NATURE AND IMPACT OF POLITICS OF FUNDING IMMUNIZATION ON PRIMARY HEALTH CARE DELIVERY IN NIGERIA

[1]MUOJEKWU Christopher Odinaka, [2]MOHAMMED Bello Baban' Umma Ph.D & [3]RUTH Caleb Luka Ph.D

[1,2&3]Department of Political Science, Faculty of Social Sciences, Nasarawa State University, Keffi.

Email: muojekwuchristopher@yahoo.com[1], Muhammedbello2244@gmail.com[2], Lukaruth81@gmail.com[3]

Abstract

The Nigerian health system is in comatose, few hospitals with few drugs, inadequate and substandard technology and a lack of infrastructural support, including electricity, water and diagnostic laboratories resulting in misdiagnosis. Medical record keeping is rudimentary and diseases surveillance is very poor. Delivery of health care becomes a personal affair and dependent on ability to pay for basic laboratory and physician services. These have exacerbated the disease burden. This study examined the nature and impact of politics of funding immunization on primary health care delivery in Nigeria. Institutional theory was adopted as theoretical framework because it explained that public programme like the immunization is determined by government institutions funding, which give its legitimacy. The study employed both primary and secondary methods. Specifically, the primary and secondary methods of data collection are inevitably necessary as data that were generated through primary method cannot be sufficient for this research without an understanding of the origin and development of the phenomenon which is contained in already existed literatures that can only be traced through the secondary method. Questionnaire and interview were used for the purpose of this study because the sources helped the researcher in getting professional information from only qualified and persons working directly with the concern department/unit of the focused institutions, while secondary data collection involves intense library search and internet browsing. The study discovered that that under-performance of the immunization program in Nigeria is a threat to the health and well-being of Nigerian children; this threat is even more pronounced against the backdrop of the health financing transition. The health financing transition is the phenomenon whereby growth in national income is accompanied by a growth in total health expenditure, particularly through prepaid or pooled mechanisms, and decreased reliance on out-of-pocket spending. At the same time, access to development assistance falls, since eligibility criteria are frequently tied to income thresholds (although disease burden, poor credit ratings and fragile and conflict status may also apply). It was recommended that The health of the Nigerian people should no longer be measured in terms of how many health centres are built or how many teaching hospitals are refurbished or indeed how many tones of fake drugs are burnt, but in terms of real quantifiable change in disease burdens and mortality. Therefore, the systems delivering health to Nigerian people need a radical reform, with clear explicit goals against which progress can be measured not just by bureaucrats but also by the common people.

Keywords: *Nature, Impact, Politics, Funding, Immunization, Health Care, Delivery and Nigeria.*

INTRODUCTION

Primary health care (PHC) is a key to accessing universal health coverage. It is an important health care component for achieving health for all, especially in the less developed countries where access to quality healthcare is minimal. The concept of "one PHC per ward" was widely accepted at the Alma-Ata Declaration of 1978 as a vehicle for ensuring that more people all over the world have access to quality healthcare (World Health Organization, 1978). The Declaration of Alma-Ata in 1978, the 1987 Bamako Initiative, and the 2006 Abuja Call all emphasized the importance of investing in PHC for health (Nnabuihe and Lizzy, 2005).

Forty-five years (1978-2023) after its support of the Alma-Ata Declaration of 1978, Nigeria is yet to meet the goals stipulated in the declaration. As a matter of fact, a large number of Nigerians do not have access to medical

health services; those in the rural areas are the worst-hit. The poor state of the PHC system in the country has made a good number of Nigerians, especially those in the middle and upper classes to seek health care services from better managed health care providers (at the secondary and tertiary health care levels). Those who can afford to seek health care services outside Nigeria without contacting PHC providers in the country are also doing so. As such many Nigerians ignore the referral health policy and services of PHC facilities which are much closer to the people than the other levels of health care.

Over the years, the Nigerian government has made concerted efforts at addressing these challenges in the PHC system by setting up policies and programmes, and partnering with non-governmental organizations. Some of these programmes are the National Health Policy, the National Health Act, the National Strategic Health Development Plan, the National Health Insurance Scheme, the National Routine Immunisation Strategic Plan, and the Minimum Standards for Primary Health Care in Nigeria, the Ward Minimum Health Care Package, the PHCOUR Implementation and the One Functional PHC Per Ward Strategy (NPHCDA, 2014). In spite of the launch of these well lauded and well meaning programmes, Nigeria's PHC system is still in a bad state as all these programmes have experienced lots of setbacks (Alenoghena, Aigbiremolen, Abejegah and Eboreime, 2014).

