ROLE OF THE NATIONAL ASSEMBLY IN PROMOTING THE HEALTH SECTOR IN NIGERIA, A STUDY OF THE FEDERAL CAPITAL TERRITORY. ABUJA

BY

Vera Oluwaloni AUDU (Mrs.)

PG//NLS/1900031

BEING A DISSERTATION SUBMITTED TO THE NATIONAL INSTITUTE FOR LEGISLATIVE AND DEMOCRATIC STUDIES/UNIVERSITY OF BENIN (NILDS/UNIBEN) POST GRADUATE PROGRAMMES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS DEGREE IN LEGISLATIVE STUDIES (MLS)

JULY, 2023

CERTIFICATION

This dissertation titled "***The role of the National Assembly in promoting the health sector in Nigeria: a case study of the Federal Capital Territory"*** presented by Vera Oluwaloni Audu (**PG//NLS/1900031)** has met the partial requirements for the award of degree of Master in Legislative Studies (MLS) of the National Institute for Legislative and Democratic Studies /University of Benin (NILDS), Edo State.

_____ _____

Prof. Sam Amdii
Project Supervisor Date

_____ _____

DR. ASIMIYU AGBOLAGADE ABIOLA
Post- Graduate School Coordinator Date

DECLARATION

I hereby declare that this dissertation is a product of my research efforts, undertaken under th e supervission of Prof Sam Amdii. It is an original work and no part of it has ever been presented for the award of any degree anywhere. All sources of have been duly acknowlegded.

_____

VERA OLUWALONI AUDU
PG//NLS/1900031

APPROVAL PAGE

This is to certify that this dissertation ***The role of the National Assembly in promoting the health sector in Nigeria: a case study of the Federal Capital Territory"*** has been read and approved as having met the partial requirements for the award of degree of Master in Legislative Studies of the University of Benin/National Institute for Legislative and Democratic Studies and approved for contribution to knowledge.

_____ _____

Prof. Sam Amdii
Project Supervisor Date

_____ _____

DR. ASIMIYU AGBOLAGADE ABIOLA
Post- Graduate School Coordinator Date

_____ _____

Internal Examiner Date

_____ _____

External Examiner **Date**

DEDICATION

I dedicate this project work to God Almighty and to my family for their love and support.

ACKNOWLEDGEMENTS

I want to first of all acknowledge God almighty who has given me the privilege to carry out this exercise, my supervisor Prof. Sam Amdii, Dr. Abiola Asimiyu the program coordinator, my lecturers and the entire staff of the Iinstitute. My beloved husband Pastor C.I Audu, my Children (Joseph Asokoghene Audu, Andrew Eselikoghene Audu, Erumese Faith Audu, and Ann Ekpemikoghene Audu the only queen in the family), My boss in the office Mr Modu Kyari, my colleagues who assisted in various ways including; Mrs Nkem Agidigbo, Mr. Jamiu Adeyinka Adekunle, Mr. Chigbu, Mr. Ukachukwu and every other colleague in the program God bless you.

TABLE OF CONTENTS

CHAPTER THREE:

Research Methodology

Abstract

The resesarch is undertaken to examine the role of the eighth and ninth national assembly in promoting the health sector in Nigeria; using the federal capital territory of Nigeria as a case study.
The objective of the research is (1) Examine the laws passed National Aassembly toward the improvement of health sector of the Federal Capital Territory. (2) Analyze the major constraint on the production of health bills to improve healthcare. (3) identify challenges to health policies in Nigeria .In achieving this, the work relies on descriptive approach, structural questionnaire and interview were used for data collection and statistical package for social sciences (SPSS) was used for data analysis. A sample size of one hundred and twenty nine srespondents across the six local government area council of FCT was used for the study.

The research finding revealed that bills passed by the national assembly did not improve Nigeria's health sector development positively and laws made by them did not significantly aid workers to discharge their duties effectively and efficiently. It is obvious from the respondents that inadequate funding, mismanagement and lack of adequate medical personnel were the major factors affecting health sector in FCT, Abuja in particular and Nigeria general.

Lack of professionalism in the various committees of the National Assembly and agencies of government are also some of the constraints that affected production of bills that would have improve health sector in Nigeria. Majority of the respondents engaged in the practice of self medication despite its consequences. Financial Constraint and bureaucratic problem in the hospital system was part the major reasons for the practice of self medication. The research recommeds that any bills to be passed into laws by the National Assembly should include the input of stakeholders in health sectors and general public. Qualified professional should be appointed to head committees of National Assembly, departments and agencies of government in charge of policy formulation. National health insurances that are compulsory for all Nigerians, will eliminate self medication and its negative consequences on Nigerians.

Finally, Federal Government, State and Local government should provide Political will to properly plan, formulate and implement policies and enacted laws that will solved the challenges of health sector development in Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Individuals and the society at large attach great importance to their health and well being. This is because sound health is undoubtedly a fundamental requirement for leading a socially and economically productive life. In spite of the importance of good health, many low-income countries have not been able to meet the basic healthcare needs of their people, especially those in the rural areas. Based on this, the World Health Assembly in 1988 mandated provision of health for all people by 2000 for all Nations of the (World Health Organisation WHO, 2012). In Nigeria, persistently low quality and inadequacy of health services have invariably impacted on the health status of the citizens. In terms of health outcomes, available statistics show that Nigeria still has one of the worst health indices in the world and sadly accounts for 10% of the world‟s maternal deaths in childbirth (WHO, 2006). There are also very high prevalence rates for malaria, cholera, diarrhoea, dysentery, HIV/AIDS among others. Even the very few public health institutions are not performing optimally. A direct consequence of public dissatisfaction for Governments‟ health system is increasing public preference for alternative forms and sources of treatment (Onah, 1995: Ukwu and Nwakoby, 1989; Onokerhoraye, 1997). This patronage of alternative sources of treatments, traditional and spiritual healers, traditional birth attendants and quacks, even in the face of known dangers of wrong diagnosis, is a measure of the degree of dissatisfaction. Skilled health personnel have also been known to have increasingly migrated to other countries because of poor conditions of service and deterioration in working environment. Some few rich elites are also known to spend huge sums of money in seeking treatment abroad. There is also the rising fad of the use of the rather expensive “ever living products” drugs in

managing ailments in Nigeria. When substantial amounts are expended by these few elites in seeking treatment abroad, pressure on the external sector spending increases and may result in negative balance of payments for the country. The siphoning‟ of money away in this manner, may cause the additional harm of helping to worsen things for health care in the country. It is common knowledge that illness brings pain, anguish, emotional stress, discomfort and distraction to the afflicted. A sick person may, therefore, not be able to work. Those that are sick and yet report for work may not be able to give their best services. This is because such persons may be forced to stop occasionally for medication or to enable them recover from temporary breakdown or loss of concentration. These stoppages (total or partial) culminate in huge man-hour losses to the economy.

Healthcare in Nigeria is a concurrent responsibility of the three tiers of government in the country. Private providers of healthcare have a visible role to play in health care delivery. The use of traditional medicine (TM) and complementary and alternative medicine (CAM) has increased significantly over the past few years. Healthcare delivery in Nigeria has experienced progressive deterioration as a result of weakened political will on the part of successive governments to effectively solve a number of problems that have long existed in the sector over many years. This directly impacts the productivity of citizens and Nigeria's economic growth by extension. Over half of Nigeria's population live on less than $1.90 a day (‘Poverty Head-count’), making them one of the poorest populations in the world. As of February 2018, the country was ranked 187 out of 191 countries in the world in assessing the level of compliance with the Universal Health Coverage (UHC), as very little of the populace are health insured, whereas even government provision for health is insignificant. Out-of-pocket payments for health causes households to incur huge expenditure. Private expenditure on health as a percentage of total health expenditure is 74.85%. The implication of this is that government

expenditure for health is only 25.15 percent of all the money spent on health all across the nation. Of the percentage spent on health by the citizens (74.85%), about 70% is spent as out-of-pocket expenditure to pay for access to health services in both government and private facilities. Most of the remaining money spent by citizens on their health is spent on procuring 'alternatives' which cost a lot. Nigeria has better health personnel than most other African countries. However, considering its size and population, there are fewer health workers per unit population than are required to provide effective health services to the entire nation. Sadly, the most commonly advertised reason is the brain drain of health professionals to other countries, especially in Europe and America.

Available evidence indicates that Health Promotion is an effective tool for galvanizing individual and collective health actions aimed at preventing diseases, improving the health and wellbeing of the populace as well as ensuring a healthier society for all. In furtherance of the Federal Government of Nigeria's stewardship role of improving the health of the Nation, the first edition of the National Health Promotion Policy (2011) and the Strategic Framework for its Implementation (2012) were developed to strengthen the Health Promotion capacity of the National Health System. The review of the National Health Promotion Policy (2011) is a major step towards effective re-positioning of health promotion in Nigeria. The process provided Nigeria's frontline health promotion managers, practitioners and technical assistants a strategic opportunity to examine the evolution of health promotion in Nigeria over the past thirteen years and the findings suggest that the key reasons for the underperformance include a weak road map and process for translating the National Health Promotion Policy (2006) into interventions; weak management structures, weak health promotion systems and infrastructure across the three tiers of government; usurpation of health promotion functions by programmes, projects, other sectors and sub-sectors in disregard of the policy; and non-prioritization of health promotion by the

political class. This 2019 revised National Health Promotion Policy sets standards and provides accurate guidance on best practices and what should be done by decision makers, managers and service providers of health promotion at various levels.

1.2 Statement of the problem

A country health system that fulfills its responsibilities to citizens cannot function in isolation. It needs good governance in terms of policy making, appropriations, oversight, and accountability mechanisms from the Legislators/Government. Democratically elected governments/legislatures must passed bills that will promote the health system and allocate adequate resources to the ministry of health. Even though Nigeria had signed the 2001 Abuja Declaration pledge to commit 15% of total government expenditure to health care, the country's average annual government spending on health care has been fluctuating from 4% to 6% of the national budget during the ensuing decade and a half (Paul Adepoju, 2019). A World Bank discussion paper bluntly observed that "the government of Nigeria spends less on health than nearly every country in the world—a reflection of its under-prioritization of the sector." (Reem Hafez, 2018). Some of the problems faced by the health sector in Nigeria threfore includes; poor health policy formulation, human and material resources, poor motivation of health workers, under funding of the health sector, insecurity challenges, weak facilities/infrastructure, health sector budget, political and bureaucratic corruption, federal government default of agreement and inter professional conflict, which has led to poor health care delivery supply and increased mortality rate in Nigeria. The national assembly has not really lived up to the expectation of the public in providing legal framweork that will ensure the development of the health sector in Nigeria.

National Assembly have not been able to promote bills that could boost the development of health sector in Nigeria . Its this failure of the NASS Assembly to promote this bills and strictly monitor it implemntation that constitute the problem of this study therefore seeks to explore the role and limit of the National Assemblies in promoting the health sector development in Nigeria.

1.3 Research questions

The following questions are derived from the research problem

i. How has the laws passed by the National assembly improved the health sector?

ii. What are the major constraints in the production of health bills to improve healthcare?

iii. What are the major challenges confronting health policies in Nigeria?

1.4 Research objectives

The objectives of this study are segmented into general and specific objectives. The general objective is to examine the role of the 8th and 9th National Assembly in promoting the health sector in Nigeria. The specific objectives are to:

1. Analyze the major constraints on the production of health bills to improve healthcare.

2. What are the major constraints in the production of health bills to improve healthcare?

3. Identify the major challenges to health policies in Nigeria.

1.5 Scope and Limitation of the study

The scope of this study will be limited to analytic comparison of the health care services before enactment of bills by the 8th and 9th National Aseembly, the analysis will be done by use of questionnaires and interview, these questionnaire will be distributed to residents in Abuja Municipal Area Council; residents of Bwari area Council, Gwagwalada, Kuje LGA, Abaji LGA, this includes some selected hospitals in the above listed area council and staff of National Assembly including staff clinic and committee in charge of health sector to obtained there views on the role of the eight and Ninth National Assembly in promoting the health sector in Nigeria, using Federal Capital Territory.

