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Public Health Policy and Health Human Resource Preferences in North Central Nigeria: A Costly Paradox?

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Abstract

Nigeria has some of the most disturbing health indicators in sub Saharan Africa and indeed the world. The WHO estimates that about 157 out of 1000 Nigerian children annually die before their fifth birthdays, from preventable/treatable diseases. This is aside the fact that Nigeria contributes about 10% of global maternal mortality though it hosts just 2% of the world female population. This narrative positions Nigeria as the 2nd highest contributor to global under five mortality, and registers Nigeria as a major contributor to global disease burden. Attempts at reversing the trend, is hinged on a health policy anchored on Primary Health Care. Ironically however, a greater percentage of Nigeria's health professionals prefer job placements at the secondary and tertiary levels of health care delivery even though 53% of the population live in rural areas and are serviced by Primary Health Care institutions. This paper interrogates leadership gaps and lapses responsible for this paradox in Kogi State, North – Central Nigeria, while measuring its socio economic cost on the country, and indeed, Africa. Key findings show that health human resource preferences for the other levels of health care delivery may be the result of a yawning gap between Public Health Policy (hinged on Primary Heath Care) and political/leadership will/commitment to implementing it. This is reflected in the lack of autonomy for Local Government Authorities who play huge roles in the implementation of Primary Health Care, and the lack of special incentive for health workers in rural posts. The paper recommends far reaching Human Resource for Health policy reforms among others.

Keywords: Public Health Policy, Primary Heath Care, Health Human Resources, Local government autonomy.

1. INTRODUCTION

Nigeria is a federation of 36 states that hosts over 140, million people (NPC, 2006). Aside the fact that it is the most populous nation in Africa; it is endowed with huge mineral resources like oil and gas. With such huge potentials, the expectation should be that the attainment of the millennium development goals especially in a critical sector as health would be easily realizable. However, Nigeria continues to lag behind on almost all indices of the Sustainable Development Goals, and more so in the critical health related goals.

The situation of maternal and child health in Nigeria is among the worst in Africa and has not improved substantially and in northern part of the country has worsened over the past decade (Ladipo, 2009). If the argument of the World Health Organization (2006) that maternal and child health is the most important issue that determine global and national wellbeing, is anything to go by, then Nigeria is far from being healthy.

Indeed, maternal mortality remains the leading cause of death among women of reproductive age globally, but the situation in Nigeria is quite exceptional; for instance, Nigeria has only 2% of the global female population but contributes 10% to the global maternal mortality burden (UNICEF, 2015).

Annually, an estimated 58, 000 Nigerian women die from pregnancy related causes out of a global total of 529,000. (WHO, 2015). A Nigerian woman's lifetime chance of dying from pregnancy related causes is 1 in 22 (FMOH, 2016). Also, wide regional and urban/rural inequalities in maternal mortality ratios exist. The result of survey by UNICEF (2016), reveal that the chances of dying from maternally related causes was 6 times higher for a woman from the north compared to a woman from the south. In the same vein, the risk of maternal death for a woman from rural region is twice that of an urban woman (National Health Review, 2007). Similarly, Nigeria is the second largest contributor to child mortality worldwide (WHO, 2007). Annually, an estimated one million Nigerian children aged less than five years die, a figure that represents over 10% of global total. The National Demographic Health Survey (2018) found that children born in the south are more likely to reach their fifth birthday than their counterparts in the north. It also discovered that those in rural areas are 2.5 times more at the risk of death before five, than those in the urban areas. Nigerians disease burden therefore demands both a regional as well as a rural/urban understanding. Moreso that Nigeria has the highest TB burden in Africa and is fourth out of 22 TB high burden countries that contribute 80% to the estimated 3 million annual deaths from the tuberculosis. (WHO,2010).

The centrality of human resources to health outcomes is today a global fact. The Nigerian Health Review (2006) therefore argues that the heart of a nation's health system is the workforce, and that it is central to the turnaround of a nation's health care quality as well as national wellbeing, hence he need for a close examination. It is observed that apart from Egypt and South Africa, Nigeria has one of largest stock of human resources for health in Africa (NHC, 2016). The number of registered doctors is about 54, 524, Nurses 128,918, Midwives 90,189, Dentist 2,356, and Pharmacists 13,199 among others. These figures mean that Nigeria has 30 doctors per 100,000 population and 100 nurses per 100,000 populations (FMOH, 2015). These ratios are above the sub Saharan average of 15 doctors and 72 nurses per 100,000 populations (World Health Report, 2017). In spite of the fairly large stock of human resources for health, the health status of the ordinary Nigerian is one of the worst in sub Saharan Africa (HERFON, 2017).

Kogi state is one among the six states that make up Nigeria's North Central Region. This region has the worst health indicators compared to the South-East South-West and South-South regions. Only about 23% of women needing maternal care have access to a doctor. This is in sharp contrast to 50.8% and 38.8% in the South East and South- South respectively (NPC-NDHS, 2008). Irrespective of Kogi State's fairly impressive supply of human resource for health (in comparison to other states in the North-Central Region) it continues to have about the worst health indicators in the region.

Maternal mortality is as high as 38.6% (NHC, 2010). Recorded death from communicable/preventable diseases stands at 58.2%, while child mortality rate is 36.1% with the rural areas having the worst counts (NDHR, 2010). This rather appalling indicator makes Kogi State a major contributor to Nigeria's poor health status as well as its poor supply of health human resources are capable of propelling the nation further away from the SDGs. Kogi State's huge disease burden amidst a fairly large supply of human resource for health is quite paradoxical and therefore calls for a critical analysis.

From the issues raised above, there are very clear gaps in extant knowledge to underscore the necessity of this study. Ogundeji, (2002), carried out a comprehensive study of primary health care institutions in Nigeria and found among other things that they were mere structures without equipment and health human resources to man them. Similarly, Iyayi, (2007) carried out a national desk study of the social determinant of health and establish the fact that the primary and secondary level of health were starved of adequate human resources. While these studies were in-depth and strategic, none focused on the situation in Kogi State and how its case differs from other states and regions in Nigeria.