Nigeria has had a complex history of immunization dating from the 1970s/1980s. Bilateral and multilateral aid agencies were active supporters of immunization efforts during that time, but aid funding was compromised during a period of political turbulence, which led donors to cut funding in the country. Under civilian rule from 1999 onwards, the National Programme on Immunization (NPI) was established with a focus on polio. NPI was subsumed into the National Primary Health Care Development Agency (NPHCDA) in 2007 and international donors reentered the arena, but for many years Routine Immunization (RI) coverage performance undulated (Oyekale 2017).

The goal of primary health care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade. The PHC aims at providing people of the world with the basic health services. Though PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts. About two-thirds of Nigerians reside in rural areas therefore they deserve to be served with all the components of PHC. Primary health care, which is supposed to be the bedrock of the country's health care policy, is currently catering for less than 20% of the potential patients (Gupta, Gauri and Khemani, 2004).

Politics is relevant to the development of the health system. In 2014, the Nigerian government spent just US$11 per capita on health care - well below the benchmark of US$86 per capita that the World Bank said was necessary to deliver key health services in low- and middle-income countries. Health spending accounted for only 6% of the total government budget - far below the 10% average for sub-Saharan Africa and nowhere near the 15% target that Nigeria had itself set more than a decade earlier. Financial support from the World Bank, as well as the Global Fund to Fight AIDS, tuberculosis and Malaria was at risk. In addition, financing from the Global Polio Eradication Initiative was set to drop by 40% in 2019, and Gavi, the Vaccine Alliance - a public-private partnership that had spent hundreds of millions of dollars to expand vaccination coverage in Nigeria planned to discontinue its funding in 2021. The government had to fill the gap. Even the much-publicized 2005 launch of a contributory national health insurance program heralded as a potential solution to the funding crisis was never seriously put into operation, and it covered only about 3% of the population anyway, with most of the beneficiaries being federal government employees. Policies regarding the primary health care system within which routine immunization is undertaken in Nigeria is linked to politics (Ezekwesili-Ofili and Okaka, 2019).

Based on the shortcoming being experienced in the process of implementing primary health care system in Nigeria, important services like immunization service to prevent some childhood killer disease are not reaching

the rural children which member is more than those in the urban, among other factors like political will of some area council in the Federal Capital Territory (FCT), basic problem of lack of inadequate insufficient /misappropriation of funds play a major role. These and others are problems encountered during immunization services in Nigeria. It is against this background that this study attempted to examine the nature and impact of politics of funding immunization on primary health care delivery in Nigeria with focus in Federal Capital Territory (FCT), Abuja.

Research Objectives

i. To examine the nature of politics of funding immunization and primary health care delivery in Nigeria;
ii. To assess how the politics of funding immunization has impacted on primary health care delivery in Nigeria.

Theoretical Framework

Institutional theory was adopted; DiMaggio and Walter (1983) were the proponents of the theory. Meyer and Rowan (1964) examined the growth of three administrative services in California public schools (school health, psychology, and curriculum) from the standpoint of institutional theory. They found that when there is a high level of consensus and cooperation within the institutional environment, diffusion of innovative structures is steady and long-lasting. However, when the institutional environment is contentious and unfocused, adoption of innovative structures is slow and tentative.

According to Gumede (2008:11), public sector institutions are integral to the public policy making process. Inherently, they influence public policies and their implementation. Fox, bayat and Ferreira (2006:12) claim that the institutional theory is premised on the basis that public policy is the product of public institutions, whose structures are responsible for public policy implementation. This, therefore, highlights the dependency factor of public policy to Institutional model. It can be further deduced that institutions, both governmental and non-governmental, have an impact on a public policy process. In that regard, the Institutional model remains a pinnacle for the implementation of public policy.

Institutionalist claims that, policy is a product, authoritatively determined, implemented and evaluated by government institutions: legislature, presidency, elective officials and the bureaucracies both at local and national level. It is further explain that, a policy does not become a public policy until it is legitimized by government entity concerned. Government policies provide legal powers that demand obligations from and command loyalty of its subjects.

