in part or full for any other programme here or elsewhere.

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This research work has been approved for the department of public Administration and Local Government, University of Nigeria, Nsukka.

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DEDICATION

This research work is dedicated to my maker who has given me this golden opportunity to undergo this special programme in my lifetime.

ACKNOWLEDGEMENT

A research work that can stand the test of time must of cause be the hand works of many. In the light of the above, many scholars had contributed in one way or the other in making sure that this research work worth its taste. As a result, I sincerely express my unreserved gratitude to my dynamic supervisor Prof. (Mrs.) R. C. Onah who did not only supervise the work but, through her creative ingenuity made me to complete this research. I pray the Almighty God to reward her abundantly, Amen. My profound gratitude goes to Dr**.** (Mrs.) M. A. O. Obi and Prof. F. C. Okoli for their motherly and fatherly role all through my Postgraduate programme. May the Lord reward you all. I equally appreciate the efforts of, Dr. T. A. Onyishi,Dr.(mrs) Uzuegbunam, Prof. Fab.Onah, and Prof. Chikelue Ofuebe who is an orator, administrative icon and indeed an intellectual wiskid. May the Lord through Christ Jesus reward you all. My special recognition is to the entire staff of the department for their unalloyed support that led to the success of this research work.

Just as I said earlier on, other people out there had indeed made substantive contributions toward the completion of this project. Among them are my family members. The effort of my wife (Mrs. Ojochenemi Ayegba) in Suring that fund is made available anytime the need arise for the programme cannot be forgotten. Also my four

children; Enechojo Ayegba, Chubiyojo Ayegba, Kedonojo Ayegba and Enyikojonwa Ayegba whose birth right of love and affection expected of a father was denied within the period of this research work is acknowledged.

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ABSTRACT

Before and after independence Nigeria was plagued with the problem of how to cope with the health status of her citizenry. This problem cut across every segment of the society. Surprisingly little or no attention was accorded it until the nation was engulfed in civil war. After the civil war, the health status of Nigerians deteriorated. A quick look at it shows a deplorable state of health of Nigeria citizens characterized by infection of all kinds or diseases and infirmities. The health aspirations of Nigeria state after the civil war was exemplified by her various health programmes and projects. It has indeed embarked upon programmes in order to accelerate the rate of growth of the Nigerians health standard. Such programmes and projects are: primary Health care Delivery, Expanded programme on Immunization, War Against indiscipline, Roll Back Malaria etc. A critical look at the above seems to suggest that the only thing that kept on changing is the nomenclatures while the contents remained the same. This research therefore, anchored on the effects of these various programmes and projects on the health status of Nigerians. It also aimed at providing the missing link (s) that may be revealed in the course of this research work through literature review and hypotheses.

The researcher, in the course of this work intends to apply probabilistic techniques which involves the application of randomization and invariably adopts quantitative research method in analyzing research findings.

TABLE OF CONTENT

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

Health Services in Nigeria have evolved via a number of historical developments including succession of policies and plans of action which had been introduced by previous administrations. The services are judged to be unsatisfactory and inadequate in meeting the health needs of the public as exemplified by the low state of health standard of the population.

Documents have been prepared against the historical background of the growth and development of health programmes. Policies and strategies that emerged from it were based on appreciation of current status of health of Nigerians with careful evaluation of major factors affecting the health of Nigerians and the nature of interventions that can result in improvement, rapidly and economically.

Federal Government of Nigeria has for long desired to have a sustainable health delivery system capable of maintaining high health status of her citizenry. Federal ministry of Health (2004) which is charged with such responsibilities came up with a well articulated document titled “Health Sector Reform Programme” (HSRP). The document was aimed at setting goals, target and priorities for federal, states and local governments to follow

not excluding health development partners in taking actions that are to address Nigerian health problems.

In line with her (Nigeria) aspirations and desires, in November 2003 a policy titled. National Health policy Declaration of the Federal Republic of Nigeria was produced. The policy stipulates that, all tiers of governments are hereby committed to take actions that will permit them to live socially and economically productive lives at the highest possible level.

Various programmes enunciated, thus far, were based on the philosophy of social justice and equity. Even the first attempt by the colonial Masters in their development package entitled "Ten year development and welfare package" of 1946-1956 addressed some health issues.

In view of the prevailing health problems in the world, in 1978 the World Health Organization (W.H.O) had a declaration at Alma-mata in then Union of Soviet Socialist Republic (U.S.S.R) captioned “Health for all by year 2000”

It was a worldwide health programme against health problems. This therefore means that every human being has the right to access health services at affordable cost and within 10 kilometers radius. Nigeria, being a signatory and in fact, a member of W.H.O had to draw her health programmes to meet the target within the time frame and beyond. Such actions of hers gave birth to the following programmes Primary Health Care (PHC), National Programme on Immunization (N.P.I), Roll Back Malaria (RBM), Riverblindness and others.

Despite all these efforts by various governments at different levels aimed at solving the problems, the situation seems to be deteriorating as

standard of living seems to be on a continuous decline as, a result of sickness and infirmities.

1.2 STATEMENT OF THE PROBLEM

Health is often referred to as wealth, for a nation to be developed, it must have high standard of living indices. Health is therefore, a folcrum on which the economy of a nation revolves. It is the core of growth and development of any nation. Olise (2007:15) observed that in the last two and half decades, many diseases that were thought to be declining and those previously unknown have become major public health problems, thus affecting Nigerian health status.

W.H.O – UNICEF (1975) report, as cited in Olise (2007) asserts that only 20% of the rural population in developing countries benefited regularly from the basic Health Services. This led to emergence of various programmes on health aimed at solving the problems.

Federal Ministry of Health (2006:6) stated that in Nigeria, malnutrition is widespread, for instance 4.3% of all children less than five years of age are stunted, 9% wasted and 25% are underweight NDH (2003). It was further reported that 6% of the death are due to underlining malnutrition.

World wide malaria day (2008:2) states that malaria has been largely responsible for the country's poor health status adding that 4 deaths of children under 5 and 1 in 10 deaths among pregnant women were direct consequences of malaria infection which has become a great drain on the

economy of the country. This has resulted in the decrease of Nigerian health status.

Various programmes were initiated to address these health problems with a view to raising living standards of citizenry. One of such programmes was House for all programmes under the administration of President Alhaji Shehu Shagari. The programme was short-lived and did not achieve the set objectives. Today problem of housing for Nigerians is enormous. Voice of Nigeria (2004) had it that virtually all the bridge in Lagos has been converted to residential quarters owing to lack of accommodation for Nigerians.

Furthermore, in 2004, the Federal Government initiated another programme called National Health Service (NHS) aimed at reducing death rate and increasing national productivity. Despite this, death is taking its toll and productivity is getting to its lowest ebb. It seems as if nothing is done to salvage the health status of Nigerians from its' total collapse, hence the need for this study, in order to find out where the problem lies so as to prefer solutions. The study questions are:

1. What are the major causes of poor health standards in Nigeria?
2. Do similar factors exist in Kogi State?
3. What are the possible solutions?

1.3 OBJECTIVE OF THE STUDY

The general objective of this study is therefore to examine the effects of Federal Government Health programmes on Nigerian health status. The specific objectives are stated as follows:

1. To find out the strategies employed in raising Nigerian health status

2. To find out the effect(s) of such strategies on Nigerian Health status.
3. To identify the obstacles militating against the achievement of the Nigeria health programmes.
4. To proffer possible solutions to the problems of poor health status of Nigerians.

1.5 SIGNIFICANCE OF THE STUDY

The prevailing socio-economic and health challenges, and the need to attain efficiency and effectiveness in health administration in Nigeria, justify the need for this study. Against this backdrop, the significance of this study is two fold viz: Theoretical and empirical.

Theoretically, this study will add to the volume of already existing literature on the Federal Government Programmes and Health Status in Nigeria. It will equally serve as a source of vital information to students and researchers alike and may equally help those who may wish to explore in greater details other dimensions of the study.

It is therefore hoped that the present enquiry will stimulates further efforts and studies in the field of health programmes administration. In the light of the above, it may enhance scholarly and intellectual criticism that will later shape and address the future needs, problems and direction of Government health Programmes in Nigeria.

