THE IMPACT OF CHANGING HEALTH POLICY ON NIGERIAN WORKERS: A CASE STUDY OF KADUNA METROPOLIS

Being, A Thesis Submitted to the Postgraduate School, Ahmadu Bello University, Zaria, in Partial Fulfillment of the Requirements for the award of the M.Sc. (Master of Science) Degree in Sociology

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DECLARATION

I Daniel Rikichi KAJANG of the Department of Sociology, Ahmadu Bello University, Zaria, hereby declare that this thesis entitled: "The Impact of Changing Health Policy on Nigerian Workers: A Case Study of Kaduna Metropolis" has been written by me and that it is a record of my own research work. It has not been presented in any form for another degree or diploma in any other institution. All quotations and sources of information have been duly acknowledged in the reference section.

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This thesis entitled "The Impact of Changing Health Policy on Nigeria Workers: A Case Study of Kaduna Metropolis".by Daniel Rikichi KAJANG, meets the regulations governing the award of the degree of M.Sc (Sociology) of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated first to my parents, Rev. Rikichi Kajang from whom I have benefited so much, my mother Zantiye whose nursing gave me survival, and to my wife Juliana D. R. Kajang and my children, Duniya Yagoro, Nehemiah Adam and Hadassah Katiyong.

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Daniel Rikichi Kajang

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ABSTRACT

This study sets to find out how the changing health policies in Nigeria affect the state of health of public servants as it relates to medical services and living conditions such as housing, feeding patterns and general welfare. It documents strategies devised by the public servants for coping with the adverse consequences of changes in the health policies and assesses the adequacy of measures taken by the government to ameliorate them. The position of this study is that the capitalist nature of the Nigerian economy is reflected in the distribution of health services and the living conditions of various classes of workers in the public service. A quota sample of 245 respondents from federal, state, and local government establishments in Kaduna metropolis responded to a questionnaire on how the removal of free medical care for public servants have affected them and how their families live and feed under SAP. Individual interviews and group discussions were employed to complement the survey data. Frequency distribution and chi-square tests were used for data analysis. The findings revealed that following the withdrawal of free medical services, the cost of modern medical services went beyond the reach of most public servants. To meet their health needs, most public servants, resorted to seeking alternative means of treatment like the utilization of faith healing through prayers (54.1 per cent), traditional medicine and spiritual healing homes (26.1 per cent) and self-medication in various forms (12.6 per cent). As regards housing 103 (60.0 per cent) said the prices of their rented houses were raised beyond what they could afford. They went to live in

substandard cheaper houses in less sanitary environments with their attendant health hazards and physical insecurity. They complained that the rent subsidy given to them was too meagre to secure any decent accommodation. The findings also revealed that 134 (65.9 per sent) of the public servants' food intakes consists mainly of carbohydrates with very limited protein and mineral contents. Furthermore, most of the public servants' families have only one or two meals a day because they cannot afford three meals. From the aggregate of the findings, it is revealed that the changing health and economic policies in Nigeria have had a significant negative impact on Public Servants' state of health and living conditions. Government measures like the introduction of meal subsidy and review of salaries and some allowances, have not adequately addressed these issues, thus compounding the workers' plight. It is observed that the labour power of workers sustains the country and the Government should ensure that the health and welfare of its workers be adequately provided for. It is therefore recommended that government should rescind its decision on the withdrawal of free medical treatment for public servants, and provide adequate subsidies for housing facilities, feeding, transportation and other welfare needs of the public servants.

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LIST OF ABBREVIATIONS

ABUTH --------- Ahmadu Bello University Teaching Hospital.

BHSS --------- Basic Health Services Scheme.

CBN --------- Central Bank of Nigeria.

DFRRI --------- Directorate of Food, Roads and Rural Infrastructure.

DRF --------- Drug Revolving Fund.

EDP --------- Essential Drugs Project.

EPI --------- Expanded Programme on Immunization.

FGN --------- Federal Government of Nigeria.

GDP --------- Gross Domestic Product.

GL --------- Grade Level.

HFA --------- Health For All.

HSF --------- Health System Fund.

IMF --------- International Monetary Fund.

NALDA --------- National Agricultural and Land Development Authority.

SAP --------- Structural Adjustment Programme.

WHO --------- World Health Organization.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

According to the World Health Organisation (WHO), health is a state of complete physical and social well-being and not merely the absence of disease or infirmity. Last (1998), assesses this definition of health as describing an ideal state rarely attained in the real world, and that nobody knows exactly what "social well-being" encompasses. Last further stated that, because we only rely mainly on measurements of phenomena that indicate degrees of absence of health, the WHO's conception is a poor operational definition. Scholars such as Stokes, Noren, and Shindell (1982) offered an alternative definition to that of WHO. They defined health as, "a state characterized by anatomic intergrity, ability to perform personally valued family work and community roles; ability to deal with physical, biologic, and social stress; a feeling of well-being; and freedom from the risk of disease and untimely death". Last (1995) indicated that the word 'health' is derived from the old English word ` hal ` , meaning hale, whole, healed, sound in wing and limb. Our position is that , the realities of the WHO's definition and conception of `health ` locates health within socio-economic contexts which determine social well-being as well as disease and infirmity. The nature of` health is therefore essentially a class issue. Health is to be viewed from the economic, social, psychological and physical points of view.

From the fiscal dimension, the attainment of health requires a large capital outlay in order to acquire health maintenance facilities. Consequent upon this, the world

expenditure on health totaled about $1.7 billion US dollars in 1990, that is, about eight per cent of global incomes that year (World Development Report 1993). Similarly, various Nigerian national development plans, have made reasonable fiscal budgetary allocations to the health sector. In all the four National Development plans, first,(1962-1968), Second, (70-74), Third (75-80) and Fourth (1981-85) for instance, the health sector was allocated the sums of N1.3 millions (12.5%), N53.million (5.2%) and N243. million (7.5%) of total planned expenditures respectively. Fiscal budgetary allocations to the health sector have therefore been quite high, an indication of the importance the Nigerian Government accords the health sector. These huge budgetary allocations to the health sector are specifically meant to reduce the devastating effects of diseases on the population. The benefits of these investments on health are to enhance a qualitative human resource base which will further enhance a quantitative performance of the national economy.

From the social view point, health is a basic need for human development. The social aspects of health include security of life and property, peaceful co-existence, prosperity, education and general knowledge about health itself.

From the psychological point of view, health is seen as a balanced emotional state of the individual, the family and the society at large. A healthy individual in this context is seen to be psychologically balanced, that is, the person has attained happiness, contentment and peace of mind.

With respect to the physical dimension, health involves the creation of a disease free environment through the promotion of environmental health and provision of

preventive and curative health institutions. A poor environment poses serious problems to the physical health of the individual. Therefore, to be in a state of good health, is not only to be free from diseases, but to be free from all social, psychological and environmental problems. In addition, being healthy includes a reasonable standard of life through adequate housing and dietary intake.

The concept of health can also be seen in the following three dimensions, namely, health as a right, health as a consumer good and health as an investment.

Health is viewed by WHO as a right, analogous to justice and political freedom. In particular, the WHO constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO 1992). Health therefore, should be seen as so fundamental that constraints to its full attainment should not only be checked in all dimensions but that impetus should be given for the development of the health sector to meet the health needs of the society. In the Nigerian context, just like the WHO definition, health is constitutionally a right to all Nigerians. However, the idea of health as a right to every citizen in Nigeria particularly under the class system is an ideal and not a practice because of the class structures that exist in society. Nigerians located at the lower segments of the society do not have equal access to health services with those located at the upper segments due to social inequalities. The distribution of health services in Nigeria follows the class structure and the capitalist mode of distribution in a free market economy.

Health is seen as a consumer good because people pay to obtain the services. In

this respect, the decision to acquire health services rests on the individual and this depends on the health needs and ability to pay. There is differential affordability and preferences for types of health services across social classes.

In Nigeria, the national health policy has been formulated within the nation's socio-economic development as is clearly stated in the preamble of the national health policy, thus:-

> To establish a comprehensive health care system, based on Primary Health Care that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social well-being and enjoyment of living (Federal Ministry of Health 1988, 1996:9).

In the context of this research, health encompasses medical services and living conditions like housing, food and nutrition, transportation and the general welfare of the public servant. The components of an ideal state of health of public servants in this context include, access to and affordability of medical services when required, nutritionally balanced diets, good housing and sanitation, and adequate welfare services.

1.2 Changing Health Policy In Nigeria

Before delving into discussing changing health policy in Nigeria, it is quite expedient to focus on the definitions of health policy. There is generally no agreed definition of what health policy is , because scholars, agencies, organizations , etc view it from different perspectives. For instance, the World Bank defines health policy as the allocation of scarce resources for health services , while scholars such as Walt (1994), consider health policy to be concerned with process and power, that is, who influences whom in policy process and how that happens. The World Health Organisation's

definition of health policy focuses on the development of health services, prevention and control of diseases, improvement of environmental conditions, development of health manpower and planning and implementation of health programmes. Thus, a major WHO's health policy in 1978 was the "attainment by all citizens of the world by the year 2000 and beyond of a level of health that will permit them to lead a socially and economically productive life" (WHO, 1978 ; Ola , 1984,: 72-73). Nigeria's conception of health policy is located within the context of the WHO's definition, which is aimed at achieving a level of health that will enable all Nigerians to attain socially and economically productive lives based on primary health care. Such health services focus on health education, disease control and prevention, supply of safe water, promotion of food supply and proper nutrition, provision of essential drugs, immunization, maternal and child health care and family planning (National Health Policy ,1988).

The position in this thesis is that health policy is seen as the process of developing health systems within available resources. Thus it can be argued that the changing Nigerian health policy is determined by available resources and the interplay of politics and power right from the colonial period to the post independent Nigerian State. In other words right from the colonial state to post independent Nigeria, the Nigerian health policy has been undergoing some evolutionary change. The colonial health policy started with curative health policy particularly for the colonial staff which later included preventive measures, although more weight was still being given to curative medicine in post independence era (Shehu, 1996).