The structure of various government institutions contribute to the context of public policy implementation. The constitution serves as the highest kind of policy to which all other policies must subscribe. Laws passed by legislature, executive orders and judicial decisions come second in terms of relevance and priority. The study of government institutions is one of the oldest concerns of political science. Political life generally revolves around governmental institutions such as Legislative, Executive, Courts, Ministries, parastatals and political parties. Public Policy is initially authoritatively determined and implemented by government institutions. Even though earlier studies of institutions tended to place emphasis on formal and structural aspect, they could be usefully employed in policy analysis. An institution is a set of regularized patterns of human behaviour that persist over time. As such they can affect decision making. Rules and structural arrangements in organizations are not usually neutral in essence; they tend to favour some interests in society over others, some policy results rather than others.

Many macro level political institutional conditions might shape broad patterns of domestic politics. Overall authority in state political institutions might be centralized or decentralized.

The legislative, executive, judicial, policing and other governmental functions within given political authorities are located within sets of organizations each with their own autonomy and operating procedures. Therefore, Government institutions give public policy legitimacy, legal obligation that command loyalty of the citizens, Universality i.e only government policies extend to all people in the society. It is precisely this ability of government to command the loyalty of its citizens, to enact policies governing the whole society, and to monopolize the legitimate use of force that encourages individuals and groups to work for implementation of public policy that constitute state power.

Assumptions of the Theory:

i. Social actions
ii. Individuals have little impact
iii. structure/design affects outcomes

Application of the Theory to the Study

Public Programme like the immunization is determined by government institutions funding, which give its legitimacy. Government institutions have long been a central focus in the determination of public goods. The relationship between public policy implementation and government institution is close, because, a public policy cannot become a public policy until it is opted, implemented and enforced by some government institutions. Funding immunization intended to cover the entire Nigerians for the provision of access, qualitative and affordable health services. For the purpose of this study, institutional theory is to be adopted based on multiple stakeholders' engagement in funding in the formal sector.

Politics of funding immunization operate within an organizational environment where a variety of external constituencies are defined. When institutions operate within the guidelines and accepted notions, external constituents such as (workers, citizens, other stakeholders) view the PHC as a legitimate organization within the Health sector. The government then assists this legitimate organization with support in terms of funding, infrastructures and others.

LITERATURE REVIEW

Abdulraheem, Olapipo and Amodu (2012) addressed Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities. An extensive search of the Pub Med database, Medline and Google Scholar was done to retrieve literature on PHC services and strategies for enhancing the use in rural community, which were published either in English or with an English abstract (foreign-language publication). The study argued that PHC is provided by local government authority through health centers and health posts and they are staffed by nurses, midwives, community heath officers, heath technicians, community health extension workers and by physicians (doctors) especially in the southern part of the country. The services provided at these PHCs include: prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health and the collection of statistical data on health and heath related events. The health care delivery at the LGA is headed politically by a supervisory councilor and technically and administratively by a PHC coordinator and assisted by a deputy coordinator. The PHC co-coordinator reports to the supervisory councilor who in turn reports to the LGA chairman. The study recommended that capacity building and empowerment of communities through orientation, mobilization and community organization as regards training, information sharing and continuous dialogue, could further enhance the utilization of PHC services by rural populations. The study concentrated so much in discussing Primary Health Care Delivery in Nigeria without connection with the nature and impact of politics of funding immunization on primary health care delivery.

Ben (2014) wrote on Routine Immunization in Nigeria: The Role of Politics, Religion and Cultural Practices. The study comprised mostly a narrative account of how politics, culture and religion have impacted the routine immunization in Nigeria. For that purpose, a search of the key words was done on Google and PubMed. The

study found that political, cultural and religious dynamics are relevant for the routine immunization in Nigeria and play key roles in determining uptake rates. The study recommended that, given the rates of childhood mortality in Nigeria, these are matters that must be addressed with sensitivity but also with urgency to stem the tide of needless deaths of children in this country. It was insisted that advocates, donors, technocrats involved in health care delivery, think-tank organizations such as the National Academy of Science need to engage political leaders and governments at all levels. It is insufficient to have these discussions at levels where there is little political power such as meeting of health commissioners. Engagement needs to target those within and outside government who have the most power to make and influence political decisions. However, the nature and impact of politics of funding immunization on Primary Health Care Delivery in Nigeria was not described in the study.

Methodology

This study adopted the cross-sectional survey research design. Both quantitative and qualitative research approaches were used here. The design is relevant to this study because, it assists the researcher to explore the relationship between independent (politics of funding immunization) and dependent variable (primary health care delivery in Nigeria). The study population consists of key stakeholders in immunization programme in Nigeria at the national level consisting officials of Federal Ministry of Health, National Primary Health Care Development, Federal Ministry of Budget and National Planning and Federal Ministry of Finance. Therefore, the total population for this research work is 1,086 staff of the above mentioned institutions. The sample size was determined using Rakesh statistical formula to arrive at 400. Purposive or Judgmental sampling technique was used for the selection of respondents for the interview while systematic sampling techniques was adopted to select respondent for the questionnaire.