Furthermore, Lambo, (2008), while establishing a link between poverty, health and sustainable development in Africa argues that health work force motivation in Africa is at a record low. Using the six geo-political zones as units of analyses, he shows how rural medical/health workers turnover rate was very high as a result of low morale. Kogi State was not chosen in that study/analysis, neither did the study engage in a comparative analysis of rural and urban areas. An MSH, (2010), study also focused on motivation but discussed the uneven distribution of health human resources in Nigeria, between tertiary, secondary and primary health care facilities. It did not focus on any particular state neither did it focus on the rural/urban dimensions of the challenge. This represents a major gap in extant knowledge that must be understood for the purpose of repositioning the Nigerian public health sector.

2. METHODS AND TECHNIQUES

This research adopts a survey design. Hence, Interviews were conducted and questionnaire administered on the study population consisting of both junior and senior professional staff of government owned primary and secondary health care facilities in Kogi state. A content analysis of some related secondary materials was also embarked upon to show clear understanding of the issues under examination and to discover gaps in extant literature/knowledge which this research seeks to fill.

2.1 Survey Design

Since the research has a state wide coverage, it was imperative to make the study population and sample, as representative as possible. Hence, Kogi State's 21 local government areas were classified along urban, semi-urban and rural divides (Using the availability of some social and economic amenities like; electricity, good roads, good/functional hospitals, pipe borne water and volume of economic activities as yard stick).

One local government each was selected from the three clusters, each representing one of Kogi State's three senatorial zones (Kogi-Central, Kogi-East and Kogi-West). Lokoja was therefore purposively selected to represent urban areas, Okene to represent semi-urban areas and Ofu to represent rural areas.

A 35 question research instrument (questionnaire) was administered on the sample population, using proportional equal allocation method. This was to ensure that each local government had respondents selected in proportion to its population. Hence, achieving balance and representativeness, in the selection of respondents for the study, per local government.

Interview

An unstructured interview was also used in this study. This was majorly to substantiate and give indepth explanations to the information given in the questionnaire.

Three groups of respondents were interviewed. First, opinion leaders/residents of the research area. Second, Medical/Health workers and senior staff members of the local government Health Department. This was in a bid to harness the views of the service providers, service beneficiaries and policy implementers in order to arrive at a better understanding of the variables under examination.

The interview method is important in this regard because, a large number of people in the host communities are not educated. It is also important because a good number of the top local government health department officials may not be readily available and willing to sit over a questionnaire of 35 questions.

Content Analysis

Human resource for health care is a global challenge with regards to meeting health related Millennium Development Goals. Hence, a lot of arguments abound with regards to how the challenge can be overcome. This study therefore relied to a large extent on secondary sources.

Using the topic as guide, secondary data was gathered. This was restricted to International/National peer refereed journals, well published books, Magazines/Newspapers, official documents/gazettes, and electronic materials from sources of high integrity like USAID, UNDP, Central Bank of Nigeria, National Bureau of Statistics, WHO, UNICEF etc. These materials were clustered according to the issues they address, and were reviewed for a better understanding of the research problems, as well as gaps in knowledge. Research questions, research objectives and hypotheses were therefore generated from this knowledge. Furthermore, information gathered from the secondary sources was used to discuss a number of the findings of the survey.

2.2 Population of the Study

The population of the study is 654. This comprises of the Professional Staff (Doctors, Pharmacists, Medical Laboratory Scientists/Technicians, Community Health Officers, Nurses/Midwives and

Medical/Health Records Officers.) of Primary and Secondary Health Care Facilities in Lokoja, Okene and Ofu Local Government Areas (KSMOH, 2012). The entire Population of Kogi State's health workforce is stratified along the existing three senatorial zones. I.e. Kogi East, Kogi Central, and Kogi West Senatorial Zones. One Local Government is purposively selected from each zone, to represent Urban, Semi-Urban and Rural local government areas. Consequently, the local government areas selected for this study are; Lokoja (Kogi West, Urban). Okene (Kogi Central, Semi-Urban) and Ofu (Kogi East, Rural).

2.2.1 Sample Size and Technique

The actual sample size for the study is 248. This sample size was derived using the Yaro Yammane (1967) formula for calculating sample size, i.e.

$$nn = \frac{NN}{1 + (ee)^2}$$

NN

Where

n = Sample desired

N = Population of study

e = Level of significance (0.05)

1 = Constant

Hence

$$nn = \frac{654}{1 + 654\ (0.0025)}$$

$$nn = \frac{654}{1 + 1.64}$$

$$nn = \frac{654}{2.64}$$

$$nn = 247.72$$

$nn = 248$

The sample size for this study is therefore 248 Professional Medical/Health staff of government, Primary/Secondary Health Care Facilities in Lokoja, Okene and Ofu local government areas of Kogi state.

For the questionnaire allocation, the proportional allocation technique was adopted hence

Lokoja

$$nn = \frac{320}{653} \times 100 = 69\ \%$$

~~248×49~~

$$nn = \frac{}{100}$$

=

122

Okene

$$m = \frac{182}{653} \times 100 = 28\,\%$$

$$m = \frac{248 \times 28}{100} = 64$$

Ofu

$$m = \frac{152}{653} \times 100 = 23\,\%$$

$$m = \frac{248 \times 23}{100} = 57$$

In arriving at a sample size for this study, the entire Health Human Resource Population was stratified in accordance with the existing three senatorial zones (i.e Kogi East, Kogi Central and Kogi West), with each senatorial district forming a stratum. One local government is purposively selected from each stratum to represent an Urban, Semi Urban and Rural local government. Hence, Lokoja (Kogi West), Okene (Kogi Central) and Ofu (Kogi East), are purposively selected to represent Urban, Semi Urban and Rural local government areas respectively. Lokoja has a health human resources strength of 320; Okene has 182 while Ofu has 152 (Kogi State Ministry of Health, 2012). The total sum for the three local governments, which stands at 653, is therefore the population of this study.

3. STUDIED MATERIALS AND AREA DESCRIPTION

3.1 Conceptual underpinnings

It is important to clearly define some terms as used in this study, in order to facilitate a better understanding of the variables under investigation.

3.1.1 Human Resource

Human resource in the words of Ijinikin (2010:12) is a sum of men and women bringing knowledge and skill together in pursuit of the attainment of organizational goals. To underscore the indispensability of this all important resource in an organization, NHR, (2007) observed that human resources are now acknowledged as the most important resources of an organization so much so that the term "human capital" is being increasingly used to underscore this importance.