The limitations to this research may include bias from individuals, time factor and bias interpretation of hospital experiences from members of society and uncooperative attitudes of medical personnel resident in Abuja Municipal Area Council; residents of Bwari area Council, Gwagwalada, Kuje LGA, Abaji LGA s, Hence the resort to key informant interview (KII) served as a complementary source of data.

1.6 Significance of the study

This study was undertaken mainly to understand the roles played by the 8th and 9th National Assembly in promoting the health sector in Nigeria. The study will review these factors from the perspective of various stakeholders such as clinic attendees, non-clinic attendees and the service providers. Information obtained from this study will help the local government responsible for service delivery at these facilities target their education and community messages to address the fundamental elements that act as barriers to proper utilization of health services. It will also help the service providers at the facility level to develop strategies and action plans that will encourage improved utilization of provided services.

These activities will help initiate the process of improving access to health care services thereby improving the overall health outcome for every individual in the state eventually. Finally, this work will be useful to scholars who wish to carry out further research on the roles played by the 8th and 9th National Assembly in promoting the health sector in Nigeria as the materials of the study will be of great importance for their enquiries.

1.8 Organization of Chapters

This dissertation was orginazed into five chapters. Chapter one contains the general introduction which consists of the background to the study, scope and limitation of the study, research questions, objectives, significance of the study and the organization of chapters. Chapter two is bordering on the variables being studied and the theoritical framework. Also, Chapter three focuses on the research methodology, while chapter four provided the presentation of data and discussion of results. Finally, Chapter five provide a surmmary, conclusion and recommedations.

CHAPTER TWO

LITERATURE REVIEW AND THEORITCAL FRAMEWORK

In this chapter, different but related studies were reviewed, The review of literature begins first with the conceptual review of the variables and finally, a concise attempt to situate the study within the frameworks of the elite theory to best conceptualized the phenomenon under review.

2.1 Conceptual Review

2.1.1 Legislature in Nigeria

Legislature is referred as parliament in Britain, national assembly in Nigeria, Congress in United States (Abonyi, 2006). The legislature occupies a key position in the process of government, with the purpose of articulating the collective will of the people through representative government (Okoosi-Simbine, 2010). Awotokun (1998) states that legislature is an arm of government made up of elected representatives or constituted assembly people whose duty is to make laws, control the activities of the executive and safeguard people's interest. Anyaegbunam (2000) defined legislature as the role of making, revising, amending and repealing laws for the wellbeing of its citizenry it represents. Lafenwa (2009) defines legislature as people chosen by election to represent the constituent units and control government. Okoosi-Simbine (2010) asserts that legislature is law-making, and policy influencing body in the democratic political system. The law makers can be described in the site of sovereignty, the expression on the will of the people. This is derived from the people and should be exercise according to the will of the people they represent.

Bogdanor (1991) affirms that legislature is derived from a claim that its members are representative of the political community, and decisions are collectively made according to

complex procedures. The state of the legislature has been identified as the strongest predictors on the survival of every democratic development (Okoosi-Simbine, 2010). The centrality of the legislature is captured by Awotokun (1998) when he asserts that legislature is the pivot of modern democratic systems. Edosa & Azelama (1995) states that legislatures vary in design, structure, organisation, operational procedures, and selection process as well as sizes, tenure of office and nature of meetings.

In a bicameral type of arrangement two legislative chambers exist in a country; one chamber seems to dominate the other. Nwabueze and Mueller (1985) noted that when they viewed that there exist some forms of dominance of one chamber to the other in some legislation, term of office, size of the constituencies represented. However, they intricate rules adopted usually harmonize the legislative function of the two chambers (upper and lower chamber). Edosa and Azelama (1995) assert that bicameral legislative is common in federal states that stem from the imperative of one house to protect the interests of minority groups in such states. Nigeria operates in a federally bicameral arrangement on the dictates of 1954 Lyttleton Constitution. The House of Senate (Upper House) and House of Representatives (Lower House) jointly called National Assembly of Nigeria. The two chambers act as a check on other arms of government; such checks are minimal because the major policy demand debate is on party affiliations rather than national interest (Edosa & Azelama, 1995). This arrangement enhance passage of law and gives opportunity for division of labour between the two houses (Okoosi-Simbine, 2010). In addition, bicameral legislature provides an opportunity for wider representation of various interests groups in a country from one democracy to the other. Nwabuzor and Muller (1985) notes that such factors like presiding officer, order of business, legislative process, legislative committee, intra-party discipline manner of debate consideration account differently among countries. Nwabuzor and Muller (1985) assert that countries that operate short-term tenure for

legislature do so because the representatives reflect on the betterment of public preference in respect of government policy.

2.1.2 Functions of Nigeria Legislature

Legislation functions are the primary and the most crucial role of the legislature (Edosa &Azelama, 1995). Laski (1992), states that the responsibility for passing laws and lay down the general rules to enhance good governance for state. These laws may originate as private members bills, or they may originate from the executive branch (Benjamin, 2010). Awotokun (1998), opine that laws made by the legislature must be in the interest of the general populace with the expectation of modifying peoples‟ behaviour and response towards a given situation, be of good quality and self-sustaining. Abonyi (2006) assert that bills is examined and passed through various stages, and in the process this could be altered by addition or deletion. However, the inputs of the legislature is the attitude of the executive and other factors such as concessions to the opposition and other groups against some aspects of proposed laws greatly reduced the legislative powers to a mere deliberative assembly. Heywood (2007) stated that the twentieth century witnesses a progressive weakening of legislation power in the form of a decline of legislatures. This situation had reduced many legislative assemblies to mere “talking shops” that do little more than rubber-stamp decisions that have effectively been made elsewhere.

Oversight: The oversight function is a major component of the activities of modern legislature irrespective of the form of government in practice. NDI (2000), states that the function of oversight is to wield enormous powers in governance by executive arms. Saliu and Muhammad (2010) indicate that legislative body takes active role in understanding and monitoring the performance of the executive arm and its agencies. It is described as surveillance on the activities of the executive arm. The legislature oversees government affairs and holds the person

responsible for any actions and omissions (Fashagba, 2009). Adebayo (1986) reveals that legislative oversight cross-check the executive by examining the activities of some chief executive, ministries, department and agencies of government. The commonwealth parliamentary association (2002) assert that the principle behind the legislative oversight ensure that public policy is administered in accordance with the legislative intent. The legislative function does not end only on the passage of bills but to follow the activity linked to lawmaking. It is the responsibility of the legislature to ensure that such laws are being implemented effectively. The representative looks diligently in all the affairs of government, the eyes and voice to the will of its constituents (Simmons, 2002). The oversight function of the legislature exists as a corollary to the law-making process for instance the legislature controls the executive in financial behaviour and appointments of key officials such as ambassadors, ministers/commissioners amongst others. Lafenwa and Gberevbie (2007) assert that effective legislature in governance enhances transparency, accountability, efficiency and fidelity in government.

Representation: representation is the central role of the legislature; the complexity of modern administration has made it impossible for the people to run the affairs of the state as it was in the early Greek City-States (Awotokun, 1998). Legislative institution is a mechanism in which the population, special interests and diverse territory are represented and guaranteed at the scheme of things. Edosa and Azelama (1995) argued that representative function provides a platform where citizens and different group is opportune to have a say in governance. This gives different groups in a society or groups the opportunity to articulate and advance their interests and concerns. Roberts (2002) states that representation play dual roles. First, they represent their people to government, and second, they represent government in their constituency. Saliu and Muhammad (2010), states that the fulcrum of a legislature articulate and aggregate diverse interests of the

represented constituencies into the policy process. The functions of representation enhances the legitimacy of public policy, reduces alienation and reduce estrangement between government and the governed to enhance stability in the system (Edosa & Azelama, 1995).

Legislative Financial Function: involves an authorization of expenditure for government. Sanyal (2009) states that all government expenditure needs to be scrutinised and sanctioned by the legislature, this can be done at annual budget process. Lafenwa and Gberevbie (2007) assert legislative function as a catalyst for sustainable democratic governance. The legislature involves in the control of public expenditure and taxation and fund management to better the life of the entire citizens.

Committee Function: Heywood (2007) sees committee functions as the power houses of the legislature; they examine legislative measures in detail. The committees oversee bills and financial demands of the government, and issues relating to ministries and financial function of the government as it concerns auditing (Edigheji, 2006). The legislative committees' functions carry out the investigative power of the legislature. The standing committees of the legislature are divided and utilized for exigency purpose, this is appointed in response to a particular development on ad hoc situation (Fashagba, 2010). The legislature is the people's branch with the purpose of expressing the will of the people. The instruments and opportunities of the chief executive is responsible for managing the machinery of government, inter-state diplomacy, budget development and this veto power makes the chief executive an advantage over the legislature and hence continues to exert the executive dominance (Rosenthal et.al., 2003). Burnell (2003) states that legislature experience secular decline, unable to arrest the accumulation of executive power driven by global financial, economic and political forces. Ray (2004) asserts that legislatures have declined in respect of powers in relation to the executive

power of governments. Adebo (1988) revealed that the legislators in Nigeria's 2nd republic spent part of their tenure on the issues of accommodation, comfort and salaries for members and threatened to boycott sittings indefinitely if their demand for luxury were not met by the government (Fashaga, 2010). Burnell (2003) states that legislature experience secular decline, unable to arrest the accumulation of executive power driven by global financial, economic and political forces. Ray (2004) asserts that legislatures have declined in respect of powers in relation to the executive power of governments. Adebo (2008) revealed that the legislators in Nigeria's 2nd republic spent part of their tenure on the issues of accommodation, comfort and salaries for members and threatened to boycott sittings indefinitely if their demand for luxury were not met by the government (Fashaga, 2010). Burnell (2003) states that legislature experience secular decline, unable to arrest the accumulation of executive power driven by global financial, economic and political forces. Ray (2004) asserts that legislatures have declined in respect of powers in relation to the executive power of governments. Adebo (2008) revealed that the legislators in Nigeria's 2nd republic spent part of their tenure on the issues of accommodation, comfort and salaries for members and threatened to boycott sittings indefinitely if their demand for luxury were not met by the government (Fashaga, 2010). Burnell (2003) states that legislature experience secular decline, unable to arrest the accumulation of executive power driven by global financial, economic and political forces. Ray (2004) asserts that legislatures have declined in respect of powers in relation to the executive power of governments. Adebo (1988) revealed that the legislators in Nigeria's 2nd republic spent part of their tenure on the issues of accommodation, comfort and salaries for members and threatened to boycott sittings indefinitely if their demand for luxury were not met by the government (Fashaga, 2010).

2.1.3 Nigeria Context of Health Promotion Policy

The National Health Policy (NHP) 2016 recognizes that Nigeria is saddled with an unbearable burden of Communicable and Non-Communicable Diseases (NCDs). This is coupled with issues such as low levels of health literacy, poor sanitation and inadequate attention to key social determinants of health. The revised NHPP (2019) is meant to contribute to achieving Nigeria's National Health Policy commitment; to deliver health care that is preventive, promotes, protective, restorative and rehabilitative to every citizen of the country.