Questionnaire and interview were used for the purpose of this study. This method will help the researcher in getting professional information from only qualified and persons working directly with the concern department/unit in the focused institutions mentioned above. The secondary sources involved books and journal articles, unpublished theses, government publications, and all other processed data that were collected were able to complement, validate, or reject certain claims in primary data and other literature**.**

This study employed both quantitative and qualitative method of data analysis. Data collected from the questionnaire was imputed into computer using the Statistical Package for Social Sciences (SPSS). Descriptive statistics such as percentages, frequency tables were employed in characterizing the respondents. Analysis of the qualitative data placed emphasis on the interpretation, description and recording/writing of what was actually said (content analysis). The study also drew qualitative information and quantitative data through content analysis of official speeches and policy review documents.

Data Analysis and Interpretation of Results

Table 1: There is no correlation between politics of funding immunization and the nature of primary health care delivery in Nigeria

Option	Frequency	Percentage
Strongly Agree	4	1%
Agree	19	6%
Disagree	166	46%
Strongly Disagree	164	45%
Undecided	8	2%
Total	**361**	**100%**

Source: Field Work, January (2023).

Analyzing responses of the respondents on the proposition that, there is no correlation between politics of funding immunization and the nature of primary health care delivery in Nigeria, the above data showed that one hundred and sixty-four (164) respondents representing forty-five (45) percent strongly disagreed while one hundred and sixty-six respondents (166) accounting for forty-six (46) percent disagreed. Respondents who agreed stood at nineteen (19) representing six (6) percent and those who strongly agreed accounts for four (4) or one (1) percent. Eight respondents (8) accounting for two (2) percent were undecided. It is therefore safe to conclude that there is no correlation between politics of funding immunization and the nature of primary health care delivery in the Federal Capital Territory (FCT) Abuja - Nigeria. The foregoing analysis was further supported by the interview result below:

An interview with a senior official of the international funding department at the Ministry of Finance show that the health of any nation is very vital to the development of that country, therefore, for any country to develop then the health care sector must adequately funded. The way health care is financed varies across different countries. Nigeria finance its public health care through tax revenue (by the federal, state and local government), out of pocket payments (also refers to as user fees), donor funding and health insurance (Interviewed 13th January, 2023). The participant went further that:

> Routine Immunization in Nigeria has suffered a severe setback due to the high concentration on campaigns and Supplemental Immunization Activities (SIAs) which have overshadowing influence over RI. The breakdown of RI was worsened by poor political commitment and bureaucratic bottle-necks, non-prioritization of RI and PHC services, inadequate funding for demand creation strategies for RI services and human resource challenges such as inadequacy and poor motivation of health care workers. Budgeting for immunization and PHC and timely release of funds is necessary for states to carry out demand creation activities and it is important that decision makers openly show commitment (Interviewed 13th January, 2023).

Leon (2019) argued that Nigeria's immunization efforts have been hampered by wastage. The result is that Nigeria has tended to spend more money for less coverage than in similarly-placed countries. A continuing passing of blame between federal, local, and state governments over who should fund primary health care and routine immunization, still obtains. State governments have in the past sought to abdicate their responsibilities and pin all of it on the Federal Government, but they budget for public health services annually and the funds are mostly misapplied. While recent years have seen some improvements, prioritization of immunization is not as high on the agenda of some state governments as it should be.

Table 2: Immunization Financing Responsibilities and Sources of Funding

Program component	Level of responsibility	Level and source of government financing Vaccines	Development support
Routine vaccines (traditional)	Federal government (NPHCDA)	• Federal government line item for routine immunization in NPHCDA capital budget • Transfers from FMOH (incl. financing from WBG polio project)	None
Routine vaccines (new)	Federal government (NPHCDA)	• Federal government covers co-financing on new vaccines subsidized by Gavi • Federal government line item for routine immunization in NPHCDA capital budget • Transfers from FMOH (incl. financing from WBG polio project)	Gavi
Vaccines for SIAs	Federal government (NPHCDA)	• Line item for SIAs (polio and non-polio) in NPHCDA capital budget • Transfers from FMOH (incl. financing from WBG polio project)	Gavi
Operational costs for SIAs	Federal government (NPHCDA)	• Line item for polio eradication initiative in NPHCDA capital budget for polio costs	Gavi; GPEI; BMGF-Dangote