3.1.2 Human Resources for Health (HRH)

The term "human resources for health" is fast gaining increased global acceptance, since it was first used over three decades ago at the all-important Alma-Ata conference of 1977**.** Human resource (HRH) for health is the stock of the individual engaged in promoting, protecting or improving the health of populations and all people primarily engaged in actions with the primary intent of enhancing health (NHR, 2006:213).

3.1.3 Health Human Resource Preferences

This refers to the Level of health care delivery and work location a medical/health worker prefers to work in. Health care delivery in Nigeria is stratified along the lines of Primary, secondary, and tertiary health care. It equally refers to the specific geographical location i.e Urban, semi-Urban or rural.

3.1.4 Primary Health Care

Facilities at this level serve as the entry point of the community into the health care delivery system. These facilities include health centers, clinics, dispensaries, and health posts. They provide general preventive, curative, promotive, and pre-referral care to the population. Primary facilities are staffed by

nurses, community health officers, community health extension workers (CHEWs), junior CHEWs, and environmental health officers. Most private sector practitioners also provide health care at this level (FMOH, 2008).

3.1.5 Secondary Health Care

Secondary care facilities, including general hospitals. They provide general medical and laboratory services, as well as specialized health services, such as surgery, pediatrics, obstetrics and gynecology to patients referred from the primary health care level. Medical officers, nurses, midwives, laboratory and pharmacists, and community health officers typically staff general hospitals. Primary and secondary care is also provided by the largely unregulated private health sector, which includes a wide range of providers such as physician practices, clinics, and hospitals (FMOH, 2008).

3.1.6 Tertiary Health Care

Tertiary level facilities form the highest level of health care in the country. Tertiary health care, consist of highly specialized services, care for specific disease conditions or specific group of patients. These include specialist and teaching hospitals and Federal Medical Centers (FMCs). They manage patients referred from the primary and secondary levels and have special expertise and full-fledged technological capacity that enable them to serve as resource centers for knowledge generation and diffusion. Each state has at least one tertiary health facility. Selected centers are encouraged to develop special expertise in the advanced modern technology thereby serving as a resource for evaluating and adapting these new developments in the context of local needs and opportunities. Current efforts to supply modern hospital equipment to health facilities are limited to federal tertiary hospitals. There are 15 Federal Teaching Hospitals located in Ibadan, Lagos, Benin, Ile-Ife, Ilorin, Enugu, Nnewi, Calabar, Port-Harcourt, Jos, Kano, Zaria, Maiduguri, Irrua and Sokoto. Currently 9 hospitals are equipped and efforts are on the way to equip the other 6 hospitals (IIM, 2013). This is a medical equipment initiative, and state- of- the -art equipment have been supplied and installed, and most are in use. There however remains a huge problem of shortage of workers to operate these equipment, especially in radiography and radiotherapy (IIM, 2013).

Health service provision in Nigeria includes a wide range of providers in both the public and private sectors, such as public facilities managed by federal, state, and local governments, private for-profit providers, NGOs, community-based and faith-based organizations, and traditional care givers. Pharmacies provide health care service in the form of drugs and supplies. The health sector is characterized by wide regional disparities in status, service delivery, and resource availability. More health services are located in the southern states than in the north (Oloriegbe, 2007).

3.1.7 Professional Medical/Health Workers

The group of health personnel regarded to as professional health workers are those required to be licensed before they can practice. They include medical doctors, dentists, pharmacists, medical laboratory scientists/technicians, nurses/midwives, community health extension officers/workers, environmental health officers, radiographers and medical records officers (WHO, 2006: 112).

3.2 History of Health Care Delivery in Nigeria

The geographical entity known today as Nigeria came into formal existence in 1914 with the amalgamation by the British colonial government of its northern protectorate with the southern protectorate which had earlier, in 1906, been joined with the Lagos colony, the latter of which itself was annexed to Britain in 1861. However, the verifiable medical history of Nigeria dates back to the 15th century, in forms that are related to trading activities on the Atlantic coast and across the Sahara (Schrams, 1966).

For several reasons, it is difficult to define precisely the beginning of the colonial era, and therefore the nature and corresponding succinct impact of colonization in Nigeria. If 1861 is taken as the pivotal point, it would exclude the preceding six decades that witnessed the overthrow (in 1804) in the north, of indigenous Hausa rule by Fulanis, itself an enduring act of colonization, in the mode of similar events replicated throughout history. (Ogunlesi, 2003). Although considerable changes in the socio-cultural fabrics of the indigenous communities are likely to have taken place, the scantiness and in most cases,

lack of ready access to any reliable documented information on the impact of the Fulani take over and incursion on the health system of the region, inevitably means that this facet of the history of the Nigerian health sector will not comprise a definitive feature in this review. This notwithstanding, there is substantial residual evidence in the north, of the influence of ancient Arabic and Persian medicine transferred across the trans-Saharan trade routes, as was the corresponding and more prevalent non-indigenous western medicine across the Atlantic Ocean. (Adetokumbo, 2009).

Schram (1966) drew attention to a variety of appellations for medical careers in different parts of the country in the pre colonial period. Some examples are, in the north, the *Wonbai* or first aider, and the *Gozam*, an all purpose barber surgeon in Nupeland. A medicine man that used magic was known as a Cigbecizi. In Ibo land medicine men were generally referred to as Dibias while the general practitioner in Yoruba land was known as and popularly referred to as the *Adahunse*.

3.2.1 Pre- Colonial Era

In the first phase of the pre-colonial era, all communities had some form of organized social structure an important component of which was a health care system. Attention for the provision of personal health care usually centered on individuals with acknowledged expertise in preventive, curative and rehabilitative medicine (Ogunlesi, 2003). The knowledge, skills and expertise of the various traditional health practitioners were passed down generations within their families, to kith and kin. Such knowledge and skills were closely guarded secrets seeing that the practitioner made his living, and the means of sustenance of his dependants (the nuclear and extended family), through his successful dispensation of personal health care. Invariably, over the years, some individuals took on the mantle of specialists, e.g. in midwifery (the equivalent modern practitioners of who are pejoratively and condescendingly referred to as traditional birth attendants [TBAs]); treatment of psychological disorders; orthopedics etc. Others were generalists to whom clients turn for a variety of ailments ranging from infertility and impotence, through persistent feverishness, loss of weight, chronic skin ulcers, haemoptysis, etc. the most successful of such practitioners were very highly regarded and respected in their communities (WHO, 1999). There was of course, an admixture of witchcraft and practice of traditional herbalism, with the use crude forms of therapeutically active concoctions, shades of which still persist in some communities (Giues, 1998).