Data generated from this study, may serve as to strike a new dimension or bargaining point in the relationship among the stake holders.

Empirically, the study may help the management of public organisations in formulating and implementing effective policies and programmes that address the future health needs of the nation. It is finally hoped to motivate and strengthen the stake holders especially if it were done well to continuously explore alternative effective strategies in the light of evolutionary trend organisation.

1.5 OPERATIONALIZATION OF KEY CONCEPTS.

Attempt has been made to define salient concepts used in the course of this project work. Below were the key operational definitions in this work.

PHASE: This is referred to as a stage of development or a stage in history. It is a critical level of development.

HEALTH: A state of complete physical, mental, social, technological and economic well being of an individual and not merely absence of any disease injury or infirmity.

PROGRAMME: This is a course of action designed to be implemented by individual governments and nongovernmental organizations. It is phased out in project form for easy implementation and evaluation.

STATUS: Social position in relation to other people within the environment or society. It is also a state of one's health position when compared with international standards.

CHANGE: Means leaving one's presence state or action to another aimed at achieving the overall objectives(s) of the programme.

CASE STUDY: is a sample taken from the universe for the purpose of study which serves as a representative of the whole or the universe as the case may be.

1.6 SCOPE AND LIMITATIONS OF THE STUDY

The scope of this study is to examine the changing phases of Health programmes as it affects health status of Nigeria citizenry. It covers a period of four years (i.e. from 2004-2008). Its intention is to x-ray the implications of these programmes on health.

The study is limited to Kogi State which serves as a case study. Relevant data and Questionnaire from the state ministry of health were analysed. In the course of this research work, the researcher was faced with enormous problems that affected his performance. The greatest limitation lies in the fact that the validity of the result or findings is based on two factors viz: the objectivity of the researchers and authors of the work consulted especially in the area of literature review, (which is a secondary source of data) and on the sincerity of the respondent in providing the essential information.

CHAPTER TWO

2.0 LITERATURE REVIEW

Literature review is of a great essence in any research work for it not only exposes the researcher to already existing literature (work done) in the area, but also enables him to identify the lacuna in the existing literature leading to a new research problem.

In the light of the above, the literature will be thematically organised in the following sub headings:

Health Care (P.H.C)

National Programme on Immunization (N.P.I)

Roll Back Malaria (R.B.M)

African Programme on Oncoherciasis Control (A.P.O.C)

Agricultural Programme-Green-Revolution.

2.1 CONCEPT OF HEALTH

It is important to note that many people misunderstand health. To some health means having a sound appearance without infirmity. To others it is all about having sound mind while some conceptualized health as a state of well being.

In modern days, health means much more than that. According to Advanced Learner's Dictionary (2002) health means conditions of the body or the mind. It also means a state of well being and free from illness.

According to World Health Organization (W.H.O) as cited in Olise (2007) Health is a complete state of physical social and mental well-being of an individual and not mere absence of disease, infirmity or injury.

Nigerian Journal of Health Administration and management (2002) viewed health as not just the cure of disease or prevention of illness but also the facilitation and maintenance of social, economic, political and cultural factors which would enhance the complete enjoyment of health in all its ramifications.

Odah (1988) States that health is a symbiotic and harmonious co-existence of the two aspects of the body - soma and the mind that make up man.

In view of the above points, I hereby submit that health can be referred to as a complete state of man any time in life. According to Professor Olawoye Lambo (1993) inserts, that man manifests temporary madness at least for 5 minutes in every 24 hours. Based on this, therefore, health could be referred to as a state in an individual where he/she performs his/her duties/responsibilities as required unaided which cut across all spheres of life.

2.1.1 PRIMARY HEALTH CARE

This is a programme designed to address health problems of this nation. It is highly embracing. It was thought to be a panacea to all our health problems. According to Olise (2007), Primary health care was used to describe the first care given to persons that are poor in health. The description was, however, irrespective of whether the care is given or not.

World Health Organisation Expert Committee on Public Health Administration (2004) defined the subject matter as; the science and art of preventing disease, prolonging life, promoting mental and physical health, and efficiency through the organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individuals in personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of diseases and the development of social machinery to ensure the attainment of every individual standard of living is adequate for the maintenance of health, so organizing these benefits is to enable every citizen to realize his birth right of health and longevity.

About a year later, the above committee had her second meeting in which she examined the following components.

Maternal and child health

Communicable disease control

Environmental sanitation

Maintenance of records for statistical purposes

Health Education of the public

Public Health, nursing and medical care.

The programme adopted was referred to as “basic health services” which encourages the use of semi- skilled manpower and local Technologies. This was based on China successful experience of Barefoot doctors of the ‘60s and the ‘70s. The programme had its core of practitioners from community with emphasis on preventive and combination of Western and traditional practices.

The Basic Health Programme had his initial support from Canadian Lalonde report. This places less emphasis on complex health institutions. The report listed the following as determinants of health; biology, life style, health services and environment. This was adopted by member nations of WHO; such as Malawi, Sudan, Nigeria amongst others.

Series of reviews of the Basic Health Services revealed that the Scheme was inadequate as was thought to be. It could not address the health needs of the rural communities. One out of these studies conducted by **WHO UNICEF (1975)** revealed that only 20% of the rural populations in less developed nations benefited regularly from the Basic Health Services. Alternative strategies to address the situation were suggested.

International Labour Organisation in (1976) documented that about 2/3 of the people in developing nations live in poverty. These studies and experiences of other nations led to 1978 international conference on primary health care. The conference re-defined Primary Health Care (PHC) and identified the subject matter as the strategy towards achieving "Health for All by the year 2000." This (i.e programme) emphasizes the salient roles of politics, element of basic health scheme and community involvement.

Health for all by the year 2000 was declared in a conference held in Alma-mata organized by the WHO in 1978 and endorsed by 30th World Health Assembly (WHA). The conference defined the subject (Primary Health Care) as; essential health 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 country and community can afford to maintain at every stage of their development in the

spirit of self reliance and self determination. This definition has four concepts which are:

1. Inter-sectoral co-operation
2. Community participation
3. Political commitment
4. Application of appropriate technology

RIGA CONFERENCE

The W.H.O organized a conference in the then U.S.S.R in March, 1988 to assess the performance of P.H.C programme since its inception. The conference took a careful study of various reports from member nations and observed that:

a. The "Health for All" is very much alive.
b. The tenets of P.H.C were valid and countries demonstrate high degree of commitment
c. However, the programme was faced with both economic and social problems that needed to be addressed.
d. It must go beyond year 2000
e. The strategies must be reviewed and
f. P.H.C is govt/community partnership venture which must not be over-looked by any party.

HEALTH FOR ALL STRATEGY

Olise (2007) argues that the concept of health for **ALL** by year 2000 actually started before the Alma-mata conference. It was indeed in 1977 at

the 30th World Health Assembly that it was agreed to the effect that by year 2000, all peoples on planet earth should have reasonable degree of level of health that will enable them live a socially and economically productive lives.

The strategy was more of access and opportunity to a healthy living. Access in this case means absence of man made barrier(s) in such a way that beneficiary requires no extra muscles to pay for the health services. It also entails presence of amenities. It further means removal of policies that are inconsistent with health programmes and free flow of information. Above all, fair and just system is required to actualize the dream of the world as it affects health system/services.

SELECTIVE PRIMARY HEALTH CARE

Shortly after one year of the commencement of P.H.C programme, scientists criticized the holistic approach to P.H.C. They argued that the approach was Utopian, not cost effective and timetable was highly unrealistic. An alternative referred to as selective fight of prevalent priority Diseases using cost effective was proposed. Amongst strategies designed were: Breast feeding and immunization, family planning, growth monitoring, oral re-hydration therapy, food supplement, and female education.

The strategies had a lot of supports from donor agencies. The supporters of P.H.C accused the proponents of selective Health care programme, reason being that they are too narrow minded by not allowing the P.H.C Programme to prove her point on holistic approach before asking for a change. The change is abrupt and untimely they said.