		• FMOH (including WBG polio project) for polio costs • No separate line item for non-polio SIAs	
Salaries for CHEWs	State and LGA budget	• CHEWs' salaries are largely paid directly from LGA-joint account managed by the state	GPEI finances top-ups
Per diems for health care workers	LGA Dept of Health budget	• Mainly not funded by government due to poor execution of operational costs/low spending	Gavi, GPEI, other partners
Midwives	National, state and LGA	• Some midwives paid through national NPHCDA budget (Midwife Services Scheme) • Other midwives paid through LGA-joint account managed by state	
Salaries for health care workers (CHEWs and other)	LGA budget (paid by the state)	• Paid directly from a LGA-joint account managed by the state • A limited number of facilities receive financing for MCH in the form of capitation payments based on number of NHIS registered individuals	GPEI finances top-ups
Overhead costs	LGA	• LGA Dept of Health budget (not always executed)	

Source: Compiled by the Researcher from the work of Sarah, Christoph, Reem, Mayowa, Ayodeji, Ayodeji, Olumide and Benjamin (2022) and NPHCDA Reports.

Government financing for the immunization program is shared across all three levels of the health system, but development partners also play an important role. Table 2 above presents an overview of the various financing responsibilities, by level of government. The federal government, through NPHCDA, is responsible for vaccine financing, while states and LGAs are responsible for financing service delivery (including the administrative support and logistics needed to deliver vaccines to end users). It is important to note that while there are line items for vaccines and SIAs in the government's "capital" budget, there is no line item for immunization service delivery, which is a shared cost in primary health care budgets and includes a mix of salaries for midwives (paid at national and sub-national levels); CHEWs (paid for at state and LGA); operational costs for PHC (for example, low-level maintenance, monitoring and supervision of the supply chain), and cash support (for example, fuel and transportation). Much of the health systems strengthening activities (e.g., training, construction, surveillance, program management, supportive supervision, cold-chain strengthening) are currently paid for through development partners. Table 2 describes the financing responsibilities and sources of funding. The high reliance on donor funds suggests that several key functions may be at risk if a plan for financing them is not developed prior to transition.

Service provision in the primary health sector remains poor. Revamping service provision especially infrastructure and personnel recruitment, are mostly politically determined at the different levels. Addressing unavailability of vaccines, enforcing performance management for inefficient and discourteous health workers also requires political action for policy change, implementation and evaluation. Such political action has not always been forthcoming.

Politics has also hampered the ability and capacity of States and LGAs to plan the location of services rationally. Political agendas have been pursued at the expense of getting the vaccines to the people who need them. Governments at state and local governments have often been inclined to invest in obvious and visible projects such as large, urban, tertiary hospitals, neglecting primary health care services, which are not only extremely necessary but also cost effective and reduce need for secondary and tertiary care. Appropriate planning and mapping for routine immunization are neglected in favour of plans that will return the elected officials at local and state levels to power. Those health centres built by hard pressed communities hardly get the needed support from the government. Decisions are made at the federal level without consultations or information to the state and local government levels, likewise States with little or no input from the Local Governments and local governments view the communities as aliens and do not consult them and rather dictate to them.

Table 3: Respondents responses on the opinion that the politics of funding immunization has impacted negatively on primary health care delivery in Nigeria