Due to globalization and other factors, the country is experiencing drastic changes in consumption patterns of alcohol, food and tobacco. Disease patterns are changing with more people affected by cancers, diabetes and hypertension. Mental health conditions, road traffic accidents, domestic violence, unsafe sex and insufficient physical activity are also on the rise.

Other threats to the Nigerian populace include insecurity, floods, Lassa fever, Ebola, Cholera, Polio and Avian Influenza.

Over the years, Nigeria's spending in the Health Sector has not fully met the 15 per cent commitment set out in the Abuja Declaration of 2001 whereby the African Union Member States committed to allocating at least 15% of annual national budget to health. The health inequities encountered reflects the linkage between peoples' health, their economic status and social conditions among states in Nigeria. This is responsible for almost all causes of illness and mortality driven by political, economic and social forces; thereby further complicating the inability of government to adequately address the social determinants of health. It is against this backdrop that health promotion becomes invaluable.

Health Promotion is defined in the Ottawa Charter (1986) as the process of enabling people to increase control over, and to improve their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO). There is growing evidence globally that Health Promotion is a pre-requisite for economic development

because Health Promotion interventions make positive contribution to the improvement of human health. It is a cost-effective approach which facilitates increased individual, family, community and social participation in health. It promotes wellbeing through the adoption of positive lifestyles by all, as well as disease prevention. It increases the use of available health services by combining approaches of equity, multi-sectorial collaboration, partnerships, alliances and networks. Health Promotion offers practical approaches to ensuring equal access to health through promotion of lawful, financial, economic and targeted environmental interventions. Hence, Health Promotion promotes high quality of life, healthy productive population with reduced morbidity, mortality and expenditure on health leading to resultant benefit of a prolonged life span.

Over the years, Health Promotion in Nigeria has remarkably evolved from purely Health Education-focused to a more holistic and inclusive era of promoting health and preventing diseases. As Nigeria experiences a demographic transition resulting in increased demand on a fragile health system, the country requires a vibrant, robust and sustained Health Promotion system. Deliberate efforts are required to integrate health interventions within a multi-sectoral context, addressing the broader determinants of health, promoting healthy lifestyles, and galvanizing health actions by individuals, families, communities and the entire populations.

2.1.4 The Historical Context of Health Policy Development in Nigeria

The period between 1472 and 1880 witnessed the arrival of the country's western-style health care delivery system. Between 1880 and 1945 saw the building and staffing of hospitals by Christian missionary health care workers according to (FMOH, 2004). From 1945 till today witnessed the development of several national health plans starting with the First Colonial

Development Plan in 1945-1955 (Decade of Development). The other ideas that evolved are the following: (i) 1956-1962: The Second Colonial Development plan (ii) 1962-1968: The First National Development Plan (iii) 1970-1975: The Second National Development Plan (iv) 1975-1980: The Third National Development Plan (v) 1981-1985: The Fourth National Development Plan (vi) 2004-2008: Five Year Strategic Plan (ScottEmuakpor, 2010). The new national health policy adopted in 2006 launched the National health insurance scheme that protects citizens against high costs of treatment, and fair financing of health care. The National Health Act of 2014 and the National Health Policy of 2016 were established to provide the framework for the development, regulation, and management of national health systems and set standards for delivering services. The new policy was a response to several unfinished agenda of the Millennium Development Goals (MDGs); the new Sustainable Mogbo and Balogun 37 Development Goals (SDGs); emerging health issues (especially epidemics); the provision of the National Health Act 2014; and the new Primary Health Care (PHC) governance reform of bringing Primary Health Care under one Roof and Nigerians' renewed commitment to Universal Health Coverage (UHC). Other considerations were globalization; climate change; challenges of insurgency, and its impact on the Nigerian health system.

Furthermore, the countries' experience in implementing the Revised National Health Policy 2004 and the National Strategic Health Development plan (2010-2015) provided the basis for the development of the new policy. The 2016 National Health Policy acknowledged the transition of disease burden in the country from communicable infectious diseases to non-communicable lifestyle diseases; thus, the strong rationale for the active involvement of physiotherapists in policy development and implementation. The underlying philosophy and central focus of the National Health Policy are based on the primary health care (PHC) concept that the services provided can reach the rural communities, where the majority of Nigerians reside. The goal of

the PHC is to prevent and treat the disease, which is responsible for much morbidity, disability, and mortality (National Health Policy, 2016). Included in the National Health Policy objective is the involvement of diverse health care workers in PHC. Unfortunately, the participation of physiotherapy in primary healthcare is yet to be appreciated and given prominence.

There has been a strong focus on PHC as the cornerstone of the Nigerian health system since 1975 (Federal Ministry of Health, 1988). WHO initiated the community-based rehabilitation (CBR) program following the Alma-Ata Declaration in 1978 to enhance the quality of life for people with disabilities and their families, meet their basic needs, and ensure their inclusion and participation (World Health Organization, 2010.) The CBR was initially a strategy to increase access to rehabilitation services in resource-constrained settings. However, CBR is now a multi-sectoral approach working to improve the equalization of opportunities and social inclusion of people with disabilities while combating the perpetual cycle of poverty and disability (World Health Organization, 2020). One of the components of community-based rehabilitation (CBR) is the provision of functional rehabilitation services in rural areas. Though captured in the 2016 National Health Policy, this program is yet to succeed in its implementation.

2.1.5 Health Care System

According to Wh HO in 2004, “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” In 1986, the WHO made further clarifications: “A resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities”. The word health has to do with complete emotional and physical well-being. Healthcare exists to help people maintain this optimal state of health. In 2009, researchers publishing in The

LancetTrusted Source defined health as the ability of a body to adapt to new threats and infirmities. Good health is central to handling stress and living a longer, more active life.

Types of health

i. Spiritual
ii. Emotional
iii. Financial health
iv. Mental and physical health

Physical well-being involves pursuing a healthful lifestyle to decrease the risk of disease. Maintaining physical fitness, for example, can protect and develop the endurance of a person's breathing and heart function, muscular strength, flexibility, and body composition.

Furthermore, looking after physical health and well-being also involves reducing the risk of an injury or health issue, such as:

i. minimizing hazards in the workplace
ii. using contraception when having sex
iii. practicing effective hygiene
iv. avoiding the use of tobacco, alcohol, or illegal drugs
v. taking the recommended vaccines for a specific condition or country when traveling.

Good health depends on a wide range of factors which includes;

a) Genetic factors

A person is born with a variety of genes, in some people, an unusual genetic pattern or change can lead to a less-than-optimum level of health. People may inherit genes from their parents that increase their risk for certain health conditions.

b) Environmental factors

Environmental factors play a role in health. Sometimes, the environment alone is enough to impact health. Other times, an environmental trigger can cause illness in a person who has an increased genetic risk of a particular disease.

Access to healthcare plays a role, but the W.H.O suggest that the following factors may have a more significant impact on health:

i. where a person lives
ii. the state of the surrounding environment
iii. genetics
iv. their income
v. their level of education
vi. employment status

Health care is the maintenance or improvement of health via the prevention, diagnosis, treatment, amelioration, or cure of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals and allied health fields. Medicine, dentistry, pharmacy, midwifery, nursing, optometry, audiology, psychology, occupational therapy, physical therapy, athletic training, and other health professions are all part of health care. It includes work done in providing primary care, secondary care, and tertiary care, as well as in public health. Access to health care may vary across countries, communities, and individuals, influenced by social and economic conditions as well as health policies. Providing

health care services means "the timely use of personal health services to achieve the best possible health outcomes"(Millman, 1993). Factors to consider in terms of health care access include financial limitations (such as insurance coverage), geographic barriers (such as additional transportation costs, the possibility to take paid time off of work to use such services), and personal limitations (lack of ability to communicate with health care providers, poor health literacy, low income). Limitations to health care services negatively affect the use of medical services, the efficacy of treatments, and overall outcome (well-being, mortality rates).

A health system is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations. There is a wide variety of health systems around the world, with as many histories and organizational structures as there are nations. Implicitly, nations must design and develop health systems in accordance with their needs and resources, although common elements in virtually all health systems are primary healthcare and public health measures. In some countries, health system planning is distributed among market participants. In others, there is a concerted effort among governments, trade unions, charities, religious organizations, or other coordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary. As with other social institutional structures, health systems are likely to reflect the history, culture and economics of the states in which they evolve. These peculiarities bedevil and complicate international comparisons and preclude any universal standard of performance.

2.2 Empirical Review

2.2.1 National Assembly and Health Sector in Nigeria

A country's health system that fulfills its responsibilities to citizens cannot function on its own, it needs good governance in terms of policy making, appropriations, oversight, and accountability mechanisms, which are, democratically elected governments/legislatures, must pass informed policies and laws that govern the health system and allocate adequate resources to a ministry of health. The responsibility of oversight (ensuring that those resources are spent efficiently and effectively on the elected government's priorities) belongs to the arms of government that can call ministries or associations to account. Failure of a health system in a democracy should have consequences through accountability mechanisms both within government, such as elections, and outside of government, through media coverage and other channels.

However, these mechanisms do not function as desired in Nigeria. Thus, strengthening the legislature's ability to make, implement, and monitor good health policy and developing its ongoing relationship with the Ministry of Health have the potential to strengthen the health system overall by moving legislators from audience to collaborators. Yet often a legislature and ministry meet only when there is a budget to defend or a disease outbreak to explain.

The National Assembly has played quite a number of major roles in promoting the health sector in Nigeria, for instance the 8th assembly passed several bills that were meant to improve the health care in Nigeria including but not limited to; National Institute for Cancer Research and Treatment bill, National center for disease control prevention (establishment, etc) bill, Federal University of Health Sciences Otukpo bill, National Postgraduate College of Medicine Laboratory Science Bill, Federal School of Medical Laboratory Technology Science bill, Federal College of Dental Technology and Therapy Bill, Radiographers (Registration, etc.) Act (Amendment) bill, Medical Residency Training Bill and Pharmacy Council of Nigeria bill, these bills are targeted at improving the healthcare in Nigeria in various ways, while some are

basically the introduction of new schools which will mean more opportunities for individuals to learn and develop more health workforce, others are establishment/modification of regulatory laws on professions, the grand goal of these bills are improvement in the health sector, the 9th assembly still have about one year and six months in office, having many bills in the pipeline. One of the bills relating to health is the Bill seeking free, mandatory healthcare for all Nigerian children; this bill has passed second reading at the House of Representative and if passed eventually will mean a great improvement in the health care in Nigeria hopefully (Medium, 2019).

2.2.2 National Assembly health policy formulation and implementation

Health policy development and its implementation in any nation are a complex and dynamic assignment that involves several stakeholders' active participation in a well-coordinated, strategic, and synergistic manner. There is no single blueprint for conducting policy processes because it varies based on the political, historical, and socio-economic situation prevailing in each country (World Health Organization, 2020).

Prior to the development of the 2016 National Health Policy, Nigeria had developed and implemented two National Health Policies in 1988 and 2004 respectively. Both were developed at critical stages in the evolution of the Nigeria Health System and had a far-reaching impact on improving the performance of the System. In between these efforts, there were several attempts to develop a holistic approach to addressing the challenges of the health sector, including the convening of the National Health Summit (in 1995) which attempted to do a diagnostic of the Health Sector. The 2016 National Health Policy, however, came shortly after the enactment of the first National Health Act 2014 for the country and at a time when there is global re-

commitment to a new development framework, the Sustainable Development Goals (SDGs), and an increasing global support for the attainment of Universal Health Coverage (UHC).