MINIMUM HEALTH PACKAGE

This was another programme experienced in health industry. It was based on the premise that at this period when countries are experiencing down turn in their economies, there is absolute need to provide quantitative cost effective services to majority of peoples. This was the initiative of W.H.O met for implementation at the district levels. Based on the P.H.C the programme was designed to ensure child survival healthy workforce and safe motherhood. Programme endorsement was done by member nations of Africa Region of the W.H.O in a meeting held in Fanonde, Cameroon. 5th-9th February 1994. It was packaged and grouped into three which were;

a. priority health intervention
b. Health related intervention
c. Health Centre Services

a. PRIORITY HEALTH INTERVENTION

This is the application of simple materials and technologies for health delivery services/interventions. Such interventions are: essential drug supply, family planning and immunization.

b. HEALTH CENTRE INTERVENTION

Some services actually fall into this subtopic for effective management of the programme. For example, both maternal and child health, treatment of common diseases and injuries fall under this.

c. HEALTH RELATED INTERVENTION

This refers to series of activities that can only be carried out in a community via inter-sectoral approach/collaboration. In other words, it is a community based activities for the well being of community dwellers. Such activities are; water and sanitation, house hold, food security, education on prevailing health problems and methods of controlling them. This school of thought believes in the package implementation at the district and ward level that would facilitate the achievement of health for all goal.

Nigeria (2001) adopted P.H.C Ward Level being the smallest political unit. The belief of this proponent was that at this level there is homogeneity and the representative is the councillor in the Local Government Area Legislative council. The package was built around a model with full compliments of health personnel's linked with other health institutions and post delivery-health services captioned fewer than 3 subheadings above. The targets of health delivery system at the ward level are; individual, households and the communities. The success of the programme is primarily determined by the commitment of village health workers and traditional birth attendants. According to WHO (2004) a strategy-called (REP) was adopted meaning Reach Every District for improving immunization and was renamed to read, Reach Every Ward (REW) in a nation. Nigeria as a member nation of W.H.O reformed her health services in line with this policy.

2.1.2 NATIONAL PROGRAMME ON IMMUNIZATION

National Programme on Immunization (N.P.I) was established by the W.H.O in 1974 aimed at reducing death and disability from six vaccine

preventable childhood diseases. The strategy is to make immunization accessible to children and women of child bearing age. The diseases to be vaccinated against are:- measles. Tetanus, Tuberculosis, Poliomyelitis, pertusis, yellow fever and hepatitis B which was later added bringing the total to seven(7).

At the beginning, the programme was conceived to achieve universal child immunization by the year 1990. Although, a reasonable number of nations have achieve universal child immunization. Others did not as the momentum began to decline resulting from differences in epidemiology of N.P.I targeted diseases.

World Health Assembly (l988) made a global declaration for the eradication of poliomyelitis by the year 2000. In the same vein the WHO drew N.P.I plans targeted at next decade.

World Health Summit (1990) endorsed the target plans for national programme on immunization. However, the realities on ground compelled the Africa Region to focus mainly on:

1. Strengthening routine immunization
2. Acceleration of the ever lingering polio. Eradication of measles, control and elimination of neonatal Tetanus as well as introduction of new innovations during the planned period.

It was a general consensus that by year 2005 using Diphtheria, pertusis and tetanus (DPTS) as a marker, it should achieve 80%, but revised in 2003 to read 2010 or before, all countries should reach 90%. In order to achieve 80-90% RED was endorsed by the task force on immunization in Africa in December, 2002. It was aimed at improving routine vaccination services at

the health facilities, districts and ward levels. See N.P.I vaccine table. See table p827 by FGN and N.P.I Basic Guide for routine immunization

2.1.3 ROLL BACK MALARIA (R.B.M)

Nigeria is one of the African states that malaria is endemic and has since remained a major health problem. The health hazard of this disease has drawn world attention to classify malaria as a global emergency. This led to change of "Africa Malaria Day" to "World Malaria Day" in 2008 with "Malaria a disease without boarder and fight malaria invest in the future" as the theme and slogan for the year.

Hassan Lawal (2008) disclosed that the federal government of Nigeria has earmarked N150 billion for malaria intervention programme for the next 3 years. He added that malaria is responsible for poor health status of the country adding that "1 in 4 of children less than 5 year and 1 in 10 deaths among pregnant women were direct consequences of malaria infection and has become a great drain on the economy of the country".

According to the Hon. Minister of health Hassan Lawal (2008) in the course of his address on world malaria day, asserts that Roll Back Malaria programme is aimed at halving malaria by year 2010. Right now 15 million insecticides covering 6 million households in Nigeria have been distributed hopping to cover the remaining 13 million households soonest.

Sofola (2008) argues that malaria is a silent killer. It is responsible for 800 deaths in a day in Nigeria.

Several measures were designed to control the disease. Such measures are:-

Intermittent preventive treatment (I.P.T)

Appropriate use of insecticide treated mosquito nets.

Case management of malaria in villages and communities

ADVANTAGES OF THE RBC

The beneficiary steps of the programme are:

a. Sleep under insecticide treated net every night.
b. Uptake of intermittent preventive treatment by pregnant women and health facility.
c. Use of ACTS for treatment of malaria
d. Keeping of environment clean

Lawal (2007) affirms that malaria has negative burden on physical, mental and social well being on the people and the economic development of a nation. To buttress the above assertion, Sofola (2006) argues that malaria infection kills during child birth, causes poverty, lead to poor academic performance of school children resulting from increased rate of absenteeism and inefficiency in adult.

Coordinator National Malaria Control (2006) blamed the problem of the disease on health related behavioural factors including practices that promote breeding of mosquitoes in our environment.

According To-Quarterly Newsletters (2008); "stake holders have renewed their commitment in reducing the scourge of malaria through policies that will control vectors in our society and encourage women and children to use Mosquitoes treated nets". Federal Ministry of health (2008)

argues that the fight against malaria is a collaborative efforts of various ministries including Women Affairs, science and Technology, Agriculture and water resources ministries just to mention but a few. It goes beyond the ministerial efforts but agencies, individuals and private organizations.

In the light of the above, the producer of an anti malaria drug called Coarten announced the reduction of the product price by 20%. In the same vein Sumitomo chemical company disclosed her plans to expand the local production of the product - Olyset nets to West Africa, through a new production facility in Nigeria capable of generating 5000 job opportunities.

2.1.4 AFRICAN PROGRAMMES ON ONCHOCERLIASIS (APOC)

This is one of the health programmes designed to address the problem of river blindness disease in Africa. The disease has a lot of social and economic implications on the society. It was first launched in 2004 with a view to eradicating the disease. According to APOC (2005) the disease is presently found in 36 countries in Africa not excluding Arabian Penninsula and the America.

The APOC is sponsored jointly by WHO, UNICEF, World Bank, UNDP, and food and Agriculture organisation. It is also supported by more than 20 donor nations and agencies.

According to WHO (2006) records have it that it has protected more than 34 million peoples. About 1-5 million peoples were completely treated and children born after the inception of the programme were freed from being victim of blindness due to the disease.

News letters, on onchoccerciasis (2006) affirms that Nigeria is using mass treatment with effect from 1990s with a view to treating the infected citizens.

PROGRAMME OBJECTIVES

The objectives of the programme are:-

1. To establish a sustainable national onchocerciasis programme in Nigeria.
2. To strengthen the capacity of APOC management.
3. To decide when and how to stop ivermection distribution
4. To achieve 65% of higher therapeutic coverage in the country.
5. To foster co-implementation of other interventions and accelerate integration of onchoceraciasis control into National Health systems.

In order to achieve these objectives APOC proposed a total budget of $13.5 million for 2007. The attainment of these objectives is expected to eliminate socio economic implications of the disease thus improving living standards of the populace. ***See table page 27, 33 & 34 for 2007***

In 2005/2006, Nigeria recorded the highest figure of about 50% of treated cases see WHO report on page 9.

2.1.5 AGRICULTURAL PROGRAMME

This issue of low health status in Nigeria cannot be fully discussed without referring to agriculture. Policies and programmes on agriculture are meant to alleviate health problems of the society.