According to Daramola (1984), at independence, the then regional governments

started operating separate health policies. In these regions the health policies made provision for free medical services particularly to the civil servants who were government employees. At the creation of states in 1967, some of the regional health services and polices were adopted by the state Governments. For instance, Kaduna State, in 1977, as spelt out in its civil services rules, adopted the free medical services particularly for public (Civil) servants and to some degree, other citizens of the state.

Nevertheless, at the onset of the Nigerian economic crisis , the health sector was affected. Certain health policies were introduced which were not favourable to the public servants and other citizens. The health policy of free medical services at point of delivery hitherto enjoyed by public servants was removed. This change in health policy had serious implications on Kaduna Public servants. This study is therefore concerned with the changes in health policy which came as a result of the economic crisis and how these changes have affected the acquisition of medical services by public servants.

From the various definitions and policy objectives of health, both globally and nationally, it is obvious that the performance of the health and its related sectors is an important indicator of development (World Development Report, 1993). Apart from the fact that health indicators like infant mortality, nutrition etc are also cited as indices of development, it is also axiomatic that the higher the health standards in a country the better able the country is to mobilize, develop and utilize the minds and energies of its people for development.

However, this understanding of health as an indicator of development only is an instrumentalist conception. The position in this thesis is that the fundamental basis of

health is that health should be seen as an end in itself that is, health should be beneficial to the individual, from the womb to tomb, which further means that one should be happy, feel good and comfortable at all times.

In 1993 the World Bank , succinctly stated the importance of health to socio-economic development. According to the report, improved health contributes to economic growth in four ways, (a) it reduces production losses caused by workers illness, (b) it permits the use of natural resources that had been totally or nearly inaccessible because of diseases, (c) it increases the enrolment of children in school and makes them better able to learn; (d) it frees for alternative uses, resources that would otherwise have been spent on treating illness (World Bank, 1993).

In accordance with the national health policy, all the three tiers of government in Nigeria accord important priorities to health as it is on the legislative concurrent list. The Federal Ministry of Health is charged with the responsibility of national health policy formulation and supervision within Nigeria and also liaises with international health organisations. Each of the thirty six states of the federation has a ministry of health which takes charge of health services and trains personnel to work in various health institutions at both state and local government levels. The local government councils perform functions which are essentially elements of Primary Health Care and determine how best to provide it. Voluntary agencies also make substantial complementary contributions to health care delivery and personnel training.

This contrasts with the initial objectives of the colonial health policy which according to Daramola (1984), was mainly to provide medical services for selected

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groups of persons which included: the nucleus of the colonial officers and members of their families; members of the armed forces and the police and, members of the civil service particularly the senior civil servants. The medical services were not established for all citizens. Such discriminatory health policy was inherited by the emergent independent government (Schram,1967). Medical care for the general public was a second rate priority. These inherited health policies according to Dienye (1985) are responsible for the lopsided health care in favour of the urban based population. The 80 per cent of the Nigerian population,at independence that lived in rural areas lacked adequate medical services.

The post independence health policies contained in the four national development plans, (1962 – 1985), did not make any specific mention of Nigeria's public servants as a group, nevertheless, all the health policies contained herein were for all Nigerians among whom were public servants who were specially catered for. According to Daramola (1984), all the regional governments had a policy whereby all public servants received free medical services from government institutions. He further stated that some states later adopted the regional policies. For instance, the Kaduna State government through its, 1977 Civil Service Rule made provision for free medical and dental services to its public servants. It therefore, means that both regional and state governments made some provision for free health care for public servants during the post independence period. However, with time government failed to maintain its policy of free medical care due to high demands for medical services and economic crises.

The economic crises have led to inadequate budgetary allocation to meet the

WHO health policy which stipulates that the health sector should be allocated at least five per cent of a country's total planned expenditure. For instance, according to the Nigerian National Planning Commission (1992), between 1985 and 1992, the highest allocation for the health sector was 3.11% of the total budget of the nation. This is far from being adequate and explains the inadequacy of health services, especially with reference to drugs, equipment and the training of health personnel. All these deficiencies determine the type of medical services available to public servants.

1.3 Perspective on the Nigerian Public Servants' Health

A public servant is defined as "an employee involved in the implementation of government programmes for promoting the welfare of the people" (Report of the Political Bureau 1987 :115). According to Weber (1963), "a public servant is concerned with the business of administration, controlling, managing and coordinating a complex series of tasks" aimed at ensuring proper implementation of government policies and decisions. In Nigeria, public servants include all categories of government employees, junior, middle and senior cadres in its employment. The public servant occupies a very strategic position in the social, economic and political developments of a country.

The role of the public servant is crucial in the implementation and achievement of goals and aspirations of both military and civilian regimes in Nigeria.Nwosu (1980), has asserted that the Nigeria public servants in their various positions as permanent secretaries, professionals in the public service, directors and managers of statutory corporations, chief executives of higher institutions and other parastatals define and interpret government policies into achievable goals.He further stated that the role of the

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public servants in decision making has increased rapidly since the end of the Nigeria civil war in 1970. In the absence of the legislature during military regimes, the federal and state public servants play a major part in the recommendation and formulation of social, economic, and political objectives of government. For instance, the federal public servants drew up the second National Development Plan 1970-74. Public servants have therefore played a significant role in the socio-economic development of the nation and a special attention has been paid to their health by government agencies in both the colonial and post colonial Nigeria.

According to Daramola, (1984), each state in the federation had a policy of free health services in government health institutions for public servants whenever available. By this policy, successive governments actually recognised the role of public servants in development and therefore made conscious efforts to cater for their health. According to Alubo (1987), this policy of providing free medical services for both public servants and other categories of Nigerians continued until these were discontinued consequent upon the advent of the Nigerian economic crisis of the early 1980s. The beginning of the economic crisis ushered in the erosion of the special medical services and privileges that hitherto accrued to public servants as a special group.

1.4 Kaduna State Government's Provision for Public Servants Health Care 1977 to 1996

The Government of Kaduna State through previous medical policies and in particular, the 1977 civil service rules, made provisions for free health care services for public servants and their families. The summary of Rules 09201-09704, dealing with the

public servants' medical and dental treatment state thus:

> The government medical facilities are provided to all officers, employees and families. However, an officer or employee who prefers to be treated by a private health centre instead of availing himself or herself of government health facilities must bear all expenses incurred through such treatment. If, however, the circumstance of the employee's action are recognised by the chief medical officer of the state government as requiring such service, he may authorize a refund to the officer or employee at such rates as he the chief medical officer considers fair and reasonable. Approval for journeys outside Nigeria for medical treatment are allowed by the Ministry of Establishment and Training on the advice of the chief medical officer or his deputy (Kaduna State Civil Service Rules, 1977 : 57-68).

Until the advent of the economic crisis in the early 80s, Kaduna State honoured her own part of this policy thereby making public servants enjoy free medical care from the State Government health institutions at point of delivery. However, in the mid 1980s, the Kaduna State Government started a gradual introduction of user fees in its health institutions thereby eroding the free health services hitherto enjoyed by the public servants because of the economic crisis.

Some of these problems resulting from the financial crisis include under financing of the health sector which led to other problems such as inadequate supply of drugs and diagnostic equipment, inadequate health manpower training,, especially for specialist programmes outside the country. There is also the problem of gradual deterioration of health facilities and introduction of user fees which invariably affected the public servants as they were not exempted from paying such fees.

1.5 Statement of Research Problem

The combined effects of the Nigerian economic crisis and the introduction of SAP as a measure of economic recovery led to changes in health policies in Nigeria. There were drastic cuts in budgetary allocations to the health sector which affected its services

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that are essentially capital intensive and depend a great deal on imported facilities like drugs, hospital equipment, medical expertise etc. In Kaduna State, there was the removal of concessions for free medical services at point of delivery by the introduction of cost recovery measures like payment for the cost of drugs, surgery, bed fees, stoppage of automatic absorption of medical and paramedical graduates into government civil service and the streamlining of the training of medical and paramedical personnel . On the part of the public servants, the emerging economic difficulties and the changing health policies affected their ability to procure health care and other health sustaining necessities such as housing, food supply, transportation etc.

From the preceding discussions, it is quite clear that health services have not adequately covered the public servants. Public servants are having varying unmet health needs. In view of this inadequacy, the critical question that comes to mind is, how do public servants as a group manage their health problems? In order words, do they have alternative ways of taking care of their health needs?

The critical issues this research seeks to investigate are :- What have been the impacts of changing health and economic policies on the health and living conditions of public servants in Kaduna Metropolis as a socio-economic group? Specifically this study seeks answer to the following research questions:

i. How has the acquisition of medical services by public servants and their families been affected by the changing health and economic policies?

ii. How have the living conditions of the public servants like feeding, housing transport facilities, etc been affected by economic hardships?

iii What are the coping strategies adopted by Public servants who fail to acquire modern medical services to cater for their health problems?

iv. What measures has the Government put in place to ameliorate the health problems of public servants as a result of changing health and economic policies?

1.6 Research Objectives

The main objectives of this study are:

(i) To examine Government health policies and welfare measures for public servants and how these are implemented?

(ii) To analyse the impact of changing health and economic policies with respect to medical services and the living conditions of public servants in terms of housing, feeding and welfare services.

(iii) To examine coping strategies employed by public servants to maintain their health and that of their families.

(iv) To analyse the differential effects of changing health policy on the state of health and living conditions of the various categories of public servants in Kaduna metropolis.

1.7 Significance of the Study

In view of the present economic problems and the degree of hardships being undergone by majority of public servants; this study sets out to document the impact of changing health policies on public servants' state of health. This study is also expected

to come up with findings which would help government improve on the system of health care and to integrate its policy measures into welfare schemes for public servants. The examination of the strategies public servants are devising to cope with the harsh realities of the changing health policies will make significant contributions to the knowledge of the effects of the Nigerian economic crisis on the citizens.

1.8 Scope and Limitation of the Study

This study is restricted to the state of health and living conditions of Public Servants' in Kaduna metropolis as a working class.