In Nigeria, the stakeholders in health policy development and implementation include but not limited to the Federal Ministry of Health as initiator, its agencies, representatives of developing partners, the private health sector, professional Regulatory bodies, civil society organizations, Ministries of health from States/FCT and the academia (National Health Policy, 2016). Inputs are also garnered from the health care professional associations and individual healthcare providers. The implementation of health policy involves transforming the policy statements into a plan of action by the agencies. Both at the national and state levels, several health policies have over the years been developed, but have failed to achieve the desired outcome due to poor implementation. Critics argued that the lack of enforcement is the graveyard of the previous health policies developed in the country.

The application of most of the national health policies is often bedeviled with challenges and abandoned unimplemented. This schism is due, in part, to the failure to harness the expertise of all relevant stakeholders. Other problems include inadequate funding, poor planning, corruption, and insufficient human and material resources (Obodo, 2017; Makinde, 2008).

2.2.3 Nigeria National health policy

The National Health Policy (2004) and Strategy to achieve Health for All Nigerians, which is a revision of two earlier health policies; represents the collective will of the government and people of the country to provide a comprehensive health care system based on primary health care. Furthermore:

• It describes the goals, structure, and strategy and policy direction of the health care delivery system in Nigeria.

• It defines the roles and responsibilities of the three tiers of government without neglecting the nongovernmental actors.

• Its long-term goal is to provide the entire population with adequate access to health care services based on the Primary Health Care (PHC) approach as its bedrock and supported by a functioning referral system. PHC is to be used to provide general health services of preventive, curative, promotive and rehabilitative nature to the population and to serve as the entry point to the health care delivery system. The PHC system was to ensure, community participation, improved inter-sectoral collaboration, functional Integration and strengthening managerial processes for health. The policy stipulates that the provision of care at this level i.e. PHC is the responsibility of the LGAs with technical support from the State Ministries of Health and Federal Government.

2.2.4 Health care delivery system in Nigeria

The health care system in Nigeria is the responsibility of the three tiers of government that comprises of the federal, state and local governments with each tier responsible for the coordination of tertiary, secondary and primary levels of health care delivery respectively though dependent on the immediate higher tier for financial provision and policy direction (Adeyemo, 2005). In the last few years in Nigeria, health service provision has been decentralized placing major health outcome responsibilities on the primary health care system (Gupta, Gauria & Khemani, 2003). Several fundamental health services provided in Nigeria are delivered through the primary health care system and it is therefore important that services provided at this level of

care are functional, available and utilized by those for whom it is provided. The National Primary Health Care Development Agency (NPHCDA) is the national agency responsible for providing a coordinated response to the implementation of high quality and sustainable primary health care services through partnerships and development of community-based systems and infrastructures. However, the actual implementation of this role is yet to be achieved especially with the deplorable state of primary health clinics nationwide probably due to poor financing of the general health care system. Health services are also provided through a variety of health care providers such as secondary, tertiary facilities and community health workers according to National Strategic Health Development Plan (NSHDP) 2010-2015

A total of 23, 641 health facilities are registered in Nigeria, 62% of these facilities are owned by the government while 38% are owned by faith-based organizations and private individuals; about 86% of the total health facilities are primary health care providers (National Bureau of Statistics, 2009). There are 774 local government areas (LGA) and 9572 political wards in Nigeria. Each LGA (the equivalent of a district in global language) has an average population of 1-2 million people, but these are further broken down into wards and each LGA is made up of about 7-15 wards. Each ward consists of about 150,000 – 200,000 persons in population; operationally the wards are better compared to a typical district and every ward has a PHCC (Scott-Emuakpor, 2010 & WHO).

There are some documented studies that show the poor use of health services for maternal health services, only 45% of pregnant women use antenatal services at least four times during pregnancy and only 39% of women deliver in the presence of a skilled birth attendant (UNICEF, 2010). In the recent times, HIV centres such as the Prevention of Mother to Child Transmission (PMTCT) of HIV have been a core focus of the government in the fight for the eradication of

HIV, this service has been decentralized to the PHCCs and despite this, a dismal 7% national uptake of PMTCT services was noted in a 2009 survey (NACA, 2010). Nigeria has the fourth largest TB burden in the world (USAID, 2009); TB treatment in Nigeria is delivered through the direct observation therapy short course (DOTS) centres located in primary health care facilities. Though there is 71% local government coverage for DOTS provision, low utilization of this service has been documented and attributed to the logistics of accessibility of care (HEFRON, 2006). The use of antenatal service can be directly related to maternal mortality rate and the outcome of maternal and child health. Antenatal and immunization services are some of the core services available in primary health care facilities (National Bureau of Statistics, 2009).

2.2.5 Traditional Healthcare System in Nigeria

Health and religious beliefs are tightly interrelated and thus have influenced how Nigerians have perceived health and healing from the earliest time of traditional medicine to the introduction of Western medicine in the late 1800s (Awojoodu & Baran, 2009; Ityavyar, 1987). The health perspectives of many Nigerians continue to be influenced by religious beliefs (Abubakar, Musa, Ahmed, & Hussani, 2007; Okeke, Okafor, & Uzochukwu, 2006). Because of the strong religious connection with health, the people of Nigeria have long believed certain illnesses to be associated with wrongdoings in the past or present world and their offense of gods and evil spirits (Nwoko, 2009; Onyioha, 1987). For example, the Hausas and Fulanis of northern Nigeria believe that cancer is caused by contact with an evil spirit (Abubakar et al., 2007). Among the Igbos, convulsions associated with malaria are believed to be diabolic (Okeke et al., 2006). Similarly, the Igbos believe mental illness to be the work of evil spirits (Nwoko, 2009). For this reason, historically, healthcare systems in Nigeria have been based on traditional medical practices and administered by traditional medical practitioners (healers) and birth attendants (Nwoko, 2009). These traditional healers often are priests or religious people with a good

knowledge of herbs and spiritual appeasements who are called on to diagnose and cure illness (Awojoodu & Baran, 2009). To be successful, healers must understand the physical, mental, spiritual, and social environment of the patients they treat (Onyioha, 1997). This practice regularly includes mending the relationship between patients and their *chi* (creator) or the spirits of the ancestors (Izugbara & Duru, 2006; Offiong, 1999). Often, traditional healers are called on to prepare healing concoctions, typically consisting of plants, herbs, and animal products (Okeke et al., 2006). In some cases, the healers perform healing ceremonies, including the use of healing concoctions and often animal sacrifices (Mafimisebi & Oguntade, 2010). Birth attendants perform deliveries, care for the health needs of pregnant and nursing mothers, and perform circumcisions; they also treat patients for infertility and manage threats of miscarriage (Ofili & Okojie, 2005). Although not adherent to strict spiritual practices associated with traditional healing medicine, birth attendants regularly use herbs when performing deliveries and providing pre- and postnatal care (Peltzer, Phaswana-Mafuya, & Treger, 2009).

Traditional medical practices have been fundamental to healthcare delivery in Nigeria because they help maintain patient–healer relationships and thus support open communication between patients and healers. Traditional healers live among the people, providing services that are accessible, affordable, and culturally acceptable to the people (Abioye-Kuteyi, Elias, Familusi, Fakunle, & Akinfolayan, 2001; Saad, Azaizeh, & Said, 2005). In addition, healers display a pragmatic approach in obtaining personal health information and histories from their patients—they use clues and language common to the people (Onyioha, 1987). When necessary, they also obtain information by observing and analyzing the patients' sociocultural environment, which may suggest the need to repair relationships between the patients and offended spirits (Ityavyar, 1987).

This pragmatic approach to particular aspects of patient information and service typically is missing from consultations between patients and Western medical practitioners (Abubakar et al., 2007). In fact, the persistent use of traditional healers and birth assistants today rests on the healers' and birth assistants' ability to understand their patients and their patients' belief systems (Saad et al., 2005), adapt their services to the needs of their patients (Offiong, 1999), and provide services based on sincere interest in patient health rather than interest in making profit (Titaley, Hunter, Dibley, & Heywood, 2010). These conditions fit well with the typical health-seeking behaviors of the people of Nigeria.

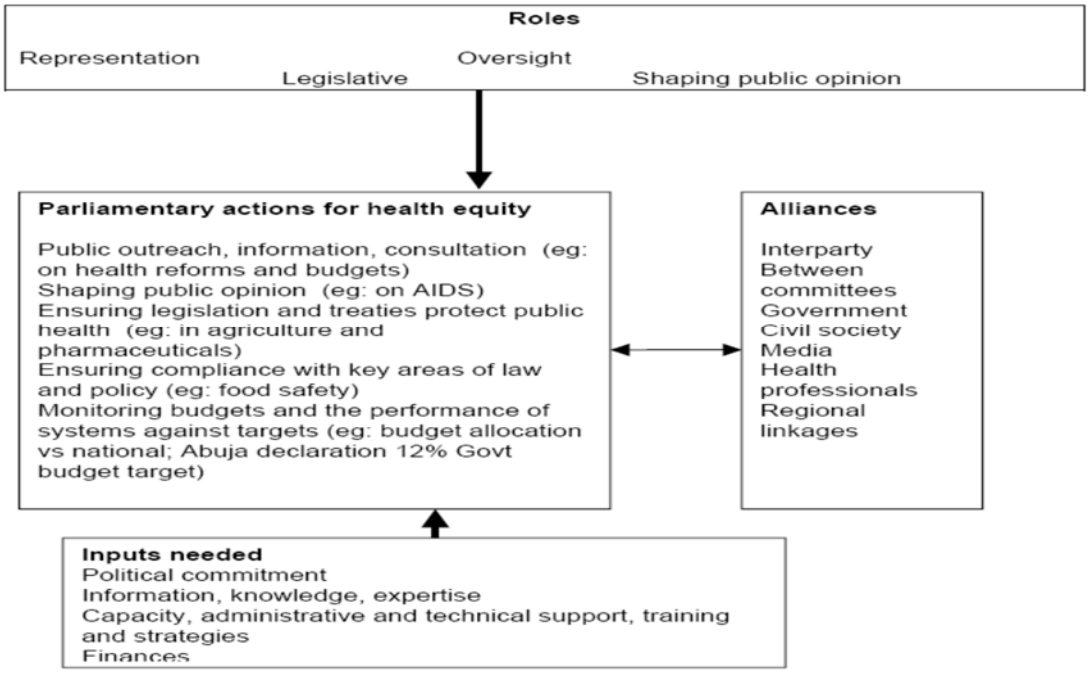
2.2.6 National Assembly Roles in Health Equity

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair (EQUINET, 2000). Social determinants of health (social conditions) are social forces acting at a collective level, shape individual biology, individual risk behaviors, environmental exposures, and access to resources that promote health. There is a graded relationship between social position and health status that affects people of all levels of the social hierarchy (EQUINET, 2003). Parliament, perhaps more than other institutions, is about relationships principally with citizens, but also with and among political parties, with the executive, and between individual members and their parties. Generally, what happens in parliament is of interest to the citizens as it affects the evolution of these relationships at least as much as it reflects the authorities, rules, procedures and resources.

Parliament is thus a key institution for addressing social determinants of health (SDH) for the promotion of health equity through its multiple functions of representation, oversight and legislation on behalf of their constituents. In simple terms, representation means acting on behalf of particular persons, and doing the best one can to secure, protect and promote their interests. In

order to adequately represent the voice of communities they represent, Legislators need to engage with civil society and the people (Sekgoma et al., 2006). Oversight refers to a culture of accountability and transparency (Sekgoma et al., 2006). Parliament is thus accountable to the electorate; citizens have an opportunity to be heard by parliament through presentations during public hearings of Parliamentary committees (Musuka, 2005). To perform their oversight role effectively, parliamentarians have to take into account the needs of the people, the State's budget, the constitutional framework and the political environment of the country (Sekgoma et al., 2006). The legislative function of parliament entails the enactment of laws that provide for the interests of all people in a particular country. In most countries, the executive presents proposals of changes in laws or new laws to parliament for consideration which Parliaments may approve amend or reject. Mataure (2003) also describes these parliamentary roles or functions in detail (see figure 1 below).