Awolowo (1981) asserted that every nation developing has her own characteristics that clearly explain the living standard. In the case of Nigeria these characteristics are; calorie deficiency, ignorance, disease etc.

Nigeria has developed various programmes in conjunction with non governmental organizations which were tailored towards improving living standard of the citizens. Some of these programmes were: operation feed the nation. Green Revolution, Lower River Basin Development Authority and Agricultural Development Project (ADP) among others.

OPERATION FEED THE NATION

Federal government of Nigeria in 1976 launched operation feed the nation programme under the leadership of Olusegun Obasanjo the then head of states and commander in-chief of the armed forces. Unfortunately the programme was short-lived because of the new government that took over which has been our tradition.

On assumption of office by the civilian government under the leadership of Alhaji Shehu Shagari as the president, the nomenclature of the programme was changed to Green Revolution. Its objectives were to stimulate food production, increase agro-allied industries, construction of feeder roads, provision of portable water and housing.

He (President) called on the farmers to rise to the challenges and take advantage of the facilities made available by the governments at all levels (Wzimo 1985)

Ujo (1999:136) affirms that government established Agro-allied services for the supply of agricultural inputs- fertilizers, seedlings chemical etc.

In the words of Oyamide (1984), "the bulk of World Bank Loans to Nigeria have been on agricultural sector. He stated further, in 1971 the federal government of Nigeria obtained a sum of US $7.2 million for rehabilitation of cocoa farming"

According to journal for federal department of rural development the percentage of lending to agriculture in US $ is shown below: -

PERCENTAGE OF LENDING US $ MILLION ON AGRICULTURE

1.	Tree crops	122.7	12.8%
2.	River Development	17.5	1.8%
3.	Integrated Rural Development	760.8	79.1%
4.	Agric Manpower Development	9.0	0.9%
5.	Livestock Development	21.0	2.2%
6.	Forest Plantation	31.0	3.2%

AGRICULTURAL DEVELOPMENT PROJECT

There is no doubt that the nation (Nigeria) has enjoyed a very high percentage of loans from the World Bank. Reasonable numbers of projects were financed which the State (Kogi) benefited immensely. Because of its success in the state, a lot of benefits were derived from it.

The programme / project's major aim was to reduce poverty by improving living conditions of Nigerians. In furtherance of Government

action to achieve the stated aim, an attempt was made to reach out to rural populace through a programme called Fadama Development Project. This is the latest project in agricultural sector. Fadama means flood, a plain and low lying area which is underlined by shallow aquifers.

In Kogi State, a lot of Fadama Farming abounds and located in different strategic places aimed at raising health status of the citizens. In order to boost health status in Kogi State, His Excellency, the Executive Governor Alhaji Ibrahim Idris (2006) advised farmers in the state to embrace opportunities provided by the Fadama project through the length and breadth of the state so as to raise their living standard socially and economically.

IMPACT OF AGRICULTURAL PROGRAMMES

There is no doubt that these various programmes on agriculture has impacted positively on Nigerians. Such impacts are briefly stated below:

Capacity Building

This involves training of Fadama Officers and users groups. This training equipped the farmers leading to high productivity. It also affords the farmers opportunity of group work and participatory planning and implementation.

Provision of bore-hole and water storage, and drainage in some communities by agricultural programmes had positive effects on the rural dwellers.

Opening up of Feeder roads by the agricultural programmes also have in no small way had a positive impact on Nigerian populace. It has indeed impacted positively on Nigerians thus raising their health standards.

2.2 HYPOTHESES

1. Effective implementation of health programmes has led to an increase in the average living standards of Nigerians
2. Effective implementation of health programmes has not led to an increase in the living standards of Nigerians.
3. There is accessibility of health facilities / services in Nigeria.
4. Health services / facilities are not accessible in Nigeria.

2.3 THEORETICAL FRAME - WORK

The conceptual frame-work of this study was drawn from the inputs and outputs analysis of systems theory. A system is referred to as a unified whole which is not only functional but operationally, have interdependent units. The comprehension and adoption of all programmes on health care delivery system in a geographically defined area as a system was developed through contributions of various authors. Such authorities were Bernard (1938), Bertalanfty (1961), Parsons (1968) and Chains and Scafer (1983). There are two types of system theory viz: open and closed. The researcher has resolved to use open system-theory because the study has to do with organization.

Karts and Khan (1996) stated that open system has the following characteristics: systems seek and import resources in both human and material forms, which are referred to as inputs. Organizations therefore transform these puts into products as goods and services via internal social

and technological processes. Indeed, open systems export their products to the external environment referred to as outputs.

Gregory M. B. (1968) asserts that system theory is an interdisciplinary filed of science developed to describe any group. The social system theory recognizes inputs, outputs and feedback- mechanisms in the external environment and inputs in the internal environment as part of a social system. A social system would of necessity relate with other relevant systems in its external environments. Outputs are also used to measure further inputs into the systems.

Health programmes or projects are organizations that have inputs such as human, finance, material, information etc. These inputs undergo a process of production through planning, organizing, controlling and marketing of goods and services. Feedback is often expected inform of information about environmental conditions and health status of the citizenry. Of course negative feedback often calls for correction of any deviation in the programme(s) while positive feedback calls for programme continuity. This type of research can be referred to as feedback mechanism. In view of this analysis therefore, input and out analysis of system theory can be applied in this study with a view to getting the true nature of Nigerian health status.

System theory provides a guide for the analysis and evaluation of social systems which the health care delivery service belong. The understanding of principles behind this theory is that fragmentation, incessant change of programmes, poor coordination, funding and supervision in a specified environment would be of course inimical to the efficient performance of the health programmes. Therefore, parts of health

programmes shall be used to explain and expose problems of the declining health state in Nigeria.

Karts and Khan (1996) states that system seeks and imports resources (human and materials) referred to as inputs. Organizations transform the inputs to products (goods and services) through internal, social and technological processes.

2.4 BACKGROUND INFORMATION ON KOGI STATE

The present area being addressed as Kogi State was hitherto known as Kabba province in the then Northern Region. Kogi State came into existence on 20th August. 1991 during State creation exercise by General Ibrahim Babagida as the president and the Commander in-chief of Armed forces. Kogi State was carved out of the then Kwara and Benue States of Nigeria having its headquarters located at Lokoja.

Two major rivers in Nigeria converged at the State headquarters known as confluence of River Niger and Benue hence the state is addressed as the "Confluence State of the Nation". Lokoja is indeed an historical town and on the ground that the capital of what is known as Nigeria today was once located - Lokoja.

Kogi as a state is centrally positioned amongst other states in the nation. Because of its position or centrality, it shares boundaries with the following states and federal capital to the worth is Niger, Nassarawa and Federal Capital Territory, to the West it is bounded by Kwara, Ekiti and Ondo and to the East by Benue, Anambara, Edo and Enugu States. The total Area covered by Kogi state is 28312.6 square Kilometer. It is a gateway to

capital city of Abuja,Eastern and Western parts of the nation just as Ogun State is to Lagos state. For the administrative convenience the state is structured into twenty-one local government areas. They are:

1. Adavi Local Government
2. Ajaokuta Local Government
3. Ankpa Local Government
4. Bassa Local Government
5. Dekina Local Government
6. Ibaji Local Government
7. Idah Local Government
8. Igalamela/Odolu Local Government
9. Ijumu Local Government
10. Kabba/Bunu Local Government
11. Kogi Local Government
12. Lokoja Local Government
13. Mopamuro Local Government
14. Ofu Local Government
15. Ogori/Magongo Local Government
16. Okehi Local Government
17. Okene Local Government
18. Olamaboro Local Government
19. Omala Local Government
20. Yagba East Local Government
21. Yagba West Local Government

Over seventy (70) percentage of Kogi State population depends on agriculture for their livelihood. This is in-fact the main economic activity in the state. Yam, cassava, rice, guinea corn, maize, palm tree, cashew, sugar-cane, melon and groundnut are the major products that Kogites are engaged in farming.

LOCATION CLIMATE

The state lies within the tropical climate and has two important seasons - Wet and Dry. The Wet season is often surface in Late April and last through October while Dry-season commences in November and ends in March. The state annual rain is in the range of 1016mm to 1524mm.