The reasons for these limitations are:

i. From the historical perspectives, public servants are a privileged group which is expected to be least affected negatively by government policy.

ii. The study is restricted to the period between 1986 and 1996. This was the time SAP as one of the economic measures was fully implemented which gave rise to further economic recession with great consequences to the social service sectors. Apart from that, in particular, the policy on the withdrawal of free health care for public servants in Kaduna State took effect in 1987. In addition between 1986 and 1996 the cost of basic goods and services such as housing, food, transportation and education became very expensive.

iii. The dearth of data on accurate morbidity pattern among public servants is one of the limitations of this study.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Introduction

This chapter reviews literature on four broad areas on which this study is focused. These are:-

(i) An overview of the political economy of health services

(ii) The Nigerian economic crisis and health services

(iii) The impact of economic crisis and SAP on health policy.

(iv) Theoretical framework.

The basic argument in this chapter is that economic crises have had tremendous negative impacts on the growth and performance of the various social and economic sectors in Nigeria. Furthermore, the Structural Adjustment programes introduced by Nigeria to ameliorate the effects of economic crisis have led to changes in Nigerian health policies with negative consequences for the health and other social services sectors to the detriment of the lower socio-economic groups.

2.2 An Overview of the Political Economy of Health Services

This section discusses an array of issues which include the distribution of medical care and access to health services by various socio-economic groups. According to Barnerji (1981), the health of a nation is significantly influenced by the social, cultural, political, economic and environmental factors. Under the socio - political sphere, some of the determinants of health services include social relations, social structure, education and the cultural milieu. The economic variables include income and its distribution,

means of transport, nutrition, technology and resource allocation. The environmental factors include sources of water supply, waste disposal and sanitation.

2.2.1 The Role of Economic Variables in Health Care

Economic factors play significant roles in the provision and acquisition of health care services. Among the economic variables, income plays a dominant role in the acquisition of health services by individuals and families. Studies from the United States of America have shown that individuals and families with higher incomes can afford to pay reasonable health services while the low income earners may not be able to do so.

Warren and Sydenstricker (1916) conducted a study in New York City in the United States of America, on the health of workers in relation to their economic status and found marked differences in health status between the poorest and better- off families. Child mortality for example was 21 per cent among the poorest families but only 12 per cent among the better-off families. They concluded that the greatest number of the poorly nourished, anemic and those who had tuberculosis belong to the lower paid groups and thus they believed that low incomes are harmful to the health of workers and their families. They further found that small variations in economic levels among the workers had great implications for the health of their families.

Colins (1926) reviewed morbidity and mortality rates by social class and infant mortality among various socio-economic groups. His review in the United State of America indicated that the rich were more healthy and live longer than the poor. Similarly, the World Bank (1993), reported that the higher a country's income per capita, the higher the life expectancy and also the longer the life-span of the people.

Correspondingly, countries with low per capita incomes have lower life expectancy. According to the report, income growth has more impact in poor populations because additional resources enable them to buy basic necessities, particularly food and shelter that yield large health benefits.The report further asserts that the distribution of income within households and within regions and countries also affect the acquisition of health services. For instance in industrialized nations like Japan, United States of America, United Kingdom and Canada where incomes are high and disparity is insignificant, life expectancy is very high. Conversely, in poor countries like Kenya, Indonesia, India etc where incomes are low and there are wide disparities in income among groups, mortality rates are higher among the poor than the rich citizens.

The World Bank (1993) also states that across countries, more than 75 per cent of the difference in health status is associated with income disparity. In a sample of fifty-eight developing countries, the report shows that a 10 per cent increase in income per capita reduces infant and child mortality rate by between 2.0 and 3.5 per cent respectively and increased life expectancy by a month. This estimate reflects the total impact of income on health. For Nigeria, Srilanka, Thailand and several Latin American countries, the report asserts that a 10 per cent advantage in income reduces infant mortality rates by between one and two per cent.

Another dimension is the introduction of user fees which affects individual incomes and the acquisition of health services in some countries. According to Russell and Gilson (1997), with the introduction of user fees in Cameroun, Sudan, Zimbabwe, Tanzania, Egypt, Iran, Jordan, Colombia, Mexico, Bangladesh, Nepal, China, Fiji, etc, all

of which are relatively poor countries, the cost of medical services went beyond the reach of the poor. In some instances, the introduction of user fees imposed barriers to the utilization of health services for women and children. Interestingly, Russell and Gilson (1997) also established that among the countries that have introduced user fees, "civil servants" and health workers were commonly exempted from user fees.

Another important economic variable of health service is that of health financing. It is important because without adequate financing, the health sector cannot thrive. It is for this reason that both government organizations and individuals participate at various levels of health care financing. At the global level, the World Bank (1993.52), reported that expenditure on health totaled about $1,700 billion in 1990 and of this amount, governments spent 60 per cent while the rest was spent by non-governmental organizations and individuals. The report further stated that of the $170 billion spent on health in the developing countries of Africa, Asia, and Latin America, government spent half the total amount.

These huge expenditures on health makes it critical to understand the importance of health services to the people. The extent to which governmental, non -governmental organizations and individuals finance health services would normally reflect the availability, accessibility and the quality of these services. The type of government policies and organizational structure of health care services operated vary among nations and are located within specific ideological contexts and national priority which are mostly based on the capitalist, socialist or welfarist ideology (Erinosho, 1998). According to Ukwu (1990), the approach of various nation's to health care financing is dependent

upon each nations political and economic structure, social realities and historical experiences.

Terris (1980), has come up with a typology of health policies based on ideological framework as follows: (a) National Health Service; (b) Health Insurance; and (c) Public Assistance. Terris, however indicated that, these three medical care systems are not fixed nor immovable but that there is a continuing process of revision or replacement. Therefore, more than one type of the three medical systems co-exist to some degree within a country. However, the dominant system for any nation is that system by which the majority of the population obtains care. Roemer (1980), in a rejoinder supported Terris's views but suggested that each of Terris's three types of medical care system could be reclassified into two or more categories because of the diversities in National health care policies based on different ideologies of more than 150 nations of the world. Roemer further pointed out that Terris' classification, has a major weakness, for paying scant regard to self-care and traditional health care systems paid for privately by a large segment of the population, which is common place in Africa and Asia. These criticisms notwithstanding, it is worthwhile in this thesis, to describe Terris's three systems of medical care as follows:

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Within the National Health Service, the national government takes responsibility for the health care needs of all her citizens and provide medical treatment free of charge to every citizen at point of delivery. In this system, services are financed by taxation and payroll taxes on employees. Services are provided by salaried physicians and other health personnel who work in government hospitals and health centres where they provide both

curative and preventive services. This is reported to be practised mostly by socialist countries in Europe which are either industrialized or undergoing rapid industrialization. The example of such countries include, Sweden, Britain, China, and the former USSR.

In the Health Insurance Policy, medical care is pre – paid by the health consumers or rendered on fee for service basis, through a mix of governmental and non-governmental insurance. The failure of most national health insurance to cover the full cost of care is a major deficiency of fee for-for-service programmes. This practice is found in Israel, Canada, Japan, USA and most countries of Western Europe.

With respect to Public Assistance, governments subsidize medical services for their citizens in various degrees . In effect, private health care providers and voluntary agencies are allowed to provide health services to augment the governments' efforts. The Public Assistance policy is mostly implemented in developing countries of Africa, Latin America and Asia. In this system, medical care is provided in government hospitals and health centres and are financed by general taxation. In this system facilities are generally under funded, overcrowded and with insufficient medical and health personnel due to poor staff remuneration.

Terris, further stated that, under the three policies or systems, government in particular plays significant roles in public health matters and in the standardization and regulation of medical practice. However, according to Terris, the adoption of the various health systems by the different countries account for variations in the provision of medical services in terms of coverage of citizens, and the quality of services available to health consumers of the different nations. Therefore citizens of the various nations of the

world are subjected to differential access to medical care through the liberal national health policies of Health Insurance and Public Assistance and also to some degrees under National Health Service policy (Widgery, 1980; See- Hellandendu, 1991:4-6).

According to Shapiro (1997), the issue of differential access to health care services is particularly worrisome under the private health insurance model operated for only those who have the ability to pay for the insurance premium. Those who are unable to pay care excluded and are denied medical care.

In Nigeria, health care financing is located within the capitalist ideological framework. The various sources of health care financing are derived from a free market economic system. These major sources include among others, government (public sector), private sector, external funding from international agencies and voluntary organizations. This mode of health care financing in Nigeria differs significantly from health care financing in socialist and welfarist countries where government is the sole financier of health services for all citizens (Alausa and Osibogun, 1996).This is what creates, the disparity in the provision of medical services to the various socio-economic groups in Nigeria.

2.2.2 ECONOMIC CRISES AND HEALTH SERVICES

"Economic crisis" refers to an economic hardship whose dimensions include; decline in Gross Domestic Product (GDP), a fall in export earnings, a fall in import purchases, increase in external debts, deteriorating infrastructure (such as roads, clinics etc), unemployment, declining educational system, deteriorating maternal and child health etc (World Bank 1990). Economic crisis can also be defined in terms of high inflationary

rates which adversely affect acquisition of human basic needs, such as food, shelter, and other social services.

This sub-section deals with the effects of economic crises on health financing. It also deals with the acquisition of medical services by various socioeconomic groups vis-à-vis short falls caused by the crises.

All over the world, economic depressions and crises and their far reaching effects on the economic and socio-political structures have been recorded at various points in time. In some cases, the onset of the crises led to negative reactions in response to their excruciating effects. Such reactions include organized strikes, revolutions, reforms etc as discussed below.

According to Davies (1962), the years 1905 - 1917 in Russia, formed an almost relentless procession of increasing misery and despair amongst the workers and the intelligentsia in the cities. In 1906 for instance, there was a bad harvest. The bad harvest affected the food and nutritional intake of the people. Response to the crisis by the working class, and merchants were immediate, bitter and prolonged and were not at all confined to the working class. The employers, merchants and white collar officials joined in the strikes which brought the economy to a virtual stand still.