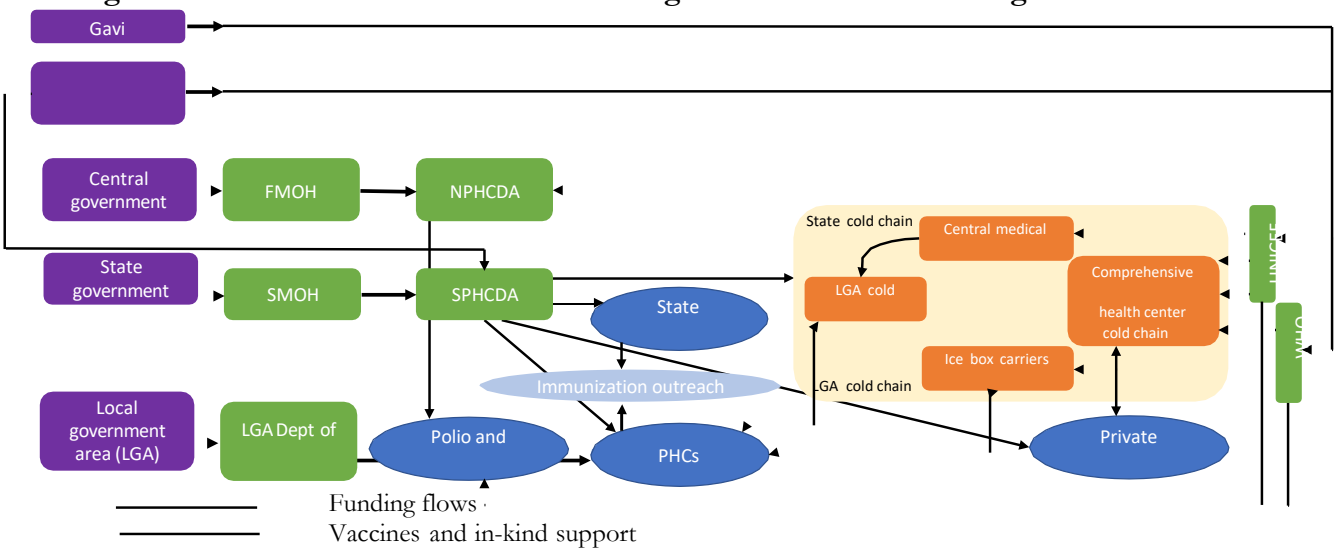
Option	Frequency	Percentage
Strongly Agree	93	26%
Agree	155	43%
Disagree	70	19%
Strongly Disagree	26	7%
Undecided	17	5%
Total	**361**	**100%**

Source: Field Work, January (2023).

On the question of whether politics of funding immunization has impacted negatively on primary health care delivery in Nigeria, the data supplied by respondents show that majority representing forty-three percent (43) or one hundred and fifty-five agreed, twenty-six (26) percent or ninety-three respondents strongly agreed. Seventy (70) respondents representing ninety (19) percent disagreed while twenty-six respondents (26) accounting for seven (7) percent strongly disagreed. Those who remain undecided were seventeen (17) or five (5) percent. This shows that politics of funding immunization has impacted negatively on primary health care delivery in Nigeria. An interview result with one of the respondents who is a senior staff of the National Primary Health Care Development Agency in Abuja indicates that:

In the context of routine immunization, politics is relevant to the development of the health system. Questions regarding what policies to adopt with regard to health issues such as routine immunization have political underlining. Policies regarding the primary health care system within which routine immunization is undertaken in Nigeria is linked to politics. Political issues such as leadership of Local Government Areas (LGA), allocation to the LGAs et cetera, eventually affects primary health care, as that level of government is mostly responsible for it. It is also important to note in Nigeria that the politics of routine immunization is broadly spread – from the top, starting with the Federal Executive Council, the Legislature (NASS), Minister of Health and the Federal Ministry of Health, the Governors, the Commissioners and the State Ministries of Health, to the Local Government Chairmen and all 774 local governments in Nigeria. The politics also extends to traditional rulers, community leaders, and religious leaders. The communities do not necessarily map on to the local governments, and this is even truer of religious inclinations and influence. The influence of religious leaders, for instance, sometimes goes beyond the borders of the particular communities in which they reside. This influence as well demonstrated by the conspiracy theories that hampered polio eradication in Nigeria is not by any means insignificant (Interviewed 10th January, 2023).

Figure 2: Flow of Funds and Vaccines in Nigeria's Immunization Program



Source: World Bank Public Expenditure Tracking Survey (2017).

The flow of funds and vaccines to the immunization program is made increasingly complex by other sources of funds flowing to the same agents and providers. Figure 4.3 outlines how funds flow to the immunization program. If the fund flows for other priority programs (for example, HIV/AIDS, tuberculosis, malaria) were also included, the figure would show a higher degree of complexity and fragmentation; in the interest of simplifying,the graph outlines fund flows that eventually reach the immunization program.

Immunization Funds are used for Procurement of Vaccines, Storage of Vaccines, Transport of Vaccines of state Central Medical Stores(CMS), Maintenance of Cold Chain, Immunization Outreach to hard to reach areas, Program Management for Immunization i.e training and Advocacy ,Communication and Social Mobilization. Immunization in Nigeria has made remarkable progress in recent times with an increase in coverage rate (Penta 3), lack of national stock out of vaccines; introduction of 3 new vaccines (Penta, IPV and PCV) in the last five years, the interruption of wild polio virus transmission which led to the delisting of Nigeria from WHO polio endemic countries in 2015. However, Nigeria faces a huge fund gap for its immunization program due to rising birth cohort, introduction of these new vaccines and a transition from Gavi support amidst broader macro-economic challenges (Interviewed January 10th 2023).