Kogi State is naturally blessed with varieties of mineral resources. Such as Coal, Lime Stone, Kaolin, Marble, Gold, Iron Ore among others.

DEMOGRAPHY

Kogi state has not been left out in the scheme of things in Nigeria. She took part in 1991 census and that of 2006. That of 1991 puts Kogi state population figure at about 2.1 million. There is no doubt that growth has taken place since this census figure, hence that of 2006 which puts the figure at, 3,4780,29. When one compares the two figures you will discover that there is an increase of 1,3780,29 being the difference.

The state is heterogeneous in nature with Ebiras, Okuns and Igalas forming the majority tribes. There are other minority tribes which include Ogori - Magongo, Nupe, Bassa-nge, Bassa-komo, Gbagi, Hausas and Kankanda. Islam and Christianity are the manifest religions in the state.

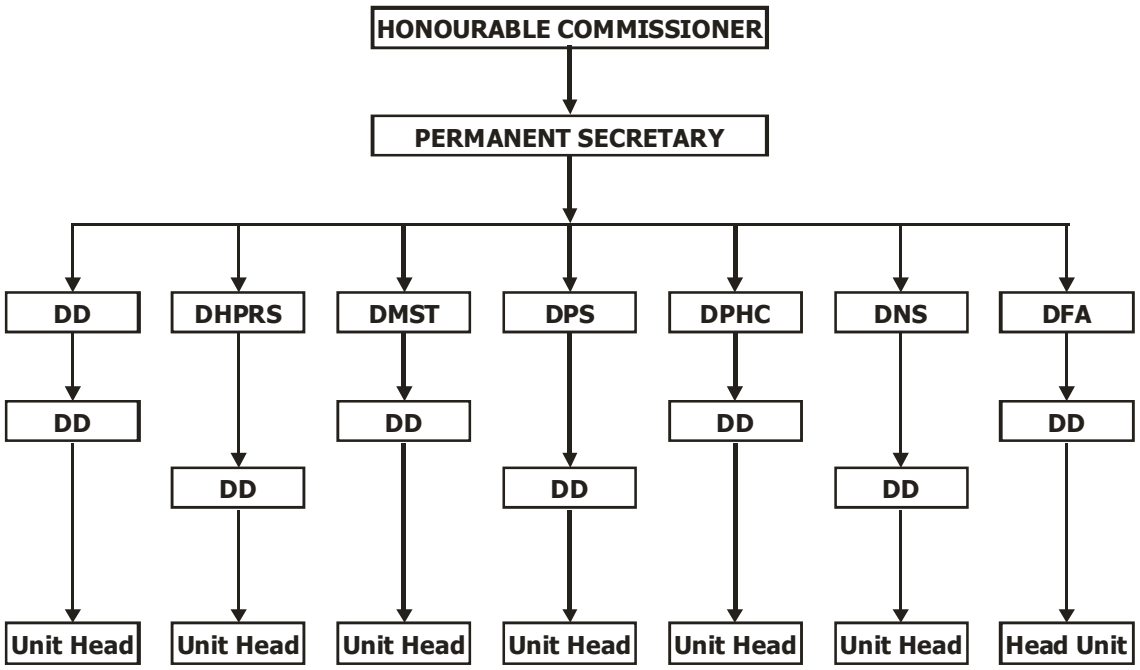
BACKGROUND INFORMATION ON KOGI STATE MINISTRY OF HEALTH LOCATION

It is pertinent to recall that this state consists of 21 Local government areas in which Lokoja is one with the headquarters at Lokoja. The headquarters of Lokoja Local Government Area incidentally is the headquarter of Kogi State. Ministries are located in the headquarters including State Ministry of Health.

MINISTRY OF HEALTH

State Ministry of Health is a creation of government just like any other Ministries. In order to discharge her constitutional responsibilities, each State Ministry is designed to carry out specific functions. In the same vein, ministry of health is concerned with health matters. It is the duty of this ministry to research into health matters, formulate policies on health, implement the approved policies and the attendant programmes and projects, and the evaluation and monitoring of these health activities. In a bid to carry out these functions, it requires the services of professionals in various health-related disciplines. It links the state to Federal government.

ORGANOGRAM OF KOGI STATE MINISTRY OF HEALTH



The above organogram shows the number of directorates each headed by a director and assisted by Deputy Director. Starting from number one, there are:

1. Directorate of Administration and supply
2. Directorate of Health planning & Research & statistics
3. Directorate of Medical service & Training
4. Directorate of Pharmaceutical Services
5. Directorate of Primary Health care services
6. Directorate of Nursing Services
7. Directorate of Finance and Accounts.

ROLES OF KOGI STATE MINISTRY OF HEALTH

Kogi State Ministry of Health performs a good numbers of roles among which are:

- Policy formulation and regulation
- Implementation of National Health policies
- Execution of programmes and projects
- Supervision of Health Services in the State
- Provides technical and logistic supports to Local governments
- Act as a recipient for state in respect of donations from donor agencies.
- It controls health service delivery in the state.

In 2004, National Health Bill empowers the Hon. Commissioner for Health to see to the implementation of National policy, norms and the standard in health. In line with this, the State Ministry of Health is involved in the treatment and prevention of communicable diseases more that ever. Such disease are; Diphtheria, Tuberculosis, Measles, Polio, tetanus. Hepatitis B and Yellow fever.

OCCUPATION OF KOGITES

Occupation industry of this part of the country is not different from what is obtainable all over the nation. Kogites are highly involved in farming, fishing, trading and hunting.

FARMING

Under this subtopic we shall look at farming to include cultivation of cash crops, fishing, hunting and others. Owing to the Vantage position in terms of location of the State, the habitants are mostly farmers of all kinds.

This ranges from cash crops, fishing to hunting. Farming is a very good occupation in this part of the world because of the soil, climate and network of rivers and lakes that abound. With less energy a farmer gets good yield. For instance most areas in the state do not call for heap making before planting cassava and maize. Most crops do well without tilling the soil. Farmers employ the services of friends and labourers. There is also communal farming. These are all applicable to 3 types of farming mentioned above. The state is centrally located and Because of its centrality, the habitants are opportune to trade with the neighbouring states. Whatever you may wish to sell you can do that without much ado. Business flourishes well in all nook and crannies of the state.

CHALLENGES FACING STATE MINISTRY OF HEALTH

1. Bureaucratic Bottle Neck
2. Lack of Finance
3. Inadequate Manpower
4. Cultural Practices
5. Political Instability

1. Bureaucratic Bottle Neck

Nigeria Civil Service is entangled with bureaucratic red-tapism. The service is full of rules and regulations referred to as due process. These rules are fixed and must be obeyed. There is no short cut to the answer. The rules are highly rigid which serve as big obstacles to the growth and development of the Ministry of Health. For instance, if ministry of health wants to execute

a project it must get clearance from the state government and federal ministry of Health as the case may be. In most cases such requests have to pass through several tables causing delay which ordinary would have been done within a few days with good results. It is more difficult when it comes to release of funds. Red-tapism has hampered execution of programmes and projects in Ministry of Health.

2. Lack of Fund

This is a serious problem in Kogi State Ministry of Health. Fund is often said to be grossly inadequate. State government do not release the approved budget to the ministry. The ministry in most cases is starved of funds except with the assistance of foreign bodies like World Health Organisation, United Nation Development program and United Nation International Children Education Fund just to mention a few. Programmes and projects that are under the ambit of Kogi state finance could not see the light of the day due to poor funding of the ministry. At times it is extremely difficult to pay her counterparts funding of some of these aids. Fund is a major problem affecting health delivery system in Kogi state.

3. Lack of Manpower

Ministry of Health in Kogi State is facing serious shortage of manpower in the course of her service delivery. The ministry is supposed to be stocked with high calibre of professionals. According to World Health Organization, a medical doctor is to 5-10 clients. The situation in-Kogi State

is far below this. A doctor is to about 8000 clients. This is highly unacceptable.