Davies further recorded that the World War II ushered in some economic depressions in Egypt. For instance, conventional exports, mostly cotton declined during this period. In 1945 about a third of the work force became jobless and this had the potential to affect the quality of life and the general health of the affected workers. The cost of living by 1945 had risen to three times the index of 1937 thereby affecting feeding,

housing, health and other basic needs.

Davies similarly looked at the effects of economic depressions of the 1930s in the United States of America. According to him, it was severe enough at least on economic grounds. Total national, private production income in 1932 reverted to what it had been in 1916. Farm income in the same year was as low as in 1900, while manufacturing was as low as in 1913. Mining and quarrying was back at the 1906 level. For much of the population, two decades of economic progress had been wiped out. There were more sporadic demonstrations of unemployed, hunger striken Americans and veterans. In New York city at least 29 people died of starvation. It is believed that such economic depression from the American experience did not only affect the individuals and their health but also affected the health sector and other key sectors of the American system. The Russian, Egyptian and the American experiences as studied by Davies demonstrated clearly the negative effects of economic crisis on various groups in different circumstances at different times. The findings here have recorded various responses that have accompanied these crises. The situations as depicted here help to understand the impact of the Nigerian economic crises on various socioeconomic groups due to thee hardships faced by the lower classes on acquisition of basic needs like medical services, housing, food etc .

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According to the World Bank (1990), the 1980s had been a decade of severe economic hardships affecting millions of people in virtually every African country. According to the publication, real per capital Gross Domestic Product (GDP) declined by nearly 20 per cent between 1980 and 1987. Export earnings fell between 1980 and 1987,

while import purchasing fell between 1981 and 1985. The terms of trade for the 34 poorest sub-Sahara countries declined persistently between 1970 and 1981. The region's debt which stood at US $6 billion in 1970 reached US $129 billion in 1987 representing 100 percent of its Gross National Product and more than 350 percent of its total export.

As a consequence of the economic crisis of the early 1980s, many developing countries in Africa changed their economic and health policies. These changes typically involved cuts in public expenditure. According to the World Bank (1993), cuts in government spending affected health budgets. For instance, Cote d'ivoire' cut down public expenditure spending between 1981 and 198 by 12 per cent. Particularly, medicines and health materials absorbed the reduction, shrinking in real terms by more than one-third during the first half of the 1980s. This is a reflection of what is happening in most African countries. The cuts in health expenditure imply cuts in the level of services to be rendered to the public.

In Nigeria consequent upon the low performance of the economy and increasing difficulties in financing the health sector in the 1980s, government started pruning down allocations and expenditures in all sectors including health. For instance, the Central Bank of Nigeria (1987), revealed that while the capital expenditure for the health sector stood at N304.5 million in 1981, it went down drastically to N123.4 million in 1983, N34.6 million in 1984, and only increased slightly to N59.9 million in 1985. This sharp reduction in health financing indicate the negative impact of the economic crisis on the health sector.

Owing to the crisis in the early 80s and the short falls in health financing, the

health sector was forced to introduce user fees in health centres. According to Ahmadu Bello University Institute of Healths' (ABUTH ,1982) report, the policy of free health services for all which started in 1968 was reversed. The costs of drugs, laboratory diagnoses, operations, etc were shifted to the consumer. By 1982, users were expected to pay for curative services which included; outpatient registration fee, routine admission and compulsory deposit fee for emergency admission. In addition, patients were required to pay for the cost of drugs and other treatments (See-Adabayo,1983). Ejembi and Bandipo (1989) stated that the introduction of fees in ABUTH led to drastic reduction in the utilization of services by citizens.

The under funding of the health sector and the introduction of various hospital fees actually affected the performance of the health sector (infrastructure, equipment, personnel etc) and the citizenry. Among those who patronize these government facilities are public servants who work in various government establishments. Such low performance of the health sector according to Gandu (1992) affected public servants patronage of these facilities in Kaduna which dropped drastically.

Apart from under-funding of the health sector, the limitations imposed by income also affects the acquisition of health services by people particularly the low income groups. Some scholars like, Muntaner and Persons (1996), have advocated for the introduction of health insurance as an ameliorating measure. These scholars argue that the availability of health insurance is a critical component in determining access to health care system. They view lack of health insurance as associated with substandard medical care with increased risks of morbidity and mortality.

An analysis of the advantages of national health insurance of various types (government insurance, private insurance and other forms of health risk coverage) show that both the poor and rich benefit and it is likely to be more beneficial to the poor income groups and workers because these groups have low incomes which the insurance scheme supplements (Edozien, 1996: 24 - 26).

In addition to health services, economic crisis also affected other health indices such as, housing, food intake, transportation, education, water supply and other social services etc. It has been observed that housing as a component of social development had a boost in the Fourth National Development Plan 1980 - 1985. An important feature of this period was the launching in 1981 of the national housing policy. This was an attempt to improve on the physical living conditions of the citizenry. However, due to the continuous prevailing economic crisis not much was achieved in this area because most of the projects were abandoned after take off due to poor financial resources to continue.

In the area of food and nutrition, the economic crisis led to an increase consumer price index. According to the Central Bank of Nigeria (1990), the consumer price index for food in 1981 rose from 149.9 to 498.5 in 1985.(Central Bank of Nigeria 9190). This escalating price index of food therefore suggested that food became increasingly inaccessible to Nigerians especially public servants whose salaries are fixed. It therefore, implied that food intake was low even as early as the 80s.

It is ironical that although SAP was introduced to serve as a solution to the economic crisis, it appears that the measures further compounded the problems created by the economic crisis particularly in relation to health services, living conditions,

agriculture and food supply, education, commerce and industry. According to Kalu (1994), SAP intensified inflationary trends which rose from 5.4 per cent in 1986 to 57.2 per cent in 1993. This consequently succeeded in curtailing public expenditure on health. Furthermore, the inflationary trends occasioned by SAP also affected the pharmaceutical industry which is an important component of health care services. According to the Federal Office of Statistics Report (1992), budgetary allocation to the health sector rose from 2.38 per cent in 1981 to 3.10 per cent in 1986 the year SAP was introduced. However, as from 1987, budgetary allocations to the health sector started witnessing sharp declines. In 1987, the allocation dropped to 1.34 per cent and worsened in 1989, with an allocation of 0.63 per cent. Since then, subsequent allocations to the health sector have not shown any appreciable increase. In a similar vein, according to the Kaduna State Report (1992), whereas the budgetary allocation to the health sector as a percentage of the total planned allocation stood at 11.4 per cent and 10.8 per cent in 1985 and 1986 respectively, thereafter, the allocation started to decline gradually. In 1988 it dropped to 9.45 per cent, 7.61 per cent in 1989 and 7.27 per cent in 1991.

The reductions in budgetary allocations in the SAP era compounded the problems of an already collapsing health sector. The purchase of drugs became difficult owing to scarce resources. Patients, including public servants could not obtain prescribed drugs in government health centres and had to buy them from drug stores at high cost and at the risk of purchasing fake and potentially dangerous drugs.

The general high cost of drugs and its consequences for the proliferation of cheaper but fake drugs subsequently led to cost recovery schemes introduced in 1989 by

the three tiers of government in the Federation. In particular, a Drug Revolving Fund Scheme (DRF) was introduced and this demanded that all patients pay for the cost of drugs and the proceeds recycled to purchase more drugs and equipment (Kaduna State Ministry of Health, Report, 1991). The Cost recovery schemes were also introduced for diagnostic and laboratory investigations, hospitalization etc. Patients were now required to pay for those services under the cost recovery scheme, a situation that did not exist before SAP. The maintenance of existing infrastructure and equipment in Nigeria's governmental health centres was also affected. The acquisition of new equipment was also greatly hampered.

Shettima (1990), in his study on the effect of SAP on the health sector in Nigeria, had found that SAP had affected the completion of health projects like the construction of new health centres because of the high cost of building materials and hospital equipment. He again argued that existing health centres were poorly maintained due to lack of funds. Consequent upon poor maintenance of the health centres, patients have strong objection to hospital admission because they lack basic utilities and amenities like water, electricity, beds, feeding etc. Further still, Shettima (1990) asserted that the pharmaceutical industry which is a major component of the health sector has been weakened by SAP resulting in the short supply of drugs and the production of sub-standard drugs in the country which has affected medication in the health centres.

The financial constraints posed by SAP adversely affected health policy with respect to manpower training and development. For instance, the Kaduna State, Health System Fund report (1993), states that fellowship training abroad for post graduate

doctors was greatly hampered for lack of funds. Similarly, basic training programmes for nurses and other health staff were rationalized and the number of candidates for available courses pruned down. Worse still, the few that were sponsored by the government and those who privately financed the cost of their training were not engaged by the government. Consequently, on there were shortages of personne in the health centres.

As regards living conditions such as housing, food and nutrition, SAP also had a negative impact. The Central Bank of Nigeria publication (1990) indicated that the removal of subsidy on farm inputs like fertilizers and tractor hiring services, led to a decline in food production. The decline in domestic food production coupled with a ban on food importation increasd the cost of agricultural inputs. Domestic inflation, emanating from SAP, pushed up the consumer food price index. The consumer price index of food rose from 498.5 in 1985 (before SAP) to as high as 1,183.4 in May, 1990 (during SAP).

This escalating consumer price index of food as at 1990 implied that food was getting out of reach of most Nigerians both in quantity and quality. This implies that for most Nigerians, food and nutritional intake were low. According to Dienye (1985) the calorie shortfalls among underfed and malnourished people are always high. He further asserted that the productivity of such undernourished people in terms of working years may grossly be affected because of early death. It therefore means that where shortfalls in quantity and quality of food intake exist, the incidence of communicable diseases among the people would be very high because of lowered resistance to diseases. This would generally be an extra burden on many social amenities particularly health facilities.

In the areas of housing, sanitation and other living conditions, the adjustment programme has affected their performance. Since the introduction of SAP in 1986, there has been rapid increase in the cost of house rent. The Central Bank of NigeriaReview (1990), indicates that consumer price index for housing accommodation rose from 257.9 in 1985 to 696.8 in 1990. Prices of building materials went up and that affected the performance of government and individuals in the development of housing accommodation. For instance, a 50 kg bag of cement which cost N5.40 in 1985 (pre-SAP period), rose to N27 in 1988, N100 in 1991 (Arowolo, 1992) and in 1996, the market survey by the researcher indicated that a bag of cement was sold between N420 and N480.