Figure 2.1: Parliamentary Roles in health equity



Source: Mataure, 2003

The above diagrame explained the parliamentary roles of Nigeria National assembly in health sector promotion, with it statutorily responsibility of representation, legislation, oversight, shaping public opinion etc, the National Assembly also form alliances with interparty committees, civil societies, media house, professionals to promote the health sector in Nigeria.

2.2.7 Nurses Role in the Promotion of Health Sector and Reducation of self Medication.

Nurses play vital role in health promotion, including aiding clients to develop responsible, informed self-medication and self-care patency. Despite the fact that people have good knowledge of the risks associated with the practice of self-medication they still practice it due to factors such as high cost of treatment, previous experience with disease and treatment. Clients should be made to understand that minor ailments could easily be treated by a physician could easily be mismanaged through self-medication, therefore health education is an important tool that should be employed by all Nurses in order to influence patients positively as regards to self-medication. It is important that nurses are knowledgeable about self-medication and self-medicated products so that they can inform the patients on each medication, including its name, appearance, purpose and effects, potential adverse effects and interactions of each medication, accurate dosage, importance of contacting the health care provider with concerns or questions and importance of taking medications exactly as directed.

2.2.8 Major challenges to health policies in Nigeria

Regardless of the important roles the legislatures have played over the years, (Aguha & Born, 2017) identified some challenges encountered by the Parliament in the process of carrying out their responsibilities towards ensuring an efficient primary health care system in most countries.

Both authors identified some factors such as; type of democracy, political environment, level of democracy, capacity and structure of the legislature as a major variable of the challenges faced by the legislature.

Despite decades of research on the relationship between the type of democracy and challenges faced by legislature in carrying out their oversight function, literature is still inconclusive about whether the parliamentary system is prone to greater challenges than the presidential or hybrid system. Some writers including Riggs (1997) have argued that presidential system is prone to a greater degree of challenge in carrying out their legislative function since there is a principle of separation of power which might result into higher conflict tendencies compared to the presidential system. In disagreement, Aguja & Born (2017) pointed out that the challenges of oversight function in presidential system might be at the same level with that of the parliamentary system where the legislature is dominated by the party of the president.

On capacity, Folscher (2006) identified that the executive is usually staffed with the level of expertise necessary to make budgetary decisions and manage their implementation. However, Gabela, Inderpal and Karodia (2015), noted that parliaments on the other hand, especially those that are weak and ineffective in the oversight process, have very little capacity for meaningful oversight scrutiny. Pertaining to political environment and challenges of legislature a report by Africa All Party Parliamentary Group (2008) noticed that although African parliament are based on western parliaments and have similar formal roles however, different forms of challenges arises as a result of social, cultural and political contexts in which they operate, are contrasting and varied both within the continent and between the continent and other parts of the world.

A few other studies including Aguja and Born (2017), Riggs (1997) have looked at challenges due to the level of democracy, and reported that countries with weak democratic foundation are

liable to be confronted with several challenges. These weak democratic foundations have posed and are still major challenges in the process of attaining an inclusive political institution that would translate to sustainable political development of the Nigerian Legislature since its re-introduction in 1999.

Other studies including Ukase & Dzeka (2018) and Babatope (2001) examined the structure of the legislature and identified that the financial autonomy of the legislature is a major challenge in legislation. With regards to representation, Jewell (1983) noted that the legislature continues to face the challenge of political institutionalization because of its inability to connect with the electorate after an election.

Health Policy Formulation; Perhaps the first step in identifying the health sector problems in Nigeria is to grope for health policy formulation organ and that is the Federal Government of Nigeria through the Federal Ministry of Health. In the first instance, the policies formulated are in most cases, one-way traffic, meaning that Abuja initiative overwhelms the policies whereas a good policy must receive inputs from all stakeholders and the beneficiaries of the policy. Worse still, the policies even when they are formulated, lack proper coordination neither are they related to any economic target. Since Independence in 1960, health policies had been enunciated in various forms either in the National Development Plans or as specific decisions. Furthermore, the political instability coupled with the unsettled economic order has also caused a serious setback to health care policy formulation, implementation, monitoring and evaluation. There has been no policy continuity owing to frequent changes of governance from the civilian to military and within the military and back to the civilian administration with different policies. In essence, good policies initiated by one regime were either frustrated or poorly implemented in contradiction to the intention which the originator of the policies had in mind

2.3 Gap in Literature

Several studies have been conducted in the area of legislative performance toward health reform, primary healthcare service in Nigeria etc. As already known, the legislature performs essential role in the enactment of laws. This is in furtherance of section 4 of the 1999 constitution that bestows the legislative powers of the federation on it, using one or more of its constitutional mandates of lawmaking, representation or oversight. However, the loftiness of the studies in this area notwithstanding, only a few attempt to focus on role of National Assembly in promoting health sector in Nigeria, focusing on the 8th and 9th National Assembly. However, this constituting a gap in the legislative literature resulted in the quest of the present study to assess role of Nigerian National Assembly in promoting the Health Sector in Nigeria using Federal Capital Territory, Abuja as a case study.

2.4 Theoretical Framework

According to Grant and Osanloo (as cited in Adom, Hussein & Agyem, 2018) theoretical framework is a 'blueprint' or guide for research. To Adom et al, a theoretical framework is a framework based on an existing theory in a field of inquiry that is related and/or reflects the hypothesis of a study. It serves as a blueprint upon which a research inquiry is built. Besides, Simon and Goes (2011), as well as Maxwell (2004), averred that the theoretical framework deepens the essence of the study. Therefore, Akintoye (2015) argued that for scholars in the field and readers, the proper selection and presence of a theoretical framework convinces them that the study is not based on the personal instincts of the researcher but rather is firmly rooted in an established theory. As a result, the Elite theory was adopted as the framework for conceptualizing this study.

2.4.1 Elite System Theory

Elite system theory's origins lie most clearly in the writings of Gaetano Mosca (1858–1941), Vilfredo Pareto (1848–1923), Robert Michels (1876–1936), and MaxWeber (1864–1920). Mosca emphasized the ways in which tiny minorities out-organize and outwit large majorities, adding that “political classes” — Mosca's term for political elites — usually have “a certain material, intellectual, or even moral superiority” over those they govern(1923/1939:). Pareto postulated that in a society with truly unrestricted social mobility, elites would consist of the most talented and deserving individuals; but in actual societies, elites are those most adept at using the two modes of political rule, force and persuasion, and who usually enjoy important advantages such as inherited wealth and family connections(1916/1935: 2031– 2034, 2051). Pareto sketched alternating types of governing elites, which he likened, following Machiavelli, to foxes and lions. Michels rooted elites (“oligarchies”) in the need of large organizations for leaders and experts, in order to operate efficiently; as these individuals gain control of funds, information flows, promotions, and other aspects of organizational functioning, power becomes concentrated in their hands. Weber held that political action is always determined by “the principle of small numbers, that means, the superior political maneuverability of small leading groups. In mass states, this Caesarist element is ineradicable” (1978: 1414). Elite theory is a theory of the State that seeks to describe and explain power relationships in contemporary society. The theory posits that a small minority, consisting of members of the economic elite and policy-planning networks, holds the most power—and that this power is independent of democratic elections. Through positions in corporations or on corporate boards, and influence over policy-planning networks through the financial support of foundations or positions with think tanks or policy-discussion groups, members of the "elite" exert significant power over corporate and government decisions. The basic characteristics of this theory are that power is concentrated, the elites are unified, the non-elites are diverse and powerless, elites' interests are unified due to common backgrounds and

positions and the defining characteristic of power is institutional position. Elite theory opposes pluralism, a tradition that emphasized how multiple major social groups and interests have an influence upon and various forms of representation within more powerful sets of rulers, contributing to decently representative political outcomes that reflect the collective needs of society. Even when entire groups are ostensibly completely excluded from the state's traditional networks of power (on the basis of arbitrary criteria such as nobility, race, gender, or religion), elite theory recognizes that "counter-elites" frequently develop within such excluded groups. Negotiations between such disenfranchised groups and the state can be analyzed as negotiations between elites and counter-elites. A major problem, in turn, is the ability of elites to co-opt counter-elites.

Application of the theory

The elite theory adopted for this research cannot be more fitting in the sense that, this study focuses on the role of National Assembly in promoting health sector. In doing so, we must look at this function within the context of the legislature's systemic characteristics as a component part of a tripartite socio-economic and political arrangement. The legislature is a critical component of the three arms of government which form the structure of the Nigerian political system. Therefore, elected representative who are members of the national assembly occupy the upper – class delineation of the elites as espoused by Nwanolue and Agabata (2005). It must be stated that the institution of the legislature within modern democratic arrangements, occupies a prime place in the governance system since all activities of government begin with laws Van Gestel (2014). Within this structure, the legislature performs functions which contribute to the effectiveness of the system to provide the dividends of democracy to the Nigerian people. Oversight performance is one of those critical legislation functions and its positive or negative conduct affects the output of the political system. The elite theory further

explains the nature and trajectory of governance in an ideal arrangement where roles are performed within the framework of extant provisions. Sadly, a sharp disconnect and blatant disregard for the demands for good health system, functional and equipped hospital and probity has seen a reversal of roles in the Nigerian context, since the elite have the financial resources to be treated outside the country when ill. The elite assumed a position of principal and the citizens are treated like agents. This leaves the legislature in a quandary in the performance of its role as a representative body and in making laws that will promote the health sector.

CHAPTER THREE

METHODOLOGY

This chapter gives an outline of research methods that were followed in the study. It provides information on the participants, that is, the criteria for inclusion in the study, who the participants were and how they were sampled**.**

3.1 Research design

For this study, a mixed research designed was used. This necessitated the use of both quantitative and qualitative data. To put it another way, Qqualitative data is frequently unstructured or semi-structured and it is not statistical. Furthermore, because qualitative data is investigative in nature and frequently left open –ended, it can be used to answer the question " why". In contrast to qualitative data, quantitative data is statistical and usually structa type, it is quantified using numbers and values. As a result, because the subject is under consideration receives insufficient literary attention, the mixed research design is justified due to the need to provide insight into the role played by the 8th and 9th National Assembly in promoting the health sector in Nigeria, using Faderal Capital Territory as a case study.

3.2 Sources and Methods of Data Collection

Data collection refers to the process through which empirical data are collected or obtained using different methods, some qualitative, others quantitative. The choice of data sources depends on the nature of the research problem as well as choice of research design. Consequently, this study accommodated both primary and secondary sources of data.

Primary data refers to the first-hand data gathered by the researcher from the field. These data were gathered through the instruments of questionnaire which was administered on the stated population. The questionnaire had close –ended-questions. This provided heuristic value for the

respondents as it serves as an easier means for self –expression. The key informant interview however permitted the research to prob concept as well as mold questions out of the responses.

Secondary data are data collected by someone other than the primary user. The secondary sources of data include jounal articles, official publications of the national Assembly, Magszines, books, internet among others, indeed, the secondary/processed data served as the source for baseline information for the most part, and in others complementray. Overall, such processed data creates the needed balance in the discussion of results.

Consequently, the questionnaire was a major instrument of data collection, the choice of the instrument was purposely because the study desires insight from respondents on the role of the National Assembly in promoting health sector in Federal Capital Territory, Abuja in particular and Nigeria in general.

3.3 Study area

The FCT consists of six area councils, namely; Abuja municipal area council, Bwari, Gwagwalada, Kuje Abaji and Kwali and the research instrument was administered to target respondents drawn from a population of these area Councils and staff of National Assembly.