Table 5: Immunization Services and Storage of Vaccines by Healthcare Facilities in Nigeria

	Anambra	Bauchi	Bayelsa	Cross River	Ekiti	Imo	Kaduna	Kebbi	Kogi	Niger	Osun	Taraba	Total
Immunization services provided	94.0	88.2	82.3	91.7	89.4	81.7	82.3	94.7	75.2	91.8	83.2	84.5	86.6
Vaccines stored at the facility	10.6	25.5	21.0	15.6	10.6	10.0	13.5	15.3	7.8	14.9	14.5	3.6	13.6
Vaccines stored at another facility	83.9	63.2	63.0	76.1	79.3	71.7	69.3	79.9	67.5	81.3	71.5	82.4	74.1
Vaccine carrier(s)	93.5	78.3	76.8	85.4	78.9	78.7	75.8	76.1	69.4	77.4	77.1	65.8	77.8
Refrigerator available	34.7	29.3	44.8	24.4	49.0	28.7	27.4	23.9	23.3	14.9	36.9	6.7	28.6

Source: Oyekale (2017)

Table 5 shows the distribution of the healthcare facilities based on vaccination services and storage of vaccines. In the combined data, 86.6% of the health facilities provided vaccination services. However, only 13.6% of the combined healthcare facilities were able to store vaccines at their facilities. More specifically, the highest values were reported in Bauchi and Bayelsa states with 25.5 and 21.0%, respectively. Vaccines were stored in another healthcare facility in 74.1% of the combined data. This is understandable given the fact that only 28.6% of the health facilities in the combined data indicated availability of refrigerators.

Table 6: Responses opinion on certain things people say/do about immunizations given in the health centre.

	Descriptions/statements	Frequency	Percentage
i.	Immunization is harmful to Children	115	32
ii.	Immunizations protect the children against deadly diseases	99	27
iii.	Immunization reduces the fertility of the Children	51	14
iv.	The white men are deceiving us with all the talks about immunization	96	27
	Total	**361**	**100**

Source: Field Survey (January, 2023).

The above table shows responses on certain things people say/do about immunizations given in the health centre. 115 respondents representing (32%) say immunization is harmful to Children, 99 respondents representing (27%) said immunizations protect the children against deadly diseases, 51 respondents representing (14%) said immunization reduces the fertility of the Children, while 96 respondents representing (27%) said the white men are deceiving us with all the talks about immunization.

DISCUSSION OF FINDINGS

i. The study discovered that in the context of routine immunization, politics is relevant to the development of the health system. Policies regarding the primary health care system within which routine immunization is undertaken in Nigeria is linked to politics. Political issues such as leadership of the area councils and allocation to the area councils eventually affects primary health care, as that level of government is mostly responsible for it. It is also important to note in Nigeria that the politics of routine immunization is broadly spread – from the top, starting with the Federal Executive Council, the Legislature (NASS), Minister of Health and the Federal Ministry of Health, the Governors, the Commissioners and the State Ministries of Health, to the Local Government Chairmen and all 774 local governments in Nigeria. The politics also extends to traditional rulers, community leaders, and religious leaders. The communities do not necessarily map on to the local governments, and this is even truer of religious inclinations and influence. The influence of religious leaders, for instance, sometimes goes beyond the borders of the particular communities in which they reside. This influence is as well demonstrated by the institutional theory which helps provide an explanation for institutional decisions and activities relating to the nature of politics of funding immunization and primary health care delivery in Nigeria.

   Specifically, the study found that there is no correlation between politics of funding immunization and the nature of primary health care delivery in the Federal Capital Territory (FCT) Abuja - Nigeria. Data from questionnaire showed that one hundred and sixty-four (164) respondents representing forty-five (45) percent strongly disagreed while one hundred and sixty-six respondents (166) accounting for forty-six (46) percent disagreed. Respondents who agreed stood at nineteen (19) representing six (6) percent and those who strongly agreed accounts for four (4) or one (1) percent. Eight respondents (8) accounting for two (2) percent were undecided.