The preceding situation implies that housing provisions by government and individual ownership have been greatly hampered. This means that individuals had to live in over-crowded houses. Such conditions facilitate the spread of communicable diseases like malaria, dysentery, hepatitis, tuberculosis, meningitis etc, as pointed out by Duncan (1996).

In the area of transport, the SAP effects led to an increase in the cost of motor vehicles and a decline in the purchase of vehicles for both private and commercial purposes. Bolade's (1989), study in Lagos revealed that the stock of newly registered commercial vehicles dropped from over 5000 in 1983 to as low as 800 in 1987. This resulted in considerable increase in both passenger fare and freight charges. The consumer price index for transport cost rose from 315.8 in 1984 to 910.8 in 1990. The implications of these increases are that people had to budget large proportions of their income for

transport fares. Ogunlade (1989), has asserted, that the proportion of Nigerias' income spent on transport in Nigeria's urban centres is estimated to be between 10 and 16 per cent of their income. This trend must have worsened in the 1990s because of the increasing inflationary trends. For instance the ownership of motor vehicles particularly on the side of the public servants has significantly reduced as a result of economic crisis. Presently, motor vehicle advances are no longer forth coming and when given, they are not adequate to purchase any road worthy motor vehicle. At best, only refurbishing loans are given to only those public servants who ready have the vehicles which are too meagre to refurbish a vehicle.

The introduction of SAP has also led to drastic reduction in welfare schemes for various groups of public servants at Federal, State and Local government levels. For instance, the Kaduna State government as at 1987 stopped bearing the full costs of medical care to its public servants as recorded by the Kaduna State Ministry of Health Report 1985 -1991. As to be expected, the combined effects of the cost of health care services and the withdrawal of government subsidy on health care is having a negative impact on Nigerians. For instance, Gandu (1992), in his study of Public and Private sector workers found that after the introduction of user charges for medical services in the late 1980s, the rates of utilization of medical services by public and private sector workers, declined drastically in Kaduna town. He established that while 82 per cent of the workers could utilize medical services whenever they fell sick in 1985, by 1990 only 27.4 per cent were able to utilize medical services whenever sick. About 50 per cent resorted to the use of traditional and spiritual healers, while 36 per cent offered prayers to God for preventive

measures and divine healing. Others, 3.4 per cent, either employed self-medication or resigned themselves to fate and allowed the sickness to run its natural course.

Erinosho (1995), also indicated that the impact of SAP has caused poor nutrition among children and a sharp decline in the Expanded Programme on Immunization (EPI's) activities. This has resulted in the increase in the incidence of parasitic and infectious diseases accounting for high incidence of infant mortality in Nigeria. Alubo (1995), argued that, upon the introduction of SAP, the poor people in Nigeria experienced several avoidable nutritional, psychological, physical and medical problems which were directly traceable to the economic problems created by SAP. He asserted that the political and economic causes of morbidity and mortality are graphically captured by the impact of SAP. Meagher and Yunusa (1996), in their study of the Structural Adjustment Programme and the Nigerian urban informal sector, revealed that SAP has increased pressures on household consumption and this has in turn hampered the quality of health of families including public servants. This is clearly manifested in the reduction in quantity, quality and variety of food consumed by families, which has affected nutritional status. The study further reveals that an average of 30 per cent of the respondents patronized hospitals/clinics for their medical care, while 25 per cent shifted to traditional medicine as an alternative to modern medical care. In some cases, the respondents indicated that they sought medical care directly from chemists/medicine stores, while others just buy as much medication as they could afford. According to this study, some operators of these chemists/medicine stores have capitalized on the SAP effects to operate illegal clinics in the medicine stores.

Dike (1997), in a similar study came up with findings which corresponded with that of Meagher and Yunusa, (1996). His findings demonstrated that the introduction of SAP has made some couples to practise family planning because of hardships experienced in catering for children. People now engage in farming, petty trading and private practice in order to provide food for the family. Poeple can also decide to live without pipe borne water and electricity when disconnected.

However, a critical examination of Meagher and Yunusa's work especially as they relate to the issues of buying drugs directly from drug stores and chemists may be a pre-SAP practice and not necessary an effect of SAP. Furthermore, one may argue that this action could be informed by lack of access to hospitals. In the case of Dike and in reference to the acceptability of family planning and immunization, it may not necessarily be due to the effect of SAP but as a result of intensive community sensitisation by the various government agencies which promote these programmes. These not withstanding, the impact of economic forces have been causal factors in changing behaviours and attitudes towards government programmes.

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Another important dimension of the effect of economic crises is that people live under similar poor sanitary conditions as Engels and Marx (1845) found in 19th century Europe. Engels and Marx investigated the conditions under which the English working class lived during the industrial revolution. The investigation focussed on health, physical, mental, moral, and economic circumstances of the workers in England. They found that most workers who were economically weak lived in unsanitary environments full of filth and stagnant pools which engendered diseases. He also found that a majority of the

working class were drawn to large cities where they were relegated to districts with poor housing. Under such conditions, most of the workers contracted numerous preventable diseases which could have been avoided if they had better living conditions. Waitzkin (1978) also found that among the most important factors in disease causation among workers is the material and living conditions of the workers. According to him, this explains the disproportionately higher incidence of morbidity among low income earners. Economic variables do not only determine the safety of the industry where the workers are employed but also determine the group at risk in an industrial environment or in the workplace (Kajang, 1987). There is a strong co-relation between economy, poor environmental health and living conditions of workers (Heinecke, 1986:53). Given this circumstance, access to health care services and acquisition of basic living conditions by the low economic groups in a capitalist setting will be in adequate, because these needs are subjected to market-like forces.

In the face of obvious shortages in medical services in particular as indicated in this review, it will mean that segments of the society who cannot afford to acquire modern medical services are likely to resort to alternative medicine for treating their health problems. One of such sources is traditional medicine which complements the mainstream western medicine in most parts of Africa (Schram, 1971; Dunlop, 1975; Oyebola, 1990; Mume, 1996). Other forms of alternative health coping strategies include divine and miracle healing based on faith as a requirement for the healing (Sofoluwe, Olofin and Popoola, 1996) It is asserted by Mume (1990), that if the shortages in modern health facilities are allowed to persist, these alternatives which

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are acceptable to and affordable by poor people in developing countries will continue to attract high patronage.

Lasker (1981) has however reported that the shortages force people who cannot afford modern medical care to resort to self- medication using both modern and traditional medicines for healing. Lasker (1981), Dean (1981) and Igun (1979) consider the decision by lay persons to diagnose and treat perceived symptoms themselves as a reaction to shortfalls in contemporary health care systems. They further observe that although self – medication is an illegal practice, poor people in particular indulge in it as a coping mechanism.

2.3 Theoretical Framework

In adopting a theoretical framework, the marxian political economy paradigm shall be applied to analyse the interplay of politics and economic forces on health care services. The section will also look at the prospects of acquiring health services by various socio-economic groups in capitalist societies.

The political economy model has its origin from Marx's dialectical analysis of class structure and exploitation that persist in capitalist societies. The theory posits that the capitalist mode of production in industrial societies creates classes whereby the few at the upper segment of the class structure have more control of economic power and control the distribution of resources. Marx (1957) asserted that the owners of the means of production constitute the dominant class and the workers occupy the position of the subordinate class. This circumstance helps to perpetuate the class structure and exploitation in society

In a capitalist system the dominant group acquires resources and services at the expense of the lower class. In times of shortages, it is the lower class that will suffer most. It therefore follows that in the distribution of health services its availability will be more readily available to people in the upper class. This is because under capitalism health services is profit oriented, is like other commodities in the market place. Furthermore, given the requirements for profit the employers will try to eschew the cost of health care for their employees. (See -Navarro 1976, Turshen 1977, Waitzkin 1978, Haralambos and Heald 1983, Turner 1987,, Ham 1992, Alubo 1995, Erinosho ,1998).

Under the condition of competitive capitalism such disposition of the capitalist employer, will mean poor health and living standards among the working class (the subordinate or lower class) which is in a relatively weak economic and political position to determine what accrues to them as welfare benefits (Ake (1981), Albalking (1983:129, Heinecke (1986), Cookey (1986:36-42,) Marx and, Engels (1975). Furthermore the low income working class families have higher incidence of diseases due to the nature of their work and the conditions in which they live. Oculi (1981), found that due to the inhuman nature of work under capitalism, children of the low income working class in Lagos, Nigeria became senile and grey haired at eleven years of age. This implies that the lower class have shorter life expectancy compared with the members of the upper class.

In the context of this study, the political economy approach is geared towards offering an explanation of the effect of health policy and the state of health of public servants within the context of the class system in Nigeria. The Nigerian Government is

equated with the capitalist employer whose reluctance to satisfy the health and other welfare needs of the employee are similar to that of the industrialist. Placing, Government in this perspective it means that the distribution of health services to its various " classes" of employees are determined by the location of each group in the class structure. In contrast to the industrialist, however, government controls the state power which places the government in a more powerful position than the industrialist. In Kaduna State, government determines who gets what and the public servants are placed in a weak position to determine what accrues to them because government has the power to subdue workers irrespective of workers' union. This is exemplified in the unilateral withdrawal of free medical care for public servants in Kaduna State.

In this study it is considered that the provision of adequate medical care and good living conditions for public servants is beyond the medical services domain but a function of economic and political factors. The public servants are in relatively weak economical and political positions in relation to government to fight successfully for such welfare needs. Under competitive capitalism this will mean poor standard of living amongst the lower classes in society. This is evidently manifest in the worsening standard of health and living conditions of public servants in Kaduna metropolis who occupy a lower class in Nigeria. Any anticipated improvement on the plight of the public servants will depend on a political and economic arrangement that will put the public servants them in the upper class and if possible at per with government in deciding their welfare needs.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter is on the methods used for this study. Various methods were employed for the collection of data. These include a structured questionnaire which formed the main instrument for the collection of data and an interview schedule used to collect information from senior managers of various health policy formation in the state and group discussions.