3.4 Nature of the people in the FCT

Gbagyi or Gbari is the name and language of the ethic group who are predominantly found in the central Nigeria with an estimated population of 5.8 spread across four states including the FCT and located in thirty local government areas. However, the scope of this work is limited to six local area councils of the FCT. Members of this ethnic group speak two dialects and they are called Gwari but they preferred to be called Gbagyi or Gbari. (2006 National Population Census)

3.5 FCT

The people of FCT, the cosmopolitan city are, are made up of different people from all other states in Nigeria, they are majorly civil servants, due to federal character. They are people of different ethnic groups.

3.6 Reason for choosing FCT.

FCT has been chosen for this research work because it is the Nigeria capital territory and no where in Nigeria is a more nationalistic feel than this city, it is a home of a lot of government ministries and parastatals so data collected from the FCT cover apparently the whole of Nigeria

3.7 Population of the study

The population of the study according to Krishnan (2004), is the group of interest to the researcher; that is the group to which we would like the results of the study to be generalized. for this study, the population consists of staff of Nigeria's National Assembly, Health staff in the six area Council of Abuja Municipal Area Council, Bwari, Gwagwalada, Kuje, Abaji , Kwali Local Government and Nigerians in general. The choice of the population is because of their respective places in promoting health care in Nigeria Health Sector.

Table: 3.1 Population of the study

S/N	POPULATION	No of questionnaires administered	Population of medical personel
1	National hospital in Abuja Municipal Area Council	27	128
2	General hospital in Bwari Local Government	21	82
3	University of Abuja Teaching Hospital, Gwagwalada Local Government	23	93
4	Kuje Local Government	21	62
5	Abaji Local Government	18	50
6	Kwali Local Government	14	57
7	National Assembly Staff	5	18
	Total	129	490

Source: FMH, 2022

3.8 Sampling Technique

Sampling is a technique of selecting individual members or a subset of the population to make interferences from the whole population. The purposive sampling technique was chosen for this study. The Purposive sampling procedure is a non probability sampling method that emphasizes respondent selection based on preconceived conditions. Explicity, the issue of promoting health sector could be limited to some experts in the respective population. Since the population is

finite, the sample size for the administration of the questionnaire was determined using Taro Yamane (1985) formula.

Taro Yamane given as:

$$N = \frac{N}{1+N(e)^2}$$

Where:

n = sample size

N = population

E = significance level

I = constant

Applying the formula

n= ?

N = 575

E = 5% (0.05)

$$\text{Therefore} = \frac{490}{1+490(0.05)^2}$$

$$n = \frac{490}{1+490(0.0025)}$$

$$n = \frac{490}{1+0.335)}$$

$$= \frac{575}{128}$$

= 4%.

Therefore: Approximately sample size (n) = 128 respresenting 4% of the population size.

3.9 Method of Data Analysis

For this analysis, both qualitative and quantitative methods were used. As a result, the descriptive (Statistical Package for the Social Sciences) (SPSS was used to analyze quantitative data, respectively. The content analysi, is typical of qualitative data, emphasized the textual presentation of data as well as aided in determining the goals, messages and effectts of communication content obtained during the study. However, Statistical Package for the Social Sciences and simple percentage was used to denoted quantitative data. Following that, the findings were presented thematically and in graphs and charts.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

This chapter presented, analyzed and discussed data obtained in the course of the research. The questionnaires were filled and returned. In its structuring, sections 4.1, 4.2, 4.3, and 4.4 laid out the social demography and the thematic representation of the objectives stated in 1.5 respectively.

4.1 Bio- Data Analyses of Respondents

4.1.1 Bio-Data of Respondents

The Bio-date of respondents were analyzed under these headings: gender, age bracket, educational qualification, and place of work . According, 56.6% of the respondents were females while 42.6% were males.(see table 4.1). the high number of women may be due to the fact that women are emotional and medical line is not as stressful as engineering

Table 4.1.1: Gender respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	55	42.6	43.0	43.0
	Female	73	56.6	57.0	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Going further, one respondent is a Second school certificate holder, 12 of the respondents representing 9.3% are OND/ND holder. 55.8% of the respondents are HND/B.Sc holders while 33.3% of the respondent are post graduate degree holders. The nature of the job description for members of the population demands a fair level of literacy (see table: 4.2).

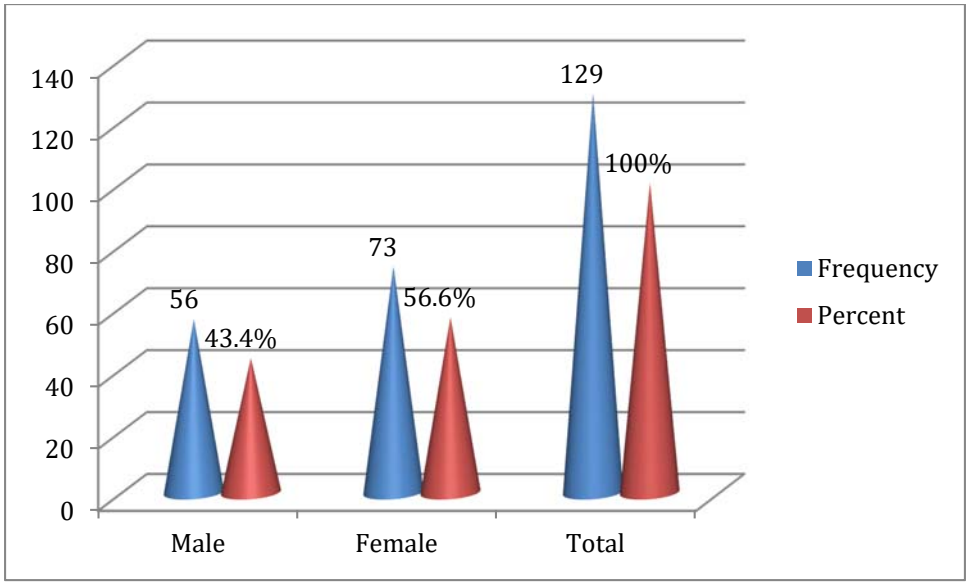


Fig 1: Respresent Gender respondents

Table 4.1:2 Educational qualification of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SSCE	1	.8	.8	.8
	OND/ND	12	9.3	9.4	10.2
	HND B.Sc	72	55.8	56.3	66.4
	Post-graduate	43	33.3	33.6	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

The age bracket are shared between the population as follows: 1.6% (18 – 25 years), 31.8 (26 - 35years), 50.4% (36 – 50years), and 15.5 % (51 – and above). The population is relatively youthful. This can be attributed to the number of youth which constitutes a sizeable number of the sampling frames. The age bracket is provided in table 4.3

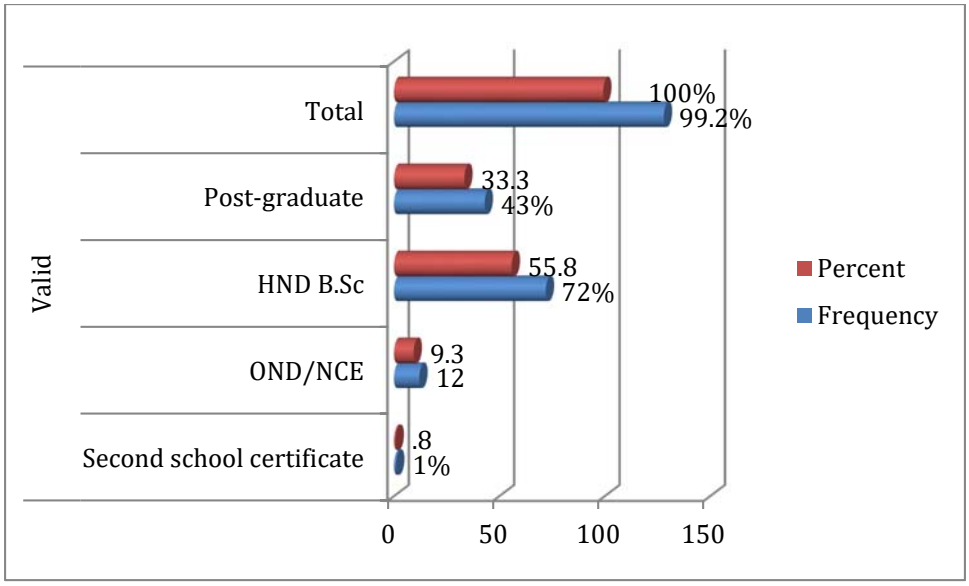


Fig.2: represents Educational qualification of respondents

Table 4.1.3:ages of the respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18 – 25	2	1.6	1.6	1.6
	26 – 35	41	31.8	32.0	33.6
	36 – 50	65	50.4	50.8	84.4
	51 – and Above	20	15.5	15.6	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

The working experiences are shared between the population as follows: 30% (1 – 4years), 21.7% (5 -10years), 25.6% (11 – 15years), and 14 % (16 – and above). The population is relatively new in their in their designation. This can be attributed to fact that health care sector is a professional field which need experienced and analytical personnel who constitute a sizeable number of the sampling frames. The working experience is provided in table 4.4

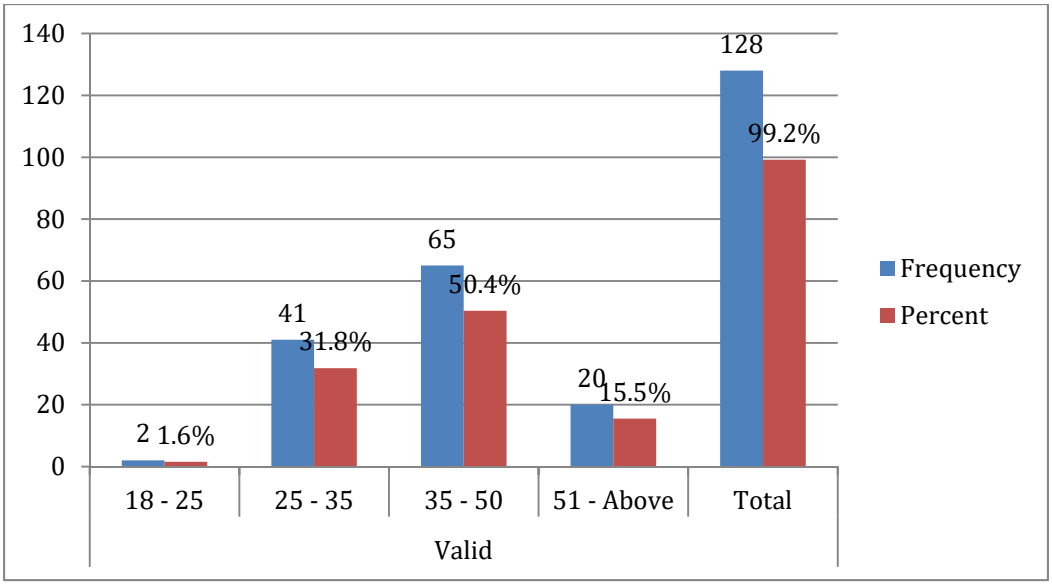


Fig 3: Age of the respondents

Table 4.1.4 : Working Experience of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-4 years	49	38.0	38.3	38.3
	5-10 years	28	21.7	21.9	60.2
	11-15 years	33	25.6	25.8	85.9
	16 years and above	18	14.0	14.1	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

Given the sample size of 128, 23.3% of the respondents are from Abuja Municipal Area Council, (AMAC), 12.4% of the respondents are from Bwari Local government, 15.5% of the respondents are from Gwagwalada, 14% of the respondents are from Kuje Local Government, 12.4% of the respondents are from Abaji Local Government, 10.1% of the respondents are from Kwali Local Government while 11.6% of the respondents are from National Assembly. The responses are contained in Table 4.5