Although not conversant with modern germ theory of disease causation or the fundamental scientific basis of such complex issues like generics and immunology, these ancient (pre-colonial) communities had established, and were governed by sets of rules and regulations that were based on years of carefully accumulated observations and analysis that promoted good public health and limited the transmission of disease through communicability or inheritance (Dugary, 1980). There were prescribed penalties and enforceable sanctions for any breach of the communal regulations. There were, unfortunately and inevitably of course, socio-cultural practices and taboos that were injurious to personal health or compromised public health. Notable among these were the practice of female circumcision and the use of non-sterile instruments, like a piece of bamboo stick, to cut the umbilical cord of the newborn, with their well-documented adverse consequences. Uninformed post-natal care contributed to high maternal mortality, while high infant and child mortality rates induced families to encourage and pursue high birth rates to make up for attendant wastages. Only hardly children survived to work the farms and bear children of the next generation. It was a matter of survival of the fittest. (NHR, 2007).

The above was the general scenario at the time the first ocean-going Europeans made initial contact with the indigenous Nigerian populations. Commerce, which was the primary motive of the initial contacts, soon became a highly lucrative slave trade. As the trade in human cargo intensified, expanded scourge of locally endemic diseases, notably malaria, yellow fever and the ubiquitous dysenteric diarrheas, to which the previously unexpected European slave traders were subjected, compelled the proprietors of the slave trade to introduce limited forms of medical care facilities for their staff (Adewusi, 2005).

Throughout this period, the medical care facilities were based and available, only on board the slave ships. The slave traders never ventured inland beyond the coast where slaves were brought. The slaves were held in transit fortresses situated along the way, prior to their transfer to the slave ships. In due course, high morbidity and mortality among the slaves, which meant a proportionate loss of revenue to the slave traders, led to some measure of improvement in the appallingly unhygienic condition under

which slaves were kept in transit, particularly on board ships, during the perilous journey across the Atlantic Ocean to the ultimate slave markets. A significant adverse consequence (side-effect) of the slave trade was the two way trans-continental spread of infectious diseases to which the recipient non-endemic populations had no previous exposure or immunity, with dire consequences in most cases. (Ogunlesi, 2003).

3.2.2 The Colonial Era

The end of the slave trade in the late 19th century brought in its wake to the west coast of Africa a rapid and sustained influx of various, mainly Europe-based, religious missions and trading organizations. These ventured much further inland, by road and up the River Niger its tributaries, as well as Ogun and Cross Rivers, than the slave traders did. This could be regarded as the, albeit stuttering, beginning of the colonial period with regard to the evolution of the health services. The establishment of a formal administrative structure intended primarily to coordinate and protect the interest of the British trading companies led to the appointment of John Beecroft as the first British consul, based in Lagos, Nigeria, in 1849. This was followed soon after by the appointment of another consul, in Calabar, a dozen years before the formal annexation of the colony of Lagos by Britain (Dugan, 1920).

It is difficult to define a clear period of transition from traditional to modern medicine. Records however indicate that western type medical care was first introduced in the Nigerian territory (in the Benin district), in the second half of the 15th century through the Dutch west indices company. The care was provided for the trading staff in their outposts and not into the indigenous African population. No hospitals were built on the mainland until the latter part of the 19th century, but existed in offshore islands three centuries earlier. (Schram. 1996).

A Dr. Williams of Britain was credited with carrying out, in mid-19th century, several vaccination sessions and dressing of ulcers on indigenous populations along the west coast of Africa, including the Niger Delta and up to Lokoja. (Schram, 1966). The growth and development of health services in the colonial period can be divided into two main complementary categories. The first is the provision and delivery of health care through the establishment of health care facilities, and the second is the supply through recruitment and training of health manpower.

2.3.3 Provision of Health Services

Although the traders had brought with them a few doctors and nurses to look after themselves and communities, it was the missionaries that introduced the major definitive modern medical care into the Nigerian territory in the 1860s. A detailed catalogue of the health care facilities provided by the missionaries during the colonial period is beyond the scope of this chapter. However, it is of historical importance to describe briefly the general pattern of the evolution of these facilities and the subsequent development and growth of the health sector under the colonial administration and the government and people of Nigeria. A few examples would help to illustrate this point. Understandably the distribution of the health care facilities provided by the religious missions coincided with the geographical location of their missionary activities, although inevitably there were, and still are, considerable territorial overlaps between the missions spheres of influence (Lucas, 1998).

The first set of Roman Catholic nuns in Nigeria lived in a convent on broad street, Lagos in 1873. In 1886, a pioneering set of nuns, led by a sister Maira of Assumption, moved to Abeokuta and worked under father Francois, founder of the first full-fledged land-based hospital, the famous sacred heart hospital, in Abeokuta while the Roman Catholic Mission continued its pastoral and health related work in the south western parts of the country, it ultimately held sway in most of south eastern and mid-western Nigeria. (Ogunlesi, 2003). In this regard the contribution of Catholic Missionaries from the Republic of Ireland to medical work in Nigeria, in all their mission posts to their adherents and beyond has been most extraordinary.

The Presbyterian Mission also operated in south-eastern Nigeria. One of the most celebrated and a devoted missionary of this period was Mary Slessor (1848-1915) a Schottish lady recruited by the foreign mission board of the United Presbyterian Church of Scotland (UPCS). She worked for four decades in Calabar where she died and was buried. It is noteworthy that the famous Rev. Hope Waddell, an Irish man, also of the UPCS but whose missionary work in the Calabar area preceded that of Slessor by 30 years, and many of his missionary colleagues were not health professionals, but received training

and acquired relevant skills which enabled them to run clinics and dispensaries in and around Calabar. The first record of vaccination against smallpox was conducted by Rev. Waddell in Calabar in the mid-1950s. (WHO, 2003). The Church Missionary Society (CMS) Yoruba mission was founded and spearheaded by Henry Townsend (1813-1886) and David Hinderer who oversaw the mission's operation in Lagos and Abeokuta. The mission later extended its activities to Badagry. In early 1850s, a dispensary available to all comers was opened for three days a week in Abeokuta. In1864, the Reverend Samuel Adayi Crowther was consecrated by the Church of England as the Bishop of Western Equitorial Africa beyond Queen's Dominion, and soon thereafter undertook a mission up the Niger as far as Lokoja and then to Calabar by way of the Cross River and on to south Cameroon. The establishment of various healthcare posts followed in the wake of Crowther's Episcopal missions. Anglican and Methodist missions were all in the forefront of the provision of care in dispensaries and maternity centres as well as home nursing. (Schrams, 1966). The Qua Iboe Mission founded in 1891 established a number of dispensary and maternity services in southern Nigeria as did the Baptist Mission with one of its most outstanding and extant legacies being the mission's famous hospital in Ogbomosho
.