When considering other health professionals; Radiologists, Lab. Scientists among others, situation is not different. The State is finding it extremely difficult to adequately staff the few-available health centres in the State. The State is yet to meet the required figures of the health personnel. Because of this inability on the part of the state, the provision of health services is negatively affected.

4. Cultural Practices

Kogi state is made up of various communities with diversed cultural backgrounds. Each community has a traditional way of handling issues. These societies find it a bit difficult to adopt new methods of doing things. For instance, Sokoto State and other states in Nigeria refused to accept immunization against six (6 killer diseases). This premised upon the assumption that it is a calculated attempt to kill their children. The same was held against family planning that it is an attempt to reduce their population.

The State Ministry of Health has to brace up in their duties to ensure that people are well informed and educated on Health practices. The State Ministry of Health was poised to action with a view to increasing the awareness of Kogites on Health matters especially on eating habits where people believe that eating of certain foods e.g. snails & some leaves are forbidding.

5. Political Instability

Of a truth, Kogi is a victim of frequent changes in political arrangement. Every government that comes to power often try to change the existing system, in terms of programmes. For instance in 1999 when Nigeria people's party took over the control of Kogi State government significant-change was effected which led to stoppage of W.H.O assistance to the State. This singular act of the State government has drawn the state backward in no small measure.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

Research methodology is the technique applied in executing research. It involves methods or principles applied in generating and analysis of data in a given research work. It deals with process of inquiry in a defined research.

3.1 STUDY DESIGN

The design of this study is survey sampling and it aimed at assessing the Federal Government Programmes and Health Status in Nigeria, using Kogi State as a study area. The adoption of this design is based on the fact that the study is targeted at eliciting information or views of the representatives of the entire populations.

The researcher has decided to choose this because it is in line with the views of Eboh, (1998) that, in survey research, only part of the population is studied and the selection is made such that the sample is representative of the whole population. Information gathered must therefore, be capable of generalization. In survey research the researcher goes to meet the study subjects to ask questions concerning their behaviours, feelings attitudes, perceptions etc and does not observe them. Responses from these subjects form his body of data to work with. No wonder Anugwom & Igbo (2001) stated that, survey gives the subject one is studying the chance to provide answers and questions on issues bothering the researcher

3.2 POPULATION OF STUDY

The general population that was used or covered in this study was the entire Kogi State. It was based on 21 local government areas. Population figure that was involved in the study was about three million three hundred thousand (3,300,000) with a total of 1029 health facilities located throughout the length and breadth of the state. {Kogi state health bulletin 2008}

3.3 SAMPLE AND SAMPLING TECHNIQUE

Simple random sampling technique was adopted in selecting the study population. The researcher made his possible best by placing his evaluation to include all the twenty-one (21) Local Government in the State. The selection of sampling subjects was done by reflecting the whole seven directorates using random sampling techniques from where a total number of 100 sampling size were drawn.

3.4 INSTRUMENT OF DATA COLLECTION

A questionnaire was developed by the researcher for data collection in this study. The development of this instrument was purely based on interviews with the 7 Directorates in the State and 13 junior staff of Kogi State Ministry of Health respectively. This selection cut across the entire directorates in the ministry. Since the design of the instrument was by the use of Lower and Senior Cadres, its application was to the entire staff of the organization.

3.5 VALIDITY OF THE INSTRUMENT

To ensure the validity of the instrument used, a good number of experts on evaluation and measurement were given the instrument to validate. They examined the framed questions. Those that were repugnant were expunged and others amended to enable the instrument (questionnaire) elicit the appropriate information required. The researcher was advised on the application of suitable options to be used. With the assistance of these experts, the validity of this instrument is not in doubt.

3.6 RELIABILITY OF THE INSTRUMENT

Reliability of the instrument was determined by test and retest method. The subjects were picked and the questionnaire was administered on them with a view to determining the reliability of the instrument. A gap of 3 weeks was given before the final administration in which an average Alpha of 0.71 was obtained. Going by this, it then means that there is high index of reliability of the instrument in this study hence, its application.

3.7 ADMINISTRATION OF INSTRUMENT

In this research work, the researcher made use of direct delivery technique in the administration of the questionnaire. The questionnaires were administered to the staff of ministry of health and this method actually afforded the researcher opportunity to clarify issues that the subject may not be clear with as regards the questionnaire. One merit of this technique

enjoyed by the researcher was high rate of return, thus bringing the problem of misplacement and delay in return to the barest minimum.

3.8 METHOD OF DATA ANALYSIS

The data collected were analysed in order to answer the persistent questions raised by the researcher at the beginning of the research work.

The responses of the studied subjects to the posed questions were weighted using modified Likert rating systems as follows:

Strongly agree	(SA) = 4 points
Agree	(A) = 3 points
Disagree	(D) = 2 points
Strongly disagree	(SD) = 1 point

Other criteria used were frequency and simple percentage among others. Where;

% = Percentage

Fr = Frequency

D = Decision

CHAPTER FOUR

4.0 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

Chapter four deals with the analysis, presentation as well as interpretation of findings of the research work. Importantly, it is the interpretation of information generated from the respondents through the use of questionnaire which were later used for generalization.

In this research, fifty questionnaires were distributed to the respondents and properly filled and returned. Two out of the fifty respondents did not fill and return their questionnaire while one of the respondents filled her own wrongly. The researcher made use of forty seven (47) questionnaires properly filled and returned by the same number of respondents.

SECTION A

4.1 Table one (1)

Gender Distribution:

Sex	Number Of Respondents	Percentage Of Respondents
Male	27	57.446
Female	20	42.553
Total	47	100%

Source: Field Survey (2009)

Table one (1) represents sex distribution of the respondents that were involved in this field study. This shows that both sexes are involved. The total number of males stood at 27 respondents representing 57.446 while that

of female's number was 20 respondents representing 42.552% giving a total of 100%

Table two (2)

Age Group:

Age Range	Number of Respondents	Percentage of respondents
20 – 34	17	36.170
35 – 45	18	38.297
46 – 65	12	25.531
Total	47	100%

Source: Field Survey 2009

The above table shows the age range of the respondents. Seventeen (17) respondents representing 36.170% are people between age 20 – 34 years (respondents) between age 35 – 45 totalled is representing 38.297% of the entire subjects used. The remaining 25.531% representing 12 respondents were between 46 – 65 years of age. This analysis indicates that the service is made of people of age 35 and above. The implication is that youth have no place in the public & Civil Service.

Table three (3)

Educational Background

Categories	Respondents	percentage
SSCE / GCE	4	8.510
ND / OND / NCE	20	42.553
HND / First Degree	17	36.170
M.SC / Ph.D / Others	6	12.765
Total	47	100%

Source: Field Survey 2009

The above table shows the level of education of the respondents. The number of respondents with SSCE/GCE as their Educational Qualification stood at four (4) respondents representing 8.510%. Holders of HND and first degree were seventeen (17) respondents representing 36.170%. ND/OND/NCE respondents were 20 representing 42.533%. Respondents with M.Sc and above and not excluding others were 6 in number representing 12.765%.

The implication of this analysis is that the organization is having less staff with high degree but more of diploma staff followed by first degree and its equivalent. This may give room for growth and development.

Table four (4)

Rank:

Categories	Respondents	percentage
Junior	4	8.510
Intermediate	10	21.276
Senior	29	61.170
Management	4	18.510
Total	47	100%

Source: Field Survey 2009.

The above were the categories of the respondents involved in this research work. The table shows that majority of the staff are in the senior cadre ie 29 respondents representing 61.170%, while the intermediate class cadre took second position with a total of 10 respondents representing 21.270%. Junior and management cadre had equal number of four respondents representing 8.510% each. Going by this, it then means that youth are yet to be taken care of. The Management figure is quite in order as such position do not demand many people for quality decision and implementation.

Table five (5)

Grade Level

	Respondents	**percentage**
GL 02 – 06	4	8.510
GL 07 - 12	27	57.446
GL 13 – 17	16	36.042
Total	47	100%

Source: Field Survey 2009

Respondents between salary grade levels 02 – 06 were 4 representing 8.510%. Those respondents that were on GL 07 – 12 stood at twenty seven (27) respondents representing 57.446%. Other respondents that fall within the GL 13 and above were 16 in numbers representing 36.042% of the total sample. Again this analysis further revealed that the service is soaked up as from the middle upward leaving the lower level virtually empty.