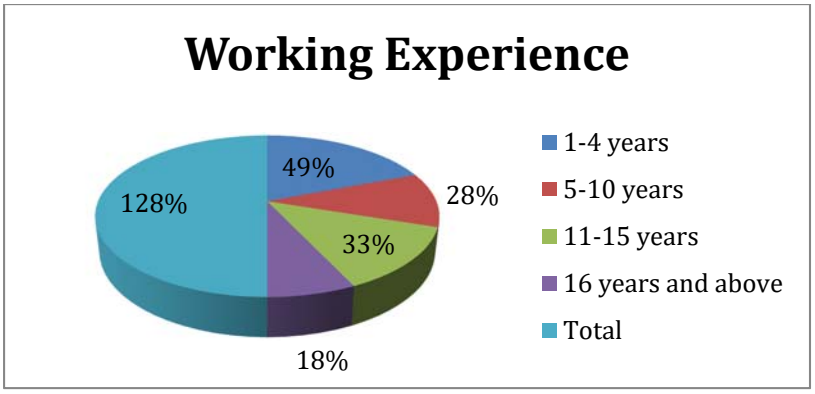


Fig 4: Working Experience of respondents

Table 4.1.5: Designation of Respondents.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	AMAC	31	23.3	23.4	23.4
	Bwari	16	12.4	12.5	35.9
	Gwagwalada	20	15.5	15.6	51.6
	Kuje	18	14.0	14.1	65.6
	Abaji	16	12.4	12.5	78.1
	Kwali	13	10.1	10.2	88.3
	8th and 9th NASS	15	11.6	11.7	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

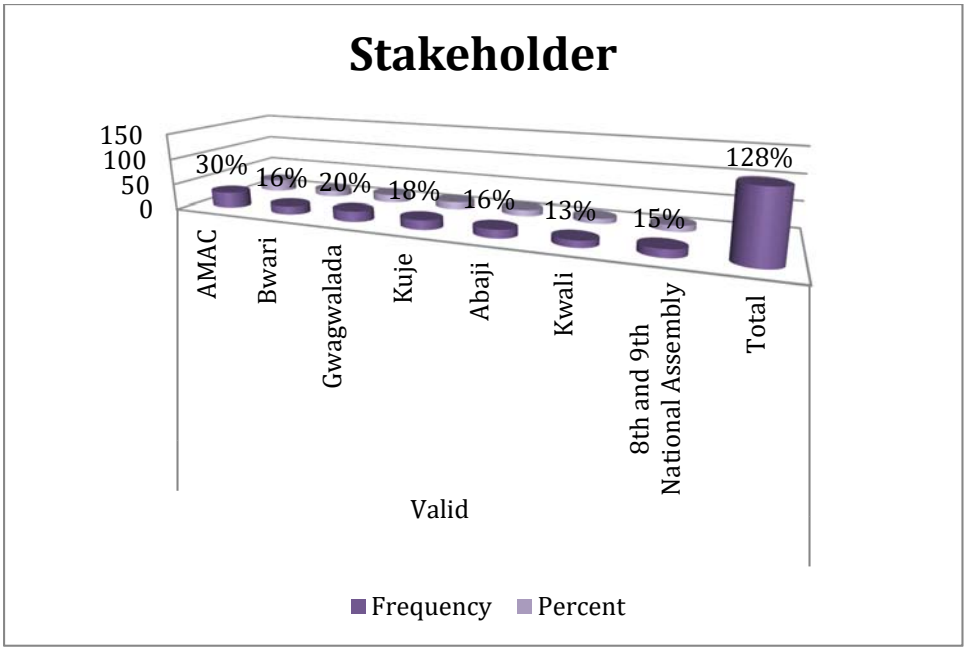


Fig 5: Designation of Respondents.

4.2 Data Presentation and Interpretation

Table 4.2.1, **Research Question one** :The laws passed by the 8th and 9th National Assembly improved health sector in Nigeria.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agreed	18	14.0	14.1	14.1
	Agreed	43	33.3	33.6	47.7
	Strongly Disagreed	31	24.0	24.2	71.9
	Disagreed	36	27.9	28.1	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, Apirl 2022

The table above indicates that out of 129 respondents, 61 respondents constituting 47.3% of the total respondents affirmed that the laws passed by the 8th and 9th National Assembly improved

health sector, while 68 respondents constituting 51.9% of the total respondents disagreed that laws made by National Assembly improved health sector in Nigeria.

From the above, it is obvious that laws made by the 8th and 9th National Assembly did not improved Nigeria health sector development positively.

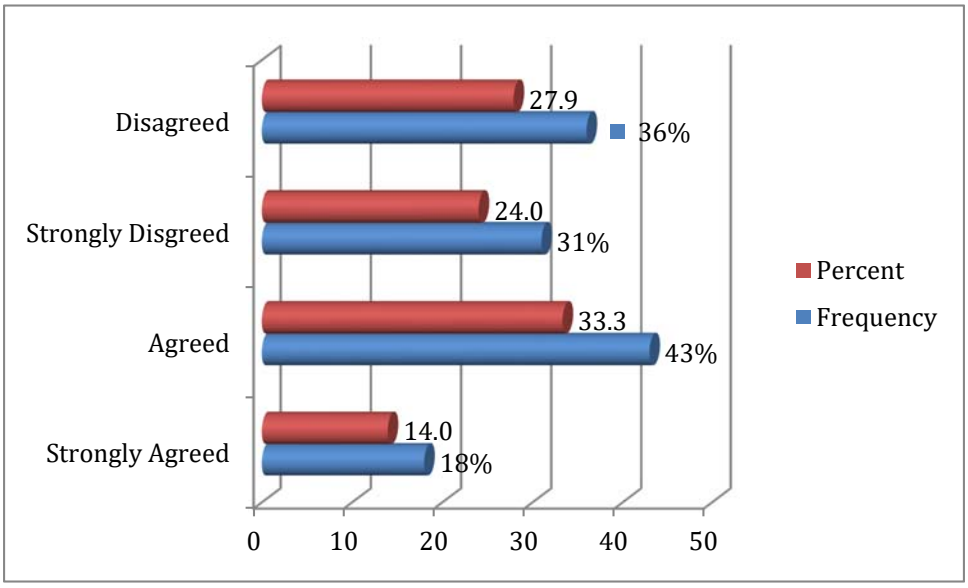


Fig 7: Above are pie chart view of respondents showing that the bills passed into laws and implemented by the 8th and 9th National Assembly has not improved health sector in Nigeria

Table 4.2.2 The law passed by 8th and 9th national Assembly has aid you effectively and efficiently in the discharge of your duties as a staff in health sector

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agreed	42	32.6	32.8	32.8
	Agreed	23	17.8	18.0	50.8
	Strongly Disagreed	41	31.8	32.0	82.8
	Disagreed	22	17.1	17.2	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

Table 4.2.2 indicates that out of 129 respondents from the sample size, 65 respondents constituting 50.4% of the total respondents affirmed that the laws passed by the 8th and 9th National Assembly aid them to discharge their duties effectively and efficiently.

while 63 respondents constituting 48.9% of the total respondents disagreed that laws made by National Assembly has significantly aid them to discharge their duties effectively and efficiently.

From the above, it is obvious that laws made by the 8th and 9th National Assembly did not significantly aid workers to discharge their duties effectively and efficiently.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agreed	37	28.7	28.9	28.9
	Agreed	53	41.1	41.4	70.3
	Strongly Disagreed	28	21.7	21.9	92.2
	Disagreed	10	7.8	7.8	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Table 4.2.3 indicates that out of 129 respondents from the sample size, 90 respondents constituting 69.8% of the total respondents affirmed that inadequate funding, mismanagement and lack of adequate medical personnel are some of the factors affecting health sector in FCT, Abuja. while 38 respondents constituting 29.5% of the total respondents disagreed that inadequate funding, mismanagement and lack of adequate medical personnel are factors affecting health sector in FCT, Abuja.

From the above, it is obvious that inadequate funding, mismanagement and lack of adequate medical personnel are the major factor affecting health sector in FCT, Abuja in particular and Nigeria general.

Table 4.2.4: Research question two, What are the major constraints in the passage of health bills to improve health.

Lack of professionalism in the various committees of the National Assembly and agencies of government are some of the constraints in the production of health bills to improve healthcare

		Frequency	Percent	Valid Percent	Cumulative Percent
	Strongly Agreed	75	58.1	58.6	58.6
	Agreed	23	17.8	18.0	76.6
Valid	Strongly Disagreed	23	17.8	18.0	94.5
	Strongly Disagreed	7	5.4	5.5	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

Table 4.2.1. Research Question Three: What are the major challenges confornting health policy in Nigeria?

4.2.8 What are the major challenges to health care policy formulation in Nigeria?

		Frequency	Percent	Valid Percent	Cumulative Percent
	Poor Planning and Corruption	36	27.9	28.1	28.1
	Inadequate funding	26	20.2	20.3	48.4
Valid	Lack of Political will of State actors	35	27.1	27.3	75.8
	lack of qualified members in health NASS health committee	31	24.0	24.2	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, Apirl 2022

Table 4.2.8 indicates that out of 129 respondents from the sample size, 36 respondents constituting 27.9% of the total respondents said Poor Planning and Corruption was the major challenges to health care policy formulation in Nigeria, 35 of the respondents constituting 27.1% said that Lack of Political will of State actors, 31 of the respondents, respresending 24% , said lack of qualified

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agreed	75	58.1	58.6	58.6
	Agreed	23	17.8	18.0	76.6
	Strongly Disagreed	23	17.8	18.0	94.5
	Disagreed	7	5.4	5.5	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

Table 4.2.4 indicates that out of 129 respondents from the sample size, 98 respondents constituting 75.4% of the total respondents affirmed that lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints that affected production of bills that will improve health sector in Nigeria. while 30 respondents constituting 23.2% of the total respondents disagreed

From the above, it is obvious that lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints affected production of bills that will improve health sector in Nigeria.

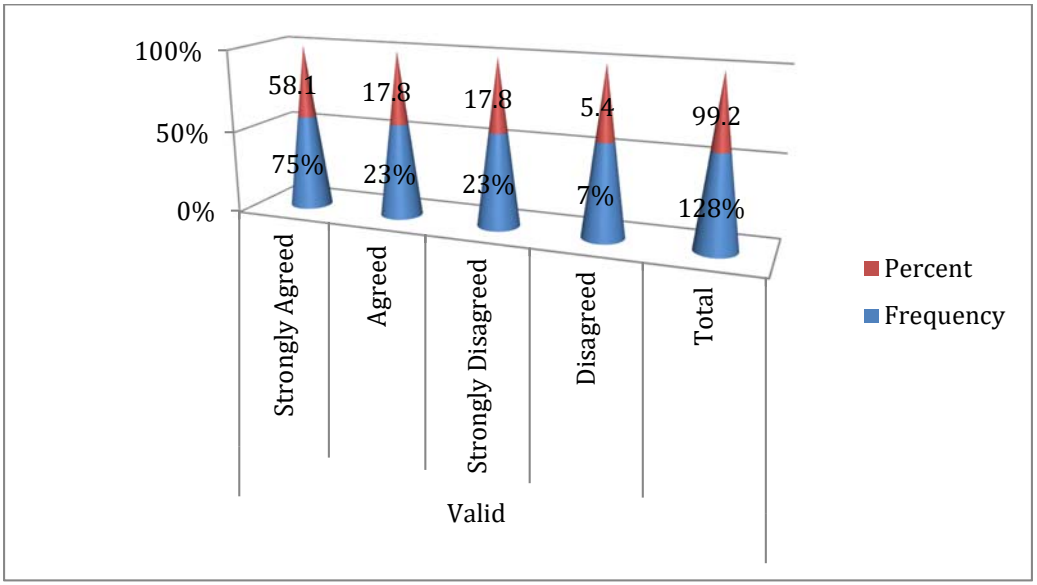


Fig 8: The above chart represents the major constraints in the production of health bills to improve healthcare

Table 4.2.5 The bills passed 8th and 9th National Assembly has affected me positively and improved the health sector in Nigeria

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agreed	39	30.2	30.5	30.5
	Agreed	22	17.1	17.2	47.7
	Strongly	57	44.2	44.5	92.2
	Disagreed	10	7.8	7.8	100.0
	Total	128	99.2	100.0	
Missing	System	1	.8		
Total		129	100.0		

Source : Fieldwork, April 2022

Table 4.2.5 indicates that out of 129 respondents from the sample size, 98 respondents constituting 75.4% of the total respondents affirmed that lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints that affected production of bills that will improve health sector in Nigeria. while 30 respondents constituting 23.2% of the total respondents disagreed

From the above, it is obvious that lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints affected production of bills that will improve health sector in Nigeria.