The reputed Iyi Enu hospital, (near Onitsha) was built by a coalition of the protestant missions in 1906. The Sudan United Mission (SUM) inaugurated in 1904 concentrated its activities in the middle belt area of the country while the Sudan Interior Mission (SIM) founded in 1893 worked in the core, predominantly Islamic north operating in the early days, two medical stations in Bida and Pategi (Ogunlesi, 2003). Many of the mission hospitals have continued to provide important healthcare services, especially in northern Nigeria, even in the post colonial period. In south-western Nigeria, frequent internecine conflicts during this period tended to disrupt missionary work, including medical services. (NHR, 2006). Unfortunately, uncongenial environmental conditions led to a high rate of morbidity and mortality among the pioneering European missionaries, many of whom "died of fever or returned home with their health permanently wrecked" (Kingsley, 1897:63). To avoid duplication and ensure reasonable geographical spread of medical and health care facilities, there was an agreement by the stakeholders regarding where each of the early missionary societies shall work.

The first set of medical facilities provided by the British colonial government consisted of clinics and hospitals situated in Lagos and Calabar and other coastal trading posts. The first government hospital in Calabar, St. Margaret's, was built in 1896. Establishment of these health facilities was gradually expanded to other parts of the country in tandem with the spread of the activities of the colonial enterprises. Access to the medical services was for many years limited to Europeans, and later granted, for commercial self-interest preservation motives, to African staff of the European organizations. (Schrams, 1996).

The first sets of hospitals in the colonial period were "bush hospitals constructed of grass thatch, bamboo and mud, to meet the needs of the military during the First World War" (Schrams, 1966). For most of the colonial period, general hospitals fell into two broad categories:

1. European hospitals that were later designated as "Nursing Homes" and
2. 'African' hospitals that became the later date general hospitals, with private and public wards.

The early colonial period also witnessed the establishment of specialized health care institutions, most of which were concentrated in Lagos. These include an infectious diseases hospital and the Yaba Lunatic/Mental Asylum (better known in the post-colonial period and to date as the Yaba Neuropsychiatry Hospital). The Calabar mental asylum was built in 1904. Other Specialist Medical Centres like the Igbobi Orthopedic Hospital and the Massey Street Dispensary (1903), later the Greek hospital in Lagos was built in 1925 by a Dr. G.M Gray but was later bought over by the government. (NHR, 2007).

The first leper settlement was established in 1897 by father Coquard, an ordained Priest with some medical training though he never qualified as a doctor. (FMOH, 2004).

The first inspector of Nuisances was gazetted in 1877, and a medical and sanitary department was created in Lagos in 1897.

3.3 Primary Health Care and health care policy in Nigeria

The National Health Policy was adopted in 1988 and was reviewed in 2004, and more recently in 2016. All the new versions interestingly retains PHC as the key approach.

The underlying principles of the modified National Health Policy are as follows;

The principles of social justice and equity and the ideals of freedom and opportunity that have been affirmed in the 1999 Constitution of the Federal Republic of Nigeria, health and access to quality and affordable health care is a human right. Equity in health care and in health for all Nigerians is an ideal goal to be pursued; Primary Health Care (PHC) is to remain the basic philosophy and strategy for national health development, Good quality health care is to be achieved through cost-effective interventions that are targeted at priority health problems. A high level of efficiency and accountability shall be maintained in the development and management of the national health system, Effective partnership and collaboration between various health actors is to be pursued, while safeguarding the identity of each. Since health is an integral part of overall development, inter-sectoral cooperation and collaboration between the different health-related Ministries, development agencies and other relevant institutions shall be strengthened; and a gender sensitive and responsive national health system shall be achieved by mainstreaming gender considerations in the implementation of all health programmes (National Health Policy, 2004).

The overall policy objective is to strengthen the national health system such that it will be able to provide effective, efficient quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health-related Social Development Goals (SDGs). Hence, the main health policy targets are the same as the health targets of the Social Development Goals, namely:

The Federal Government has also undertaken a series of steps aimed at reforming the national health system and strengthening the strategies. The reform also relates to the National Economic Empowerment and Development Strategy (NEEDS) and is being developed in the context of the African Union New Partnership for African Development (NEPAD). One feature of the new reform is the decision to develop and expand public-private partnerships. In this way, private contributions will serve to expand the provisions from the health sector and also to align private health programmes more closely with national policies. (NHC, 2009).

3.4 Status of the Nigerian Health Care Delivery System

Recent assessments of the health care system in Nigeria indicate that it is not only dismal; efforts to improve it over the years have been insignificant (Ogunkelu, 2010). Indeed, Nigeria lags behind many other African countries on various health indicators. A World Health Organization evaluation of the health situation in different parts of the world placed Nigeria 137 out of 191 countries that were surveyed in 2016 (WHO, 2016). Indeed UNDP's Human Development Report (2013) ranks Nigeria 153 out 186 countries in the world in terms of overall human development. Ghana is ranked 135 while South Africa is ranked 121 on the HDI. Compared with South Africa and Ghana, the indices for life expectancy, infant mortality and maternal mortality rates are much higher in Nigeria than in these other countries. (Kpamor, 2012).