The above result is in agreement with the findings of Oyekola (2017) who submitted that government of Nigeria has chronically underinvested in its health sector and spends less on health than nearly every country in the world. In 2016, government health spending was 0.6 percent as a share of GDP or just $US11 per capita, and is much lower than even fragile and conflict affected states such as South Sudan. As a share of total government expenditure, government health spending at the federal level was 6.1 percent. The fact that Nigeria, a lower-

middle income country cannot deliver the most basic, cost-effective groups of interventions available indicates major system underperformance and inefficiencies. Despite the limitations of resource tracking for immunization, the data indicate that Nigeria spends more than other lower-middle income countries, but achieves poorer health outcomes. Estimated total financing on immunization amounted to $48.20 per live birth – nearly five times more than the average spending level in Gavi-support middle income countries ($10 per live birth).

As assumed by the institutional theory public programme like the immunization is determined by government institutions funding, which give its legitimacy. Government institutions have long been a central focus in the determination of public goods.

ii. The study revealed that under-performance of the immunization program in Nigeria is a threat to the health and well-being of Nigerian children; this threat is even more pronounced against the backdrop of the health financing transition. The health financing transition is the phenomenon whereby growth in national income is accompanied by a growth in total health expenditure, particularly through prepaid or pooled mechanisms, and decreased reliance on out-of-pocket spending. At the same time, access to development assistance falls, since eligibility criteria are frequently tied to income thresholds (although disease burden, poor credit ratings and fragile and conflict status may also apply). This is supported by questionnaire analysis stating that politics of funding immunization has impacted negatively on primary health care delivery in Nigeria, the data supplied by respondents show that majority representing forty-three percent (43) or one hundred and fifty-five agreed, twenty-six (26) percent or ninety-three respondents strongly agreed. Seventy (70) respondents representing ninety (19) percent disagreed while twenty-six respondents (26) accounting for seven (7) percent strongly disagreed. Those who remain undecided were seventeen (17) or five (5) percent. Therefore, research proposition two (2) is valid.

The finding corresponds with the argument of Leon (2019) that Nigeria's immunization efforts have been hampered by wastage. The result is that Nigeria has tended to spend more money for less coverage than in similarly-placed countries. A continuing passing of blame between federal, local, and state governments over who should fund primary health care and routine immunization, still obtains. State governments have in the past sought to abdicate their responsibilities and pin all of it on the Federal Government, but they budget for public health services annually and the funds are mostly misapplied.

The finding is also supported by the relevant of institutional theory to the study which emphasized that politics of funding immunization operate within an organizational environment where a variety of external constituencies are defined. When institutions operate within the guidelines and accepted notions, external constituents such as (workers, citizens, other stakeholders) view the PHC as a legitimate organization within the Health sector.

Summary/Conclusion

In summary, Nigeria has a relative abundance of primary health care centers, reasonable geographic access to PHC, and relatively high health worker density. However, the performance of the PHC system in Nigeria is hindered by key system, inputs, and service delivery challenges. Nigeria's story shows that adequate numbers of health facilities and health workers are necessary, but not sufficient for a strong performance of PHC. Despite several decades of financial and human capital investments, Nigeria failed to achieve the MDG targets by 2015. The coverage of key health indicators is still low even by Sub-Saharan African standards, quality of care is inadequate. Nigeria has the highest population of unimmunized children in the world and is one of few countries with less than half the population covered with essential health services. Low coverage of services poses a threat to the health and well-being of Nigerian children, but this threat becomes even more pronounced against a backdrop of the "health financing transition",

Poor immunization performance in Nigeria poses a threat to the health and wellbeing of Nigerian children, but this threat is even more pronounced against a backdrop of the "health financing transition". Nigeria still struggles to mobilize sufficient resources for health and channel those resources through prepaid, pooled resources in a way that ensures accountability and financial protection.

Recommendations

i. The Federal Government should explore ways towards improving access to primary health care. Extending the reach of primary health care and improving its performance requires action on several fronts' simultaneously-including new delivery models to increase access, a greater role for nonprofit and private organizations in service delivery, and the introduction of performance incentives to improve it.

ii. The systems delivering health to Nigerian people need a radical reform, with clear explicit goals against which progress can be measured not just by bureaucrats but also by the common people. Examples of such targets could be a 20% reduction in maternal mortality over the next 5 years or putting 100,000 people living with HIV/AIDS on treatment in the next 3 years. The health of the Nigerian people should no longer be measured in terms of how many health centres are built or how many teaching hospitals are refurbished or indeed how many tones of fake drugs are burnt, but in terms of real quantifiable change in disease burdens and mortality.

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