3.2 Location of the study area

The research was conducted in Kaduna metropolis, the capital of Kaduna state. The state has twenty three 23 Local Government Areas and covers a land area of 43,365sq km. According to the 1991 census figures, Kaduna State has an estimated population of 3,935,618million people. Kaduna metropolitan city comprises two core Local Government Areas namely; Kaduna North Local and Kaduna South and in fact parts of Igabi and Chikun Local Government Areas.

Distributive trade is a major occupation in Kaduna town but subsistence farming predominates in the rural areas. Most of the industries are located in the Southern part of Kaduna city, while most of the State Ministries are located at the Northern part. In all, the state has eight Ministries and one Federal Secretariat complex housing federal ministries and parastatals all located in Kaduna town.

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3.3 Population of the Study

In order to have a representative sample of all public servants in Kaduna metropolis, respondents were selected from the Federal, State and LGA public servants residing in Kaduna metropolis.

The main guiding principle for the selection of respondents (sampling units) from various arms of public servants in the state is the numerical strength of the ministries/parastatals which are categorised into large, medium and small. Thus the Ministries of Education and Health (large). Agriculture, Works, (medium); Finance and, Commerce and Industry, (small). Furthermore, Boards such as Kaduna State Water Board,(large), Kaduna State Revenue Board (medium) and the Kaduna State Media Corporation (small) were selected to represent the State parastatals while the Federal Secretariat Kaduna which houses the federal ministries of Works, Health, Agriculture, Industry, Transport, Finance etc and the Kaduna Polytechnic represented the Federal public servants. The Kaduna North, South and Chikun Local Government Areas which are located within the Kaduna metropolis were selected to represent the local government areas. To a large extent, the Federal, State and Local Government public/civil service departments in Nigeria operate similar labour conditions and thus all operating similar health policies for their workers.

The population of the study comprised senior, middle and junior level public servants in the three tiers of government in Kaduna metropolis. According to the Kaduna State Civil Service Reforms, 1988, Senior officers are those on salary grade levels 13 to 17, middle grade officers are on grade levels, 7 to 12 and junior officers are those on

levels 1 to 6 (Kaduna State Civil Service Reforms, 1998), thus, the different categories of workers have different access to social welfare services.

3.4 Methods of Data collection

A combination of methods were employed for the collection of data for this study, namely, the questionnaire method, interview schedule, group discussions follow-up interviews for selected respondents and market survey, for price of selected items and services. The type of data collected for each of the technique are explained below:-

i. The Questionnaire Method

A self administered questionnaire which consisted of both open ended and close ended questions covered four broad areas, namely, background information on the respondents, (such as, place of work and department, age, sex ,marital status, educational attainments and family size), employment and income such as (length of service, salary grade level, sources of extra income etc) , medical and health services were specifically investigated, self reported morbidity, types of medical services utilized, health expenditure, and selection of health centres for medical treatment was distributed to literate respondents. Under living conditions, information was sought; on the section of Kaduna where respondents live and residential status, rent subsidy, housing conditions, food intake, welfare services and coping behaviours. (See appendix I)

ii. Interview Schedule

This structured interview method was targeted at senior Health Managers and professionals (Director General, Director Planning, Medical services, Pharmaceutical services, Primary Health Care, as well as Deputies, Assistant Directors and Chiefs within

these unit) of the Kaduna state Ministry of Health and Kaduna Polytechnic medical units. The interview borders on health policy objectives as they relate to public servants in the state (See guide in appendix ii).

iii. Group Discussions

The group discussions using structured questions were held with selected health tutors{6}, a class of students of School of Health Technology T/Wada. Kaduna and 7 respondents of the Ministry of Finance Kaduna. The interviewees included males and females cutting across the three cadres{junior, middle and senior staff} These three groups of interviewees were meet with at separate sessions on appointment in their respective stations. The group discussions focussed on the effect of changing health policies on the health sector and the distribution of medical services, living conditions and coping strategies of public servants.

This group discussion differed, in composition from a conventional focus group discussion in the sense that, the groups were not homogenous in terms of gender, income size, and educational attainment. This was because information was needed across board as a follow up to the questionnaire and the interview schedule.

iv. Follow-up Interviews

Follow-up oral interviews using unstructured questions were conducted with some of the respondents (after applying the questionnaire) in order to elicit further explanation on some of the responses in the questionnaire. The follow-up interview provided incisive information being a follow-up exercise to the Questionnaire in such areas as medical refunds, access to amenity wards in government medical centres, public appeals for

financial assistance for medical needs, monthly family expenses on medical treatment, rental payments, meals intake, behaviour of medical personnel in governmental health centres etc.

v. Market Survey: Market surveys using oral interview methods were conducted on the cost of certain aspects of living conditions such as cost of housing accomodation, cost of medical treatment ,cost of basic food commodities, cost of transportation, etc.

3.5 Sampling

The investigation set out to have a sample of 250 public servants. It was also believed that such sample size would present a fair representation of the public servants' views and opinions. Specific sub-samples quotas were proportionately allocated to the three tiers of government based on their populations as shown in Table 3.1

Table: 3.1 Break Down of Respondents by Tier of Government Ministry, Board and Parastatal As At The Time of Survey

Tier/Sub tier population		Quota Sample Of Total Poptn. No	%	% of 250 sample Size
1. Federal Sector and - Various units.	(3,148)	(40)	1.3	16.0
2. State Ministries and Parastatals.	(11,968)	(166)	1.4	66.4
a. Min. of Education		50		
b. Min. of Health		30		
c. Min. of Works		16		
d. Min. of Finance .		20		
e.Min. of Agriculture		10		
f. Min. of Trade & Ind.		20		
g. Kaduna State Revenue Board.		5		
h. Kaduna State Water Board.		10		
i. Kaduna State Media Corporations.		5		
3. Local Governments	(3,611)	(44)	1.2	17.6
a. Kaduna North		14		
b. Kaduna South		16		
c. Chikun		14		
TOTAL	18,727	250	-	100%

The number of public servants included in each establishment in Table 3.1 was decided on the proportionate number of employees in each establishment.

The quota sampling procedure was employed for the selection of the individual public servants in each tier, Ministry, Parastatal and salary grade levels. Specific proportionate numbers were selected from specific stratum based on the population size of each stratum. In each ministry, board and parastatal surveyed, the nominal roll of the staff and

their respective grade levels (GL) was obtained. Using such nominal roll the public servants were picked based on the sub-sample sizes allocated to the senior, middle and junior staff respectively. Those available were given the questionnaires to fill.

The Federal public servants and the local government public servants constitute 33.6% of the respondents, while the State Public Service constitutes 66.4% of the respondents.

Table 3.2 shows the distribution of the public servants according to Grade Levels.

Table 3.2 Salary Grade Levels of Sample Respondents and Strata

Income Group (GL)	Total Poptn. And No. Selected in Each Stratum Poptn. Sample Size		%Of Stratum	% of Sple.
1 – 6(junior)	6050	80	1.3	32%
7 – 12(middle)	9580	120	1.3	48%
13 – 17(senior)	3097	50	1.6	20%
TOTAL	18,727	250	-	100%

The salary grade level was used to approximate the income of public servants. However, it is known that some public servants have other means of income which they may or may not measure accurately. Both the salary grade levels and the other sources of extra income are however used to determine the real income of the public servants in data analysis.

Of the 250 questionnaires distributed, 245 (98.4 per cent) were completed and returned. All the LGA and federal public servants returned their questionnaires while the

state public servants had 97.5 per cent return rate.

3.6 Key Variables Under Investigation

The key independent variables under investigation, include real income (salary grade level and extra income), age and educational attainment. The dependent variables in this research are health and living conditions. Their indicators include crude morbidity, medical treatment, meal intake, patronage of alternative means of treatment, housing conditions, and welfare services.

3.7 Methods of Data Analysis

Both the uni-variate and bi-variate analyses of the responses are made to determine the differential effects of SAP on the various categories of the public servants. The computer soft were "Statistical Package for the Social Sciences (SPSS-PC^{+}) was used for the analysis of data for all the statistical analyses in this study.

3.8 Problems Encountered in the Field

The first problem encountered in the field work was the apathy exhibited by some respondents. They were initially reluctant to fill in the questionnaire. This also contributed to the difficulty encountered in retrieving the questionnaires. This situation prolonged the duration of the field work (May - July 1996). The busy schedules of some top government officials (i.e the Health Managers of the State Ministry of Health) also prolonged the interview period which took almost eight weeks instead of the two weeks planned for the task. This was completed in September 1996 and the group discussions ,follow-up interviews and market surveys were completed in December,1996.

Another problem was that the researcher was called upon to resume duty by his

employer after the course work which interrupted the collection of data and the final report. These problems were resolved by converting the status of the studies from full-time to part-time. Savings were also made from monthly salary in order to finance and actualize the production of the thesis.

CHAPTER FOUR

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS, HEALTH SERVICES AVAILABLE AND COPING STRATEGIES FOR MEETING SHORTFALLS IN MEDICAL NEEDS.

4:1 Introduction

This chapter is divided into two main sections as follows:-

(1) Socio-demographic characterist of the respondents, and

(2) The impact of changing health policy on the health of public servants:-

4.2 Socio-Demographic Characteristics of the Respondents

In this section, the socio-demographic characteristics, (gender, age, marital status, family size, level of educational attainment and income) are analysed.

4.2.1 Sex and Age Composition of the Respondents

Of the 245 respondents who returned the questionnaire, 180 (73.5 per cent) are males, and 65 (26.5 per cent) females. The government health policy is applicable equally to both sexes except for maternity leave and shorter working hours for mothers during the first eight weeks of resumption from maternity leave.