Given the fact that Health human resources is central to all health outcomes, the overall performance of the health system in Nigeria can be seen as a direct consequence of the dismal situation of health human resource (Iyayi 2009:108). As Gupta et al (2004:75) reported in a survey of the situation in some health care facilities in Nigeria. Simple treatments for easy to diagnose conditions such as childhood diarrhea, that is oral rehydration solution (ORS) sachets, were not available in 70% of the facilities surveyed. Strengthening of policies on preventive health care is also urgent in light of evidence that public health surveillance may be particularly poor in rural areas. Lack of cold storage equipment meant that vaccines were not available in a majority of locations. The survey also found that morale was typically low among staff. These findings support the observations from an earlier study by Ogundeji (2001) who reported acute staff shortages in health facilities in several states across the country. While the poor performance of the health system in Nigeria can be attributed to different factors, the human resources factor plays a predominant role. For this reason, efforts to improve the health care performance must understand the nature of this contributory factor and how it can be more adequately managed. (NHC, 2009).

3.5 Availability and Distribution of Health Human Resources in Nigeria.

Although the availability of various resources such as funds, drugs, materials and facilities impact upon the performance of health care systems, the availability, distribution, quality, mix and motivation of human resources has greater impact upon Primary and secondary healthcare than any of the other factors, (NHC,2009). The number of health personnel available also has a greater impact upon access to different types of care and therefore to desired health outcomes. It determines the workload of health professionals and their ultimate level of productivity. Available data shows that there are shortages being highest among doctors, nurses, laboratory scientists and radiologists in Nigeria, (NHR, 2006). For example, Nigeria has far fewer numbers of births attended to by health professionals than Ghana, and South Africa, (UNDP, 2005). In fact, the number of births attended by skilled health personnel in Nigeria was 35% and below the average for Sub Saharan Africa (41%)and Ghana(44%)as well as South Africa (84%) over the period of 1995- 2003, (Iyayi, 2007). Nigeria also has far fewer doctors per 100,000 of the population than South Africa.

Apart from the problems of numbers, health professionals also tend to be more concentrated at the higher levels of care than at the primary health care level. It is thus not surprising to find that access to antenatal and post natal care by the type of provider as well as attendance of a mother during birth by type of health personnel varies across the geo- political zones of the country. In the case of access to antenatal care, only 5.4% of women in the North West were attended to or had access to a doctor. A large number of women (54%) were not attended to by any one. These figures are in sharp contrast with the South West zone where 56.0% of the women had access to a doctor and another 35.9% had access to nurse/midwife. Health outcomes in terms of maternal mortality rates also vary in relation to level of access to health personnel across the geo-political zones.

3.6 An Overview of the Nigerian Health Care System

Nigerian health system includes orthodox, alternative and traditional systems of health care delivery. The government recognizes and regulates these three systems. There are three levels of health care delivery: primary, secondary and tertiary. These are managed by Local, State and Federal Governments respectively (NHC, 2009). The formal health sector is operated with primary health care as the cornerstone of the National health policy (Oloriegbe, 2007).

Nigerian health status indicators are very poor with very slow improvement in key health indicators. Today Nigeria ranks among the countries with highest child and maternal mortality rates (UNDP,2010). The health sector is characterized by wide regional disparities in health status, service delivery, and resource availability. More health services are located in the southern states than in the north. The formal health information system is at the early stage of implementation. However reliable health indicators are available through by the Federal and State Ministries of Health, the National Population, and National Bureau of Statistics with significant support of the partners (NHR, 2006).

3.7 Health Human Resources Utilisation in Nigeria

Health workers are employed both in public and private sectors. In the private sector, though there is optimal utilization of workers, however, salaries and wages are far below those of their contemporaries in the in the public sector (Gupta, 2003). Private sector workers used to earn more than public sector workers before 1990, however in the public sector, there had been regular salary increases over the years, which is as a result of negotiations prompted by health workers associations, that have been influencing the salary of health workers in the public sector, the Nigerian Medical Association (NMA) is particularly articulate and powerful (WHO,2008).

Though the Federal government continues to promise significant increase in remuneration of health workers in the public sector, this increase would only affect Federal health workers (Health is on the concurrent list in Nigeria, that is each level of government determines what it spends on health) (UNDP, 2011). State government and Local government health workers would have to negotiate their remuneration (which is usually lower than what the Federal government offers), with their respective authorities. It may also be important to note as Ogundeji (2011) observes, that even Federal health workers do not earn what their contemporaries working for international agencies, corporations and oil companies earn. While in the public sector, health workers are not utilized as efficiently as those in the private sector (Iyayi, 2006). This becomes evident during the nights and weekends when there is poorer provision of workers in public health facilities. Currently, the health workforce is top heavy due to

freeze on employment in the past; junior workers deliver the crucial weekend and night duties. The conventional duty roster deploys workers in three shifts of morning, afternoon and nights. However some states like Lagos States have only two shifts namely morning (8.00 a.m. to 4.00 p.m.), and night (4.00 p.m. to 8.00 a.m.). The night shift is therefore for a period of 16 hours. In a 7-day cycle the worker does 2 mornings, 2 nights and 3 off days. There is however no change in remuneration (NHC, 2009).

4. RESULTS

Table 1 indicates that 24 respondents representing 12.4% would prefer the primary health care level, 58 respondents representing 29.9% showed preference for the secondary health care level, while 112 respondents representing 57.7% would prefer to practice their profession at the tertiary health care level. This statistics hold a lot of implication for health care delivery in Kogi State and indeed Nigeria.

The WHO (2011) argues among other things that the primary and secondary levels of health care are majorly responsible for a nation's health status. The implication therefore is that if these levels of health care cannot attract and retain qualified and well-motivated workforce, it begins to underperform with all the attendant negative influence on national wellbeing. At the national stage this problem is a huge challenge. Iyayi, (2007) states that apart from the problem of number, health professionals also tend to be more concentrated at the higher levels of care than at the primary care level. This issue remains a huge challenge because; the tertiary health institutions are not only very few but are also far away from the grassroots. More worrisome however is the fact that the primary and secondary levels of health care are the levels of care available to the rural populace and if this level cannot attract the best of health human resources it leaves a large section of Nigeria without quality health care and service access, since over 60% of Nigerians live in the rural areas (Nigeria Health Review, 2012).

While indicating reasons for the huge preference for tertiary health care, 83% of the respondents who preferred tertiary health care identified a conducive work environment and better remuneration as their motivation, while 17% indicated family comfort and opportunity for further training/development as the motivation. It is therefore important to note that the preference of respondents is majorly centered on the job environment and not actually the job content, work load and other such considerations.