SECTION B

Table six (6)

Information on Healthy Programme

Responses	No of Respondent	Percentage of respondent
Yes	45	95.744
No	2	4.255
Total	47	

Sources: Field Survey 2009

Table six (6) above shows the distribution of the respondents based on their awareness of health programme(s), out of 47 respondents forty five (45) affirmed that they have heard about the programme on health representing 95.744% while only two respondents averred that they have not heard about the programme representing 4.255%

Table seven (7)

Awareness of Health Facilities

Responses	No of Respondents	Percentage of Respondents
Negative (No)	3	6.382
Positive (Yes)	44	93.317
Total	47	100%

Source: Field Survey 2009

Table seven (7) affirmed that three respondents representing 6.382% said that they do not know of any health programme in their locality while

forty four respondents representing 93.317% averred that they know of heath programmes in their environments.

Table eight (8)

Types of Programms	Respondents	Percentage
NPI	27	48.936
HIV	8	17.021
NHS	3	6.382
Malaria	2	4.255
Eye treatment	2	4.255
Health education	1	2.127
Water	2	4.255
None responses	6	12.765

Source: Field Survey 2009.

The above table shows the distribution of respondents to question eight on the list of questionnaire. A total of twenty three respondents representing 48.936% were in favour of National Programme on Immunization. Eight (8) respondents representing 17.021% said that Human Immune Defficiency Syndrome/ Acquired Immune Deficiency Syndrome was executed in their areas. Out of 47 respondents, three respondents affirmed that National Health Service is provided in their environment. 4.255% representing two respondents stated that there is malaria programme going on in their areas. The same percentage (i.e. 4.255%) attests to eye service treatment

In the case of health education, only one respondent representing 2.127% is in favour. On the issue of water project, two (2) respondents representing 40.255% indicated that there is water project in their areas. A total of six respondents were indifference which represents 12.765%.

Table nine (9)

Did you take part in the execution of any of these programme?

Responses	No of respondents	percentage
Positive Yes	9	19.148
Negative No	38	80.851
Total	47	100%

Source: Field Survey 2009

Nine (9) respondents ticked yes that means they took part in the programme execution which represents 19.1248%. The number of respondents who ticked no was thirty eight representing 80.2851%. This shows that people are not involved in all these programmes / projects.

Table ten (10)

State the names of the programme you have taken part in:

Programmes	Respondents	%
N P I	7	14.893
HIV/AIDS	1	2.127
Eye Service	1	2.127
No programme	38	80.851
Total	47	100

Source: Field Survey 2009

From the above, seven (7) respondents representing 14.893% agreed that they have taken part in one of the programmes i.e. National Programme on Immunization while one respondent each representing 2.127% asserts they have taken parts in HIV/AIDS and eye service programme respectively. 80.55% which represents 38 respondents affirmed they have not partaken in any of the health programmes. On the whole, the activities are more on National Programme on Immunization. This shows that majority of the Nigerians are not involved in the programmes

Table eleven (11)

How long were you involved in these programmes

Length of time	No of Respondents	%
6months – 1year	-	-
2months – 3years	3	6.382
4 – 5years	4	8.510
6years & above	2	4.225
No of respondents not involved	38	80.851
Total	47	100

Source: Field Survey 2009

This shows that there was no staff involved in any of the programmes for the past 6months to one year hence, no percentage of such figure. Three respondents representing 6.382% was in the programme for a period of 2-3years. Four (4) respondents representing 8.510% affirmed that they were

involved in the health programmes running between 4-5years. (2) respondents which represents 4.225% said they were involved in the health programmes. A total of thirty eight (38) respondents stated that they were not involved in any of the health programme. This figure represents 80.851% of the sample size.

Table twelve (12)

Has there been any change in the content of programmes for the past five years:

Responses	No of respondents	%
Positive Yes	33	70.212
Negative No	14	29.787
Total	17	100

Source: Field Survey 2009

This table analyses the responses of respondents as regards the content of the health programmes. Thirty three respondents representing 70.212% agreed that there is change in the contents of the health programmes. While fourteen respondents representing 29.787% said that, there is no change in the programmes as far as the contents are concerned.

Table thirteen (13)

Factors responsible for change in the content of programmes

Items	Frequency/No of respondents	%
Corruption	19	40.425
Change of government	6	12.765
Lack of direction	9	19.148
Absence of national goal	5	10.382
Not applicable/indifference	8	17.021
Total	47	100

Source: Field Survey (2009)

This table analyzes the frequency and it shows the percentage of the respondents in each category. Going by this therefore, nineteen respondents assert that corruption is responsible for the change in the content of the programme representing 40.425%. Six (6) respondents was the total frequency that was of the view that frequent change in government is responsible for the change. This represents 12.765% of the sample figure. 19.148% representing nine (9) respondents supported the argument that, it was due to lack of direction. A total of (5) study subjects representing 10.382% opined that the change was due to absence of national goal. Eight (8) respondents representing 17.021% were salient on the subject matter. This means they are ambivalent.

Table fourteen (14)

Frequency and distribution of respondents on the effects of health programmes on community dwellers

Comments	Fr	%	D
Strongly Agree	20	42.55	SA
Agree	23	48.93	A
Disagree	2	2.25	D
Strongly Disagree	2	2.25	SD
Total	471		

Source: Field Survey (2009)

42.55% (n-20) of respondents strongly agreed (SA) that health programmes are having effects on the community dwellers. 48.93% representing 23 respondents agreed that the programmes are indeed having positive effects on community dwellers while, 4.25% (n-2) of the respondents disagreed with the assumption that health programmes are having positive effect on rural dwellers. Lastly, two respondents representing 4.25% strongly disagreed with the assumption that Federal Government Health Programmes is having positive effect on rural dwellers.

Table fifteen (15)

Problems affecting implementation of health programmes are as a result of:

Causes	Fr	%	D
Finance	15	31.91	SA
Poor leadership style	11	23.40	A
Corruption	16	34.04	D
Lack of manpower	5	10.38	SD
Total	47	100	

The above table shows that 31.91% (n-15) of the respondents strongly agreed while eleven (11) respondents representing 23.40% ticked poor leadership style which falls under agreed. 34.04% (n-16) of the respondents ticked disagreed which means corruption is not responsible for poor implementation of health programmes. Five respondents representing 10.38% strongly disagreed with the view that lack of manpower accounts for poor implementation of health programmes in Nigeria.

Table sixteen (16)

What is your assessment of health programmes?

Assessment	Fr	%
Very effective	6	12.76
Effective	26	55.31
Not effective	15	31.91
Total	47	100

Source: Field Survey (2009)

This table shows the breakdown of the assessments of health programmes. 12.76% (n-16) of the respondents affirmed that programmes were very effective, while 55.31% representing 26 respondents said that it is effective. On the contrary, 31.91% (n-15) of the respondents opined that the programmes were not effective.

Table seventeen (17)

Measurement of level of achievement(s) on health programmes:

Responses	Fr	%
Below average	22	46.80
Average	15	31.91
High	7	14.89
Very high	3	6.38
Total	47	100

Source: Field Survey (2009)

This table assesses and analyses the achievements of the programmes thus far. 46.80% representing twenty two respondents averred that the performance is below average. Fifteen (15) respondents which represent 31.91% affirmed that the performance is high. On the final analysis, 6.38% representing three respondents were of the view that the programmes are in fact very high.

Table eighteen (18)

Solutions to health problems

Solutions	Fr	%
To Control corruption	5	10.63
Good leadership style	20	42.55
Devolution of power	3	6.38
Employment More staff	7	14.89
Provision of health services / facilities	12	25.53
Total	47	100

The above table is the analysis of respondent's views on how to solve the problems of health programmes as its affects health status of Nigerians. Five solid suggestions were put forward by the respondents. 10.63% representing five respondents were of the view that if only corruption can be controlled, problem of health programmes can be brought to the barest minimum. 42.55% which represents twenty respondents asserted that good leadership style is the only panacea to health problems. Three respondents out of forty seven respondents representing 6.38% opined that power should be de voluted in order to allow people at the grass – root plan their health programme. 14.89 percent (7) respondents were of the opinion that employment of adequate and qualified staff is the answer to the health problems. About one quarter (1/4) of the respondents (25.55%) representing 12 respondents affirmed that, health facilities should be made available. That will be the solution to the health problems the nation is facing.