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The ages of the respondents are shown in Table 4.1

TABLE 4.1: The Age Composition of the Public Servants

AGE (YEARS)	FREQUENCY	PERCENTAGE
26-35	79	36.9
36-45	113	52.8
46 and above	22	10.3
TOTAL	214	100.0

Missing cases = 31 (Did not indicate their ages)

Table 4.1 shows that most respondents, 52.8 per cent, are between the ages of 36 – 45 years. The Table also show that while 36.9 per cent of the respondents are 35 years or younger, only about 10 per cent are above 45 years. The analysis further shows that, majority of the respondents, 121(49.4 per cent) had 11 to 20 years of service, 75(30.6 per cent) have worked for ten or less, 43(17.6) 21 to 30 years and only 6 (2.4 per cent) have up to 31 years of service or more.

4.2.2 Marital Status and Family Size

Table 4.2 Shows marital status of respondents

TABLE 4.2: Marital Status of Respondents

MARITAL STATUS	FREQUENCY	PERCENTAGE
Single (Never Married)	35	14.4
Married	202	82.8
Divorced	2	0.8
Separated	3	1.2
Widowed	2	0.8
TOTALS	244	100.0

Missing case1 = (Did not indicate marital status)

From Table 4.2, most of the respondents (82.8) per cent) are married. As married people it is expected that males in particular who constitute the bulk of respondents have wives, children and other dependents. Apart from themselves, they have to provide for their medical needs, feeding, housing etc.

The family sizes of respondents are shown in Table 4.3

TABLE 4.3 Family Sizes of Respondents

FAMILY SIZE i.e NUMBER OF PERSONS	FREQUENCY	PERCENTAGE
1-5	103	47.0
6-10	107	48.9
11+	9	4.1
TOTAL	219	100.0

Missing cases, = 26 (26 respondents did not answer this particular question)

Table 4.3 reveals that the family sizes of the respondents are quite large. Most families have between 6 and 10 members. Such large families can have far reaching effect on the acquisition of health services. This also affects the feeding patterns, and the types of houses they live in. This implies that the public servants have high degrees of responsibility for catering for large families.

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4.2.3 Education Attainment of Respondents

Table 4.4 shows formal educational attainment by respondents.

TABLE 4.4 Level of Formal Educational Attainment of Respondents

LEVEL OFEDUCATION	FREQUENCY	PERCENTAGES
None	21	8.6
Some/Full Primary Education	27	11.0
Secondary or Equivalent	46	18.8
Post-Secondary	151	61.6
TOTAL	245	100.0

Table 4.4 shows that the bulk of the respondents have attained one form of formal education or the other. The table further reveals that 61.6 per cent of the respondents have acquired post secondary level of education. The remaining respondents have also either acquired primary or Secondary education. A statistical analysis of the relationship between level of education and age using cross tabulations illustrates that most public servants between the ages of 26 and 45 years have acquired either post primary, post secondary, or university education.

The large proportion of respondents who have attained some level of formal education implies that most of them know about illnesses and health needs. The constraints for their acquisition of appropriate health services if any is likely to be

financial resources, beliefs, tastes and preferences and other confounding factors.

4.2.4 Primary Income and Total Annual Income of Respondents

In this sub-section, the research centred on the income distribution of respondents. The Income is derived from their rsepective Grade Levels (GL), and extra incomes if any. Table 4.5 shows the income distribution of the respondents according to their salary grade levels as at 1996.

TABLE 4.5 Salary Grade Levels of Respondents as The Primary Source of Income

GL-RANGE	SALARY RANGE	FREQUENCY	PERCENTAGE
1-6	N4,356-N11,220	77	31.4
7-12	N8,748-N28,812	118	48.2
13-17	N21,858-N44,928	50	20.4
TOTALS	=	245	100.0

Federal Establishment Circular FED/1 January 1995.

In the questionnaire, the respondents were asked to indicate whether they have other sources of income apart from their salaries. The responses show that 58 (23.7 per cent) respondents, had other sources of income obtained from activities like farming 18 (31.0 per cent), trading 10 (17.2 per cent), contract 2 (3.5 per cent), consultancy service 2 (3.5 per cent), private practice 14 (24.1 per cent), rent 5 (8.6 per cent), as well as others constituting 7 (12.1 per cent). The total incomes from salary and the secondary occupations are shown in Table 4.6

TABLE 4.6 Total Annual Income of Respondents: Salary Grade Levels Plus Secondary Sources Where Applicable

INCOME RANGE	FREQUENCY	PERCENTAGE
Less than N10,000.00	37	17.4
N11,000.00 – N30,000.00	108	50.8
N31,000.00 – N50,000.00	55	25.7
N51,000.00 – N90,000.00	13	6.2
TOTALS	213	100.0

Missing cases = 32 respondents (Did not answer this question)

Table 4.6 shows that the majority of the public servants 50.8 per cent earn a real total annual income of between ten and thirty thousand naira and 25.7 per cent earn between thirty one and fifty thousand Naira. The table further shows that 17.4 per cent of the public servants have a real annual income of less than ten thousand Naira, and only 6.2 per cent earn N51,000 and N90,000.00 per annum. These categories of the annual income also include the contribution of the members of the family who are employed. The amount of money earned by other family members range from N1000 to N10,000 per annum.

On further investigations on the actual time the respondents started doing supplementary work to earn extra income, the findings show that 38 (65.5 percent) of these 58 respondents who answered this question had started between 1986 and 1996 which corresponds with the SAP period. Nevertheless, 9 (15.5 per cent) respondents had started supplementary work between 1981 and 1985.

A close examination of the statistics indicates that between 1981 and 1985, an insignificant proportion of the public servants had started to source extra incomes as

compared to post SAP period, 1986 and onward. When the relationship between age and period of starting sourcing for extra income is analysed, (Table 4.7 ,) the findings show that some respondents between the ages of 26 and 45 years had been sourcing extra income since 1981 but the number increased between 1986 and 1995.

TABLE 4.7: Relationship Between Age and Periods of Starting sourcing of Extra Income

Age RANGE IN YEARS	PERIOD WHEN WORKERS STARTED SOURCING FOR OF EXTRA INCOME				TOTALS
	1981 – 1985	1986 – 1990	1991 – 1995	1996	
25 Years or less	1	3	2	2	8
26 – 35	2	6	7	3	18
36 – 45	7	8	9	3	27
46+	1	1	1	2	5
TOTALS	11	18	19	10	58

Missing cases = 187 (Are not raising extra income)

The inference that can be drawn from Table 4.7 is that the main push factor for sourcing extra income is the inadequate wages to meet the materials needs of workers and their families in the SAP era. However, barriers, especially the lack of capital for take off, physical strength etc are major hindrances for public servants' engagement in raising extra income.

A further analysis of the data shows that a high proportion 76.6 per cent started doing supplementary work between 1986 and 1996. This period corresponds with the

SAP years. This means that between 1986 and 1996, the economic situation served as a push factor for raising extra income from other sources like farming, trading, contracts, rentals and skilled professional services like consultancies and other forms of private practice. Those who have tertiary levels of education formed the majority of those involved in raising income from the other sources as illustrated in Table 4.8.

TABLE 4.8 Educational Attainment and Raising of Extra Income

Level of education	SOURCES OF EXTRA INCOME (FREQUENCY)					
	Farming	Trading	Contract	Consultancy	Rent	Totals
Primary	2	1	1	3	3	10
Secondary	2	2	1	4	3	12
Tertiary	14	6	2	8	8	36
TOTALS	18	9	4	15	12	58

Missing cases = 187 (Are not raising extra income)

**Tertiary means educational qualification acquired after secondary education in Universities, Polytechnic lodges of education etc.*

X^2 = 21.67, df = 8 significant at 0.05 level

Although all categories of public servants engage in sourcing for extra income, the data in Table 4.8 indicates that the higher the educational attainment the higher the likelihood to source for extra income. Also the public servants level of educational attainment determines what they do for raising extra income as indicated by the chi-squire test.

This study also sought to establish the relationship between salary grade level and the sourcing of extra income from both skilled and non-skilled sources. The results are shown in Table 4.9

TABLE 4.9: Relationship Between Salary Grade Level and Sourcing of Extra Income

Salary Grade Level	TYPE OF EXTRA INCOME						
	Farming	Trading	Contract	Consul-tancy	Private	Rent	TOTALS
1-6 (N=)	3	1	0	0		5	9
7-12 (N=)	4	7	0	12		1	24
13-16 (N=)	7	4	4	8		2	25
Totals (N=)	14	12	4	20		8	58

Missing cases = 187 (Are not raising extra income)

Table 4.9 shows that the majority of public servants who engage in such practices mostly belong in grade levels seven and above. It is surprising that public servants in the lower salary grades 1 to 6 who should be keen on raising extra income to supplement

their meagre income, are less likely to do so than those who are on high salary grade levels. This is explained by the fact that those on higher salaries are better equipped financially to engaged in such extra ventures.

Generally, from Tables 4.5 and 4.6 public servants' incomes appear to be insufficient to cater adequately for their medical needs and other necessities in the face of the inflationary trends and demands to pay for health services which were hitherto free at point of delivery.

4.3 Medical and Health Services Available To Public Servants.

This section focuses on the medical and health services available to public servants. It also discusses the coping strategies of the public servants consequent upon unfavourable changes in medical care policies for public servants.

As a take-off point, the respondents were asked to indicate whether they always seek modern medical treatment when they fall sick. A majority of the respondents,237(96.7 per cent) indicated that they do. Furthermore, the respondents were asked to state the type of health services provided for them by their employers namely, the various arms of government: The responses are tabulated in Table 4.10.

TABLE 4.10 Types of Health Services Provided by Employers to Public Servants

TYPE OF HEALTH SERVICES/ASSISTANCE	FREQUENCY	PERCENTAGE
Free medical care	40	17.5
Payment of medical allowance	21	9.2
Credit facilities for medical care	6	2.6
None of the above	161	70.7
TOTAL	228	100.0

Missing cases = 17 (Did not answer this question)

In Table 4.10, 70.7 per cent of the respondents indicated that no medical services are provided for them by government. However, based on further analysis of the question, some of the respondents (17.5 per cent) from the Federal sector (i.e Kaduna Polytechnic and the Federal Secretariat) indicated that they are enjoying free medical care while other respondents indicated that they are paid medical allowance (9.2 per cent). An insignificant proportion indicated that they are paid credit facilities for medical care. The medical credit provides for public servants to incur expenses in designated health centres which are later paid by their employers. This is practised in a few parastatals, especially the Kaduna State Media Corporation(KSMC), Water Board and the Revenue Boards as indicated by the respondents.