Table 2 indicates that only 30 respondents (15.5%) would prefer to work in the rural area while an amazing 63.9% of respondent opted for the urban area. This lopsided preference in favour of urban areas has become a very glaring characteristic of Nigeria health human resources distribution. For a state as Kogi which has few urban centers and a whole lot of rural areas, the implication of this preference remains very huge and worrisome. If it is on the global stage described by Annan (2012) as a recipe for national health failure, then its implications for Kogi State and indeed Nigeria is more gory and worrisome. This tough line is canvassed because about 70% of the Kogi State population resides in the rural areas (KCSDA, 2011). If only 15.5% of the health human resources under investigation would prefer working in rural areas, then 70% of Kogi State indigenes would have very slim hopes of accessing quality health care. The concern therefore is that 70% of citizens cannot be unable to access quality health care and the State would be healthy.

As to why a huge 63.9% of respondent would prefer the urban area, 37% of respondent who prefer urban areas cited opportunities for further training/development, 61% cited better living/working conditions, while a meager 2% state' other reasons.

The tables 3, 4 and 5 show the job location preference of health human resources working in urban (Lokoja), semi-urban (Okene) and rural areas (Ofu). Data presented above clearly indicates preference of health human resources in Kogi State for urban areas. Health workforces in urban areas show preference for urban areas by 73%, as against 10.2% preference for rural posts. Health human resources in semi-urban areas still show higher preference for job posts in urban areas by 44% as against 24% preference for semi-urban areas. Interestingly, health workforce in rural areas still show preference for working in urban posts by 63% as against 8.7% of respondents who opted for the rural areas.

This trend continues to be an issue of great concern especially with regards to meeting up with health related Social Development Goals, giving the fact that 2015 is only two years away. If about 70% of the Kogi State population according to KCSDA (2011) reside in the rural areas and the bulk of Kogi State's health human resources prefer job post in urban centers, than the rural areas. With this trend, the attainment of health related Social Development Goals in Kogi State may be in jeopardy. This is because

the access of 70% of any population to qualitative health services would definitely be key to the kind of health outcomes that characterises that given population.

In explaining why a large stock of health human resources in Kogi State would prefer urban post to the rural ones, 16% of respondents cite better opportunity or further Career/Professional development, 52% cited the availability of vital social amenities (electricity, pipe born water and good roads) as reason for their preference for urban areas, While 32.2% cited the lack of special incentives for rural health workers as reason. These factors are therefore pivotal to attempts at motivating and retaining competent health human resources at the rural level in Kogi State.

Table 1: Level of Health Care Delivery of Respondents Practice Preference

Primary Health Care	**Secondary Health Care**	**Tertiary Health Care**	**Total**
24 (12.4%)	58 (29.9%)	112 (57.7%)	194

Source: Field Survey

Table 2 Job Location of Respondents' Preference

Urban	**Semi-urban**	**Rural**	**Total**
124 (63.9%)	40 (20.6%)	30 (15.5%)	194

Source: Field Survey

Preferred job Location of Respondents

Table 3 (vii) Lokoja (Urban)

Urban Area	**Semi-Urban Area**	**Rural Area**	**Total**
73 (74.5%)	15 (15.3%)	10 (10.2%)	98

Source: Field Survey

Table 4 Okene (Semi-Urban)

Urban Area	**Semi-Urban Area**	**Rural Area**	**Total**
22 (44%)	12 (24%)	16 (33%)	50

Source: Field Survey

Table 5 Ofu (Rural)

Urban Area	**Semi-Urban Area**	**Rural Area**	**Total**
29 (63%)	13 (28.2)	4 (8.7%)	46

Source: Field Survey

5. DISCUSSION

Uneven distribution of health human resources in Kogi State: The study discovered that the distribution pattern of health workforce in Kogi State along Tertiary, secondary and primary health care, as well as Urban, Semi-Urban and Rural areas is very uneven, and skewed in favour of the urban and sometimes semi-urban areas, neglecting primary health care, and the rural areas. The Federal Ministry of Health (2006) in the Human Resources for health (draft) policy document identified these challenges as key factor of health systems underperformance in Nigeria. Understandably therefore, 63.9% of respondents in this research prefer job posts within the urban areas, 20.6% would prefer semi-urban areas while as little as 15.4% would opt for rural job posts. This lopsided statistics would be better appreciated within the fact that about 70% of Kogi States population reside in rural areas. Health workforce preference for urban areas therefore means that a larger part of the population could be denied access to quality health care thereby worsening an already challenged health care delivery system.

Quite disturbing also is the discovery that 63% of health human resources in the rural areas prefer urban post as against 8.7% who would not want to leave their rural post. Interviews with stakeholders reveals that a number of health human resources in rural posts lobby continually for a transfer to urban areas while those in the urban areas consider it punitive to be re- assigned to a rural post. Infact, Lucas (2007), explains that most health administrators use rural posts to scare and arm- twist employees to do their biddings. Hence, rural posts are abandoned such that even Medical/Health workers that are posted to rural area remain in urban centers and only visit the rural work posts once in a while and some do

not even show up at all. It is therefore not surprising that though Nigeria has a fairly large stock of health workforce, it trails Egypt, Ghana and South Africa, and even smaller African countries like Botswana and Cape Verde, with regards to the percentage of births attended to by trained professionals (Iyayi, 2007). Besides, this Urban-Rural health human resources disparity may explain for why the WHO (2010) estimates that the Nigeria woman is 500 times more likely to die from childbirth complications than her European counterpart. When this finding is brought within the analytical frame of Structural-Functionalism which is the theoretical premise of this paper, it becomes clear that the entire Kogi State health system in both urban and rural areas is a structure and if the distribution of Health Human Resources to the rural area (Which is a component of the Structure) is deficient as seen in the findings of this research, the entire system would be adversely affected. The paradox here is highlighted by the fact that, Primary healthcare which is adopted and often described as the fulcrum of the Nigerian health care system is mostly positioned to service the teaming rural population, making it pivotal to the overall health outcome and wellbeing of the nation. The discovery that this level of health care delivery is starved of adequate health human resources because of a multiplicity of factors offends the pivotal role it ordinarily should play in the health delivery system, with its attendant grave consequences.