4.3 Presentation of Interview

The views of the respondents were articulated and presented in tabarlarized form.

S/n	Respondent	Interview questions	Respondent Views
1	Resident Doctor (AMAC) National Hospital Abuja. May 2022.	What are the challanges confronting health policies in your Hospital	The respondent said corruption and bad ledership lead to lack of basic essentail insfrastructural amenties, bad leadership and corruptions in government and among health workers have led to lack of adquate power supply in hospitals, lack of qualified health workers been employed. Poor funding of health sector etc Training money for health workers are not account for because of corruption.
2	Health Committe member (NASS)	What do you think are the major constraint facing the production of health bills	In his view, the respondent said lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government was part of the constraints affecting production of bills that will improve health sector in Nigeria. He said " many of the people in health committees of national assembly are not qualified intellectually to be there" they are appointed as political favor or political considerations.
3	Senior Registrar (Kuje)	How has the laws made by the national	The respondent affirmed that the laws passed by the 8th and 9th National Assembly did not

	Kuje General Hospital. May, 2022	assembly improved health sector and your service delivery.	improved health sector, beacsue in her view, the laws do not have inputs of stakeholders in the health sector. They were mainly for political gains rather than meeting the needs of Nigerians.

4.3 Disscussion of Findings

Whilst embarking on the field survey, 129 questionnaires were administered and 128 was returned, male respondents were 55, the female respondents were 73, the distribution of the respondents by gender shows that the numbers of female respondents male.

The result of the study reveals that 43 of the respondents have PhD as their highest educational qualifications while the lowest qualification is SSCE/NCE with 1 respondent, HND/Degree have the highest respondents with 73 representing 55.8%.

It is also evident to note that most respondents believed that laws made by the 8th and 9th National Assembly did not improved Nigeria health sector development positively and laws made by them did not significantly aid workers to discharge their duties effectively and efficiently. , it is obvious from the respondents that inadequate funding, mismanagement and lack of adequate medical personnel were the major factor affecting health sector in FCT, Abuja in particular and Nigeria general.

The result of our finding indicated that lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints that affected production of bills that would have improve health sector in Nigeria.

The outcome of the research work indicated that mmajority of the respondents agreed that Poor Planning, Corruption, Lack of Political will of State actors and lack of qualified members in health committeees of National Assembly was the major challenges to health care policy formulation in Nigeria. From the finding majority of the respondents want national assembly to make it compulsory for all government officials to use government hospital, that will promote and provide adquate facilities in the hospital and many of the challanges the health sector in Nigeria facing will be resolved.

CHAPTER FIVE

Summary, Conclusion and Recommendations

5.1 Summary

The outcome of the research work indicated that majority of the respondents agreed that Poor Planning, Corruption, Lack of Political will of State actors and lack of qualified members in health committeees of National Assembly was the major challenges to health care policy formulation in Nigeria. From the finding majority of the respondents want national assembly to make it compulsory for all government officials to use government hospital, that will promote and provide adquate facilities in the hospital and many of the challanges the health sector in Nigeria facing will be resolved. The finding comfirmed that laws made by the 8th and 9th National Assembly did not improved Nigeria health sector development positively and laws made by them did not significantly aid workers to discharge their duties effectively and efficiently. Nigeria's Health Sector is replete with inadequacies and shortcomings and weaknesses in the areas of capital, material and human resources which hinder effective health care delivery services. It is obvious from the respondents that inadequate funding, mismanagement and lack of adequate medical personnel were the major factor affecting health sector in FCT, Abuja in particular and Nigeria general. The result of our investigation showed that lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints that affected production of bills that would have improve health sector in Nigeria.

The Nigeria Health Sector can only be improved if Nigeria statesmen are less self-centered but much more committed to health policy formulation, implementation, monitoring and evaluation. Significantly, the Nigeria Medical Association (NMA) must also insist that necessary facilities

are put in place so that doctors can be encouraged to uphold professionalism as negligence is presumed until the contrary is proved. The study also revealed that majority of the respondents are aware of the risks associated with self-medication, however they still engage in this dangerous practice for various reasons because of lack of fund, etc. It shows that knowledge does not automatically translate to practice. In addition, stemming down the tide of self-medication in Nigeria may require effective and efficient enforcement of the existing regulations against free display and sales of drugs in unauthorized places such as markets, shops, roadside stalls, motor parks and other public places by individuals not duly licensed. The finding aslo confirmed that majority of the respondents engaged in the practice of self-medication despite its consequences.

5.2 Conclusion

The current health care situation in Nigeria requires relevant reforms at the levels of policy formulation, implementation of plans, infrastructural development, as well as resource distribution strategies. The state of health sector in Nigeria is deplorable. The current lack of doctors, basic drugs, medical supplies, equipment and qualified staff is causing many Nigerians to live unhappily, suffer diseases, and die prematurely from preventable causes. There is an urgent need to align health programs and services with the healthcare needs of the Nigerians. Our legislatures needs to make laws that will promote health sector to be adequately equipped to meet the needs of Nigerian and address obstacles identified in this study that prevent residents from accessing healthcare services, irrespective of their social, economic and geographic conditions. Access to healthcare services should always be explored in the context of the population or environment in which those services are provided.

From the study, the laws made by the 8th and 9th National Assembly did not improved Nigeria health sector development and majority of the medical health worked said it did not significantly

aid them to discharge their duties effectively and efficiently. Inadequate funding, mismanagement and lack of adequate medical personnel was discovered to be the major factor affecting health sector in Nigeria as lack of professionalism in the various committees of the 8th and 9th National Assembly and agencies of government are some of the constraints affected production of good of bills that would have improve health sector in Nigeria. Financial Constraint was the main reasons Nigerians engage in practice of self medication despite its consequences and it is believed by majority of the respondents that if national assembly makes and enforced legislation which stop sales of drugs without prescription and make it compulsory for all government officials to use government hospital, that it will promote and provide adquate facilities in the hospital and many of the challanges the health sector facing will be resolved..

5.3 Recommendations

To strengthening the role of National Assembly in promoting the health sector in Nigeria, the following recommedations are made based on the finding from the research questions.

i. The laws passed by the National Assembly should have input of stakeholders in health sectors and general public so that it discounted from the reality Nigerians and the health sector are facing as currently witnessed. Laws made by the National Assembly should effectively and efficiently aid workers to provide solutions

ii. Qualified professional should be appointed to head committees of National Assembly, departments and agencies of government in charge of policy formulation.

iii. Policy makers should be proactive and make people oriented policies and laws that will improve the living standard of Nigerians and there should be National health insurances that is compulsory for all Nigerians, this will help promote the health sector .

v. Federal Government, State and Local government should provide Political will to properly plan, formulate and implement policies and enacted laws that will solved the challenges health sector development in Nigeria.

REFERENCES

Abiodun, A J (2011). Quantitative analysis of efficiency of public health care facilities in Nigeria, PhD Thesis. Nigeria: Covenant University.

Akinremi, R. (2019, June 6). Health bills the 8th National Assembly failed to pass. Retrieved December 21, 2021,

American Medical Association. (2022). defining basic health care.

Aregbeshola, B. (2018). Health care in Nigeria: Challenges and recommendations

Ajayi, F. (2009). Socio-cultural factors influencing primary health care services in Nigeria. Paper presented at the Nigeria National Health Conference, Uyo.

Bolaji, i., 1973. African traditional religion: a definition. Maryknoll, ny: orbis books,

Constitution of Federal Republic of Nigeria (1999): Decree no. 24, Federal Republic of Nigeria

Federal Ministry of Health Report: First National B Prevalence Survey, 2012.

Federal Ministry of Health Saving New-born Lives in Nigeria: NEWBORN HEALTH in the context of the Integrated Maternal, New-born and Child Health Strategy, Revised 2nd edition, 2011.

Federal Ministry of Health, The National Quality Assurance Policy, 2016.

Federal Ministry of Health, The Nigeria Supply Chain Policy for Pharmaceuticals and other Health Products, 2016.

De Leeuw, E. (1989) Health Policy. An Exploratory Inquiry into the Development of Policy for the New Public Health in The Netherlands. Maastricht University, Maastricht

Döhler M, Manow P. Staatliche Reformpolitik und die Rolle der Ver-bände im Gesundheitssektor. In: Mayntz R, editor. Gesellschaftliche Selbstregelung und Politische Steuerung. Campus: Frankfurt a.M; 1995.

Federal Ministry of Health (2004). Revised National Health Policy.

Maloy, J. S. (2016, May 26). Elite theory. Encyclopedia Britannica.

Mamma, J. T., Amako, S. & Omoniyi, S. O. *(2017). Security Challenges In Nigeria:* Implications for health, health services delivery and sustainable development.

National Population Commission [Nigeria] and ICF Macro. Nigeria Demographic Health Survey. 2008. Abuja (Nigeria): National Population Commission and ICF Macro; 2009.

National Population Commission of Nigeria (web), National Bureau of Statistics

Nwabughiogu, L., (2021, November 18). Bill seeking free, mandatory healthcare for all Nigerian children passes second reading at House of Representatives.

Omoleke, I. I. & Taleat B. A. (2018). Contemporary issues and challenges of health section in Nigeria. Research journal of health sciences, Vol 5(4)

Osibogun, A. (2004). Crisis and challenges in the Nigerian health sector. Journal of Community Medicine & Primary Health Care, 16 (2) 1-7.

ROBERT DE JOUVENKL, La République des camarades, Bernard Grassel Paris, 1914.

Scrambler, G. 2002. Health and Social Change, a critical theory. Issues in Society Series. Buckingham: Open University Press.

Tejuoso, O., Alawode, G., & Baruwa, E. (2018). Health and the Legislature: The Case of Nigeria. Health Systems & Reform, 4(2).

Harris, M. (2008). The role of primary health care in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol.

Hausmann-Muela, Ribera, J. M., Nyamongo, I. (2003). Health-seeking behaviour and the health system response

Federal Ministry of Health. (2006). National health promotion policy. Abuja, Nigeria:

Federal Ministry of Health. (2004). Revised national health policy. Abuja, Nigeria:

Hargreaves, S. (2002). Time to right the wrongs: Improving basic health care in Nigeria.

Waitzkin H. A Marxist view of medical care. Ann Intern Med. 1978 Aug;89(2):264-78. doi: 10.7326/0003-4819-89-2-264. PMID: 354452.

World Health Organization. (2021). WHO remains firmly committed to the principles set out in the preamble to the Constitution.