4.2 TEST OF HYPOTHESES

Hypothesis one: Effective implementation of health programmes has led to an improvement in the living standards of people of Kogi State.

The result of this study has clearly shown that there is effective implementation of health programmes. The key indices used in this were item number – 11, 14, 16 and 17 drawn from the research questions listed above.

Test of Hypothesis Table 1

S/no	Questions	NR	0/0
11.	How long were you involved in any of these programmes 6months – 5years	9	19.12
14	Do you think these health programmes are having any effect on community dwellers?	23	48.93
16	How do you assess the role of Federal government on health programme	26	55.31
17	The level of achievement of these programmes that is above average	25	53.18

Source: Field Report (2009)

From the above table, 19.12% representing nine (9) respondents out of 47 affirmed that theY were involved in the programmes. In the same vein, 48.93% which represents twenty three (23) respondents agreed that health programmes are effective on rural dwellers, also twenty six (26) respondents

representing 55.31% averred that health programmes are effective while a total of five respondents having 53.18% assessed health programmes and rated it to be above average

From the fore – going, all the responses to the posed questions yielded high significant responds that are in favour of hypothesis one which confirms the hypothesis. The hypothesis one is therefore proved right by the information gathered, analyzed and in fact, in line with the responses of the respondents.

Hypothesis 2 H2: Health facilities are accessible to all the indigenes of the State. In order to test this hypothesis, question 7 & 9, are analysed and which yielded high percentage as can be seen on the table below:

	Questions	Fr	%
Q7	Do you know of any health programmes/ project(s) that have been carried out in your area?	44	93.32
Q9	Did you take part in any of these programme execution?	38	80.85

Source: Field Report (2009)

The table above illustrates those forty four (44) respondents representing 93.32% confirmed that they know of different health programmes/projects that were carried out in their areas. 80.85% of the 100% which represents 38 respondents said that they took part in those programmes. This shows that only 19.25% representing 9 respondents did not take part in any of these programmes' execution.

4.3 FINDINGS

The major objective of this study is to examine the effect(s) of federal government health programmes on Nigerian health status. A critical study of Kogi State Ministry of health, the outcome of the study establishes the fact that living standards of Nigerians has improved due to the Federal Government Health Programme. This was shown by the level of achievement assessed by the respondents and that of the federal government roles on health service delivery.

The findings stressed the importance of positive change as this goes to explain the effect of such changes on the Health of Nigerians. It also revealed that for a nation to have positive health, it must address the issue of involvement/participation of rural dwellers in the programme.

According to the findings, the bottom line of health problems as it concerns Nigeria States is nothing but, poor leadership style by the Nigerian leaders at all levels in most cases. The emerging leaders should recognize this mistake and ensure that they do not fall victim.

The findings also revealed that there is shortage of manpower. It was suggested that corruption should be controlled.

The findings revealed that service positions are filled with old people especially at senior officers' cadre which have 93.5% including management staff. Amongst the Health programme was national, programme on immunization.

4.4 DISCUSSIONS OF FINDINGS

Health is Wealth and thus, the over-all state of any nation depends solely on the health status of her citizenry. The health status of Nigerians can be assessed through various programmes and projects executed by the government. The federal government is the initiator and controller of all health programmes carried out at the three levels of governments - Federal, States and Local governments. Ministry of health aimed at improving health status of Nigerians.

The present method of providing health services should be improved upon & enable larger portion of Nigerian populace enjoy dividend of democracy health wise. This is in line with the position of **World Health Organisation** (2006) that, health services be made available and accessible to the people in all parts of the state. In furtherance to this, **WHO** proposed health services at the ward level monitored by the cancellor in charge of the ward? **Lawal** (2004) averred that malaria disease /fever shall be halved by the year 2010. This therefore, follows that planning or policy formulation is never a sine – quanon to effective execution of health programmes that will subsequently lead to high level of health standard. A good policy must be followed by implementation and strict supervision which is the hall – mark of growth and development of any nation.

The findings further revealed that the work force is made up of male – folk and more of adult than youths. This reverses the pyramid as against its normal position. This does not augur well for the service as it may come to a time when continuity will be disrupted. Also, the study shows that very low percentage of people was involved in the programmes.

The implication is that the life span of such programmes could be short – lived thus drawing the state backward.

The study subscribes to the concept of reduction of corruption as shown in the study. Such move will surely reduce incessant change in the content(s) of the programmes thus, encouraging fair & transparent leadership style.

In similar manner, Federal Ministry of Health should often play her supervisory roles so as to curb the excesses of the other two levels of government thus ensuring the success of programmes put in place. It is in the light of this that **Olise (2004)** affirmed that, National programme on Immunization should be monitored by the Federal Ministry of Health to ensure its efficacy. This assertion can be applicable to all other programmes on health.

The study is of the view that power should be devolved to a reasonable extent to allow managers / administrators use their initiatives for the over all success of the programme. This is in line with the position of Association of Health Administrators (2000) who assert that, provision of health services should be a joint effort of all stake holders each contributing his quota in terms of planning, execution, monitoring and evaluation to the overall success of the programme

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS.

This research work have had critical assessment of Federal Government programmes on health as regards their effects on Nigerian health status using Kogi State ministry of health as a case study..

The study finds out that, with adequate planning, implementation, monitoring etc. the success of the programmes cannot be over emphasized. Finally, involvement of community members in all the phases of the programme will enhance programme performance thus leading to attainment of programme objectives within the stipulated period.

CONCLUSION

This research study has tried to assess the effects of Federal Government programmes on Nigerian healthy within the past four years. In the course of literature review, it was found out that to realize maximum health there must be a sustainable policy that allows the participation of rural dwellers. The programme should be community based. Obstacles to the programmes were x – rayed along with possible solutions. Based on the findings, suggestions were offered which deemphasizes the maintenance of statusquo i.e central control programme embraces world health services delivery. This encourages full participation of every member of the society.

There is every need to have a change in the programme so as to achieve programme objectives. The study shows that due to the Government Health Programme, there is a relative improvement in the living conditions of Nigerian people. However, in order to achieve the over-all objective of the

programme, problems of corruption, leadership style etc should be addressed. The issue of under staffing should be addressed by way of employing more qualified personnel.

It is important to stress that the essence of any programme is to effect positive change in the lives of people; hence, government should create an enabling environment for the participants to perform. In addition, states and local governments should be properly monitored for the success of programmes.

Equally important, is the availability of fund that can be utilized by the relevant bodies and not centralizing it. All these are the result of good management style which is an indication of growth and development.

RECOMMENDATIONS

The Recommendations of this research work are largely drawn from the findings of the study to enable the governments, non governmental organizations and individuals to effect positive change in the health status of Nigerians. The study therefore recommends the followings;

1. There should be a uniform policy of the entire nation that is visible and practicable by all in health industry.
2. More qualified staff should be employed to dispense health services to every nook and cranny in accordance with W. H. O policy on health.
3. Emphasizes should be on health projects like, water, immunizations and housing among others.
4. There should be quality leadership that will engender qualitative health delivery service.

a. More stringent laws should be put in place to guard against corruption or reduce it to the barest minimum. Such laws should be made in such away that anybody that is guilty should be excommunicated from the larger society including taking part in political and traditional activities.

5. That as a matter of policy, more health centres be built in line with the World Health Organization policy, of establishing health centre within 10 kilometres distance. This means people should not be made to travel more than 10 kilometres distance before accessing health services.

6. As a matter of urgency, government should have national goal which is the pivot of nation's policy. Such policy will make it impossible for any government that might have come on board to change existing policies, programmes and even projects. This will reduce abandoned projects if not its total elimination. I strongly believe that strict compliance with the above points, health status of Nigerian populace in general and Kogi State in particular will no doubt be positively affected.

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