Furthermore, in an attempt at understanding why most Medical/Health workers detest rural post, 16% of respondents cited opportunity for further career/professional development, 52% cite the lack of vital social amenities (water, electricity, good schools) in rural areas, while 32.2% of respondents cite the lack of special incentives for health workers on rural posts as a limiting factor. Equally disturbing is the fact that the Kogi State government has no policy that extends special incentives to Health Human Resources in rural posts, thereby leaving them largely unmotivated. Addressing these issues therefore may be importance to any attempt at reversing the ugly trend.

6. CONCLUSION

Kogi state is among six states that make up the North Central region of Nigeria. This region has the most alarming health indicators when compared to the South – East, South – South and South – West regions respectively. Only 23% of women needing maternal care have access to a doctor. Consequently, maternal mortality stands at high as 38% while recorded deaths from preventable/easy-to-treat disease conditions stand at 38% of deaths while under 5 child mortality rate is 36% of total child mortality. This indeed is an expression of a huge systemic failure that has, in this work, been viewed through the lenses of structural functionalism.

The study among others discovered that the health human resource stock in Kogi State is inadequate to facilitate positive health outcome. Besides, the available health human resources are so unevenly distributed that while the urban areas have so much, the rural areas/primary health care level lacks a wide range of the most essential health workforce stock. This is not a plus to a state that has about 70% of its entire population in the rural areas. The implication of this finding is that the larger percentage of people in Kogi state have no access to quality health care, this is because 70% of the Kogi State population reside in the rural areas and if a huge 70% have no access to quality health care then it implies that its ripple effect would translate into poor health for the citizens and thereby jeopardizing the realization of health related Social Development Goals.

Another interesting dimension that makes the rural/primary health care delivery system in Kogi State really weak is the finding that there are no special incentives given to motivate health human resources in rural areas. This position is supported by 86.1% of respondents. This is one reason why most health workers in rural area in Kogi State abandon the work location and only decide to visit such rural places at the end of the month or during screening exercises. So, although the state ministry of health has in its records a number of people posted to rural areas, an empirical research as this would discover that these workers are not actually present at their duty posts.

When all these are viewed through the lenses of structural functionalism it becomes clear that the performance of functions can indeed be impaired by a dysfunctional unit (primary health care) of the structure. This lack of optimum performance is caused by the absence of an adequate rural workforce motivation strategy. The sad implication is that it leaves the teaming rural population at Kogi State without adequate access to quality health care. Little wonder over 50% of deaths in the state are as a

result of preventable and easy-to-treat disease conditions. Critical to the many woes of the Nigerian health care delivery system therefore, is the yawning gap between Nigeria's health policy hinged on Primary health care, and the brazen neglect of that level of health care delivery. This neglect is among a myriad of other factors, the result of the lack of political will to frontally address and confront the concerns of health human resources at the primary health care level, in Nigeria and indeed Kogi state.

7. RECOMMENDATIONS

The following recommendations are based on the findings of this research.

1. The Kogi State government should launch an accelerated health human resource production scheme that would sponsor indigenes to study medical courses along the lines of its greatest human resource deficiency like, Medicine, Pharmacy, Radiology, Medical Laboratory Science etc. Besides, work environment and incentives should be made very attractive to health professionals from across other states of the federation and more.
2. The issue of Kogi State's complicated uneven distribution of health human resources between urban and rural areas should be urgently addressed by a detailed health human resource policy that would figure out a road map that ensures the adequate supply to rural posts in Kogi State. This policy should make it mandatory for 80% of Medical/Health student's on Internship/Housemanship or Practicals to do them in rural areas. It should also ensure attractive extra incentives to Medical/Health workers in rural posts by establishing a Rural Health System Fund that makes it compulsory for local governments and Donor Agencies supporting Health Care Delivery in the state, and the state government to contribute a percentage of their resources for the funding of health human resources in rural posts. This would motivate them to stay in difficult terrains and ease the uneven health human resource distribution in the state. Furthermore, a strong monitoring and evaluation mechanism should be put in place with indigene/immediate beneficiaries of health services and other stakeholders involved. This mechanism should monitor the activities of health workforce and evaluate services being rendered to ensure that they conform to best practices and that resources being spent are justified.
3. The Kogi State government should take seriously, the motivation of her already inadequate and 'threatened' health human resources. Particularly, the findings of the study reveal that remuneration, opportunity for further training and a conductive work environment are the most important factors of health human resource motivation in Kogi State. This implies that improving remuneration, providing opportunities for further training, and providing a conducive work environment would go a long way in motivating health workforce in Kogi State. Government should therefore purposefully pursue those goals by reviewing health human resource salaries/other incentives every five years, providing opportunities for further training by not just releasing health human resources on study leave with pay but much more, responsibility for the payment of such programmes, hospital offices and quarters should be provided and well maintained, to make it habitable and conducive.
4. One of the findings of this research is that above 69.5% of health workforce in rural areas have never attended any seminar/refresher training since they started working with the Kogi State Government. To think that this group of health human resources are responsible for the health and wellbeing of about 60% of the Kogi State population makes it a challenge that the government and indeed all stakeholder must rise up to. A highly re-enforcing factor of the state's poor health workforce training/re-training is the fact that the state's 3,325,256 people is serviced by 3 schools of Nursing and Midwifery, 1 school of health technology and no functional medical school. These reality implies that Kogi State must as a matter of urgency invest hugely in health/medical education by establishing and equipping such schools in the three senatorial zones of Kogi State. Beside, Kogi State Government should take as priority, the adequate funding/equipping of the recently established a Faculty of Medicine/teaching hospital at the State University. Hence, the required resources should be deployed to give it the appropriate start up it requires, including building and equipping of the teaching hospital. This would be a huge boost for health human resources production, as well as a positive progress toward the attainment of health related Social Development Goals in Kogi State.
5. The findings that 58.2% of Kogi State health workforce are willing to welcome job opportunities from outside Nigeria is the sign of a serious tendency toward brain drain which is already an issue confronting health care delivery in Nigeria. The Kogi State Government should therefore work

towards ensuring job satisfaction for health workers and should immediately begin investing in the training and relative comfort of health human resources and placing them on bond to remain for a mutually determined number of years, in the Kogi State public health sector.

6. Though there is a National Health Human Resource Policy document, Kogi State has no such policy document to guide and address her health human resources concerns/peculiarities. This lapse affects issues ranging from health human resource recruitment, motivation and distribution to training and development. The Kogi State Government must therefore urgently put down measures to put together a solid health human resource policy framework that would strategically address health human resource issues and concerns.

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