The differences in the provision of health services for public servant particularly

between the Kaduna State core Ministries and the Boards as identified during the interview with health managers are due to the fact that the core Ministries operate strictly within the provisions of the Kaduna State Civil Service rules, while the boards, are allowed to provide additional welfare schemes for their workers.

It should be emphasized here that the Local Governments, core ministries at both state and federal levels operate separate medical policies for their employees, which tend to differ to some extent from those of their extra ministerial departments. The local government and the core ministries for instance, operate a policy of refund of medical expenses incurred by public servants while boards and extra – ministerial departments apart from refund of medical expenses, also provide for payment of medical and retainership schemes (provision of credit facilities).

Although government has made provisions for the refund of medical expenses in the core ministries, it is apparent that only a few well placed public servants and especially those in the medical field enjoy such a facilities. The Kaduna State public servants pointed out during follow-up interviews that the procedures for obtaining refunds are too cumbersome and distressing. If a public servant is not treated in a government hospital, such refund, may not be made because of the discretionary powers of the government medical officers on refund of medical expenses incurred in private clinics. Some public servants indicated that their applications for the refunds are either delayed, misplaced or get missing in the process. Some applications for refund were reported to be yet to be processed after there years of submissions.

The 40 (17.5 per cent) of the respondents who enjoy free medical services and

6(2.2 per cent) who enjoy credit facilities are those from well to do federal and state organizations such as Customs service, Immigration, Kaduna State Water Board, Kaduna State Media Corporation, Kaduna State Board of Internal Revenue and Kaduna Polytechnic. In the case of Kaduna Polytechnic, all aspects of health care delivery are free except pregnancy. The authority considers pregnancy as a voluntarily acquired condition and not an illness.

The responses of the public servants were corroborated by the responses received from the management staff of the Ministry of Health. When interviewed, they indicated that although government has withdrawn free medical services at point of delivery, the policy on the refund of medical expenses to public servants was put in place and is still in operation.

From follow-up interviews, the respondents indicated that in some cases, refunds are made if treated in government owned hospitals although the procedures for claiming refunds are cumbersome. In the cases of those treated in private clinics, some of the bills are considered suspect and rejected. Apart from these, some of the bills approved for refunds were drastically slashed down, in some instances, by more than half the amount applied for.

Of the 21 (9.2 per cent) of the respondents who indicated that they enjoy medical allowance, majority of them 14 (68.0 per cent) receive a maximum of N500 per month as medical allowance. When they were further asked to assess the adequacy of the monthly medical allowance paid to them by government, a considerable number 16 (76.8 per cent) indicated that the allowance was very inadequate while only 23.2 per cent felt

that it was adequate. When officials of Boards and Parastatals who pay the medical allowances were asked to comment on the adequacy of medical allowance paid to their employees, they said it was inadequate but argued that, that was what they could afford.

From the foregoing it is evident that, with the introduction of SAP, different medical and health policies began to emerge from government ministries, Boards, and Parastatals for their workers. The quality of medical services provided for workers by these agencies depend on the volume of revenue collected by them. The bottom line of this is that the bulk of the public servants are not covered by any specific health services and have to source for alternative means of treatment.

Some of the respondents further disclosed during group interviews that, SAP policies have created conditions which have led to increase in morbidity and mortality due to lack of adequate drugs, equipment, medical personnel and other facilities in governmental health centres. Some of the respondents disclosed that they had lost some of their colleagues and family members who had otherwise curable medical and surgical problems, due to lack of fund to pay for such services. Some of the male discussants complained that they have lost their wives in childbirth because they could not afford to pay for the cost of caesarian section. In some cases however it is the health centres that lack the basic facilities to provide for the immediate needs of the patient. In such circumstances patients' lives are sometimes lost before any referral arrangements are made.

Some of the medical staff among the discussants complained of inadequacy of manpower training in the health sector and the exodus of medical specialists in search of

greener pastures in other countries. For those who have managed to remained in the health centres, their productivity is dwindling because of their engagement in other ventures for raising extra income. They discussants also indicated that the contribution and participation of Non-Governmental Organisations (NGOs) in the health sector especially in the implementation of Primary Health Care activities have reduced due to the fact that these NGOs now insist on joint financing of projects with government instead of the sole financing by the NGOs concerned.

4.3.1 Attitude Towards Government Cost Recovery Schemes and Affordability of Governmental Health Services

The respondents were asked to indicate where they have been receiving modern medical treatment for ailments. The responses show that 67.8 per cent go to government health centres while only 32.2 per cent indicated that they go to private hospitals. In government health centres where services are relatively cheap and where there is a good number of health personnel, it is apparent that public servants are receiving good attention. However, absence of some categories of medical specialists and diagnostic tests in governmental health centres serve as push factors for public servants to go to private clinics.

The study investigated the Kaduna State Cost Recovery Scheme introduced in governmental health centres in1987. The cost recovery scheme policy was introduced as a result of the economic crisis in the health sector. The scheme is aimed at generating revenue for further recycling particularly to sustain drugs supply, equipment, diagnostic facilities in the hospitals. Furthermore, this was to make health services accessible to all

the citizens for those who could afford to pay for the services. The respondents were asked to indicate their awareness of the cost recovery schemes introduced by the Kaduna State Government Health Centres. Their responses show that only 33.6 per cent were aware, while the rest claimed not to have any knowledge of the scheme. This ignorance was further confirmed by the Director of Medical Services of the Kaduna State Ministry of Health. He said that there was no official government circular on the matter to the Kaduna State Public Servants.

For those public servant (n=68) who were aware of the cost recovery scheme, 33.8 per cent indicated that they heard it from hospital staff, 20.6 per cent, from government statement, 17.7 per cent, from radio, and 11.8 per cent, from newspapers. Of the 68 respondents who claim awareness of the recovery schemes, 60.2 per cent indicated that government was justified for the introduction of the schemes, while 42.3 did not see any justification for such scheme. Table 4.11 shows the reasons for the support of the scheme.

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TABLE 4.11 Respondents' Reasons for Supporting the Introduction of Cost Recovery Scheme in Government Health Centres in Kaduna Metropolis.

REASON	FREQUENCY	PERCENTAGES
1. To Ensure availability of Drugs	5	12.1
2. High cost of health services	6	14.6
3. To provide high quality health services	7	17.1
4. Government alone can not cope with increasing demand of medical services	9	22.0
5. Services are cheaper	7	17.1
6. Generate revenue	2	4.9
7. Others	5	12.2
TOTAL	41	100.0

Most of the respondents who indicated support for the introduction of the Cost Recovery Scheme are health and medical personnel working in the various governmental health centres and also as health managers in the state ministry of health headquarters. The health sector personnel are very well informed about the importance of the cost recovery scheme and hence their support for the scheme.They have been made to understand that the government alone cannot cope with the increasing demands for medical services and that the scheme is to help generate the necessary revenue needed for the provision of adequate medical services. Some view this as an opportunity for the local pharmaceutical and medical industries to boost their skills and productivity to meet

local demands.

However, a majority of the respondents who object to the introduction of the cost recovery scheme are the non-health staff from other ministries, boards and local governments. They decried the poor handling of the scheme, and the meagre incomes of public servants, from which they are to pay for medical treatment. Some felt that government has enough financial resources to provide free medical services and therefore there is no justification for the schemes.

The respondents were also asked to express their opinion about the cost of obtaining medical services in Kaduna metropolis. Their responses are depicted in Table 4.12.

TABLE 4.12 Cost of Medical Services in Kaduna Metropolis

OPTION	FREQUENCY	PERCENTAGE
Cost of medical services are too high	193	82.1
Cost of medical services are fairly high	27	11.5
Cost of medical services are moderate	12	5.1
Cost of medical services are low	2	0.9
Cost of medical services are very low	1	0.4
TOTAL	235	100.0

Missing cases = 10 (Did not answer this question)

It is evidently clear from Table 4.12 that the majority of the respondents 193 (82.1 per cent) consider the cost of obtaining medical services to be too high. However senior ministry officials opined that the medical services are still cheaper in governmental

health centres. Further analysis shows that of the 193 respondents who indicated that the cost of medical services are too high are made up of 62 (32.1 per cent) junior staff, 106 (54.9 per cent) middle cadre and 25 (23.0per cent) are senior staff. Both junior, middle and senior staff across board indicate that the cost of medical services are too high.

It was established from drug stores and medical practitioners that the average costs of complete treatment for common illnesses such as malaria and typhoid fever in an approved health centre is N350 for malaria and N750 for typhoid fever in the absence of complications. This covers cards, fees, consultation, laboratory investigations and drugs. From the cost presented here the salaries and real income of most public servants cannot cater for their health needs even for common illnesses. It therefore, means that some of the respondents and their respective dependents suffer from ailments that are either inadequately treated or not treated at all vis-à-vis the meagre incomes of the respondents.

4.3.2 Health Coping Behaviours of Public Servants

This sub - section centres on the coping behaviours of public servants occasioned by their inability to acquire adequate medical services. The respondents were asked to indicate whether they utilized medical services whenever health problems arose to which 96.7 per cent responded in the affirmative.

The respondents were then asked to specify the diseases they consider threatening enough for which medical attention must be they sought. Their responses are tabulated in table 4.13.

TABLE 4.13. Diseases Considered Threatening Enough to Seek Medical Help by Respondents.

HEALTH PROBLEM	FREQUENCY* Out of 245	PERCENTAGES
1. Malaria	80	32.7
2. Typhoid Fever	80	32.7
3. Hypertension/ B/Pressure	70	28.6
4. T.B	64	26.1
5. Diabetes	62	25.3
6. Cholera	60	24.5
7. Surgical Operation	59	23.3
8. C.S Miningitis	57	21.2
9. Measles	57	21.2
10. Delivery/Gynea Cases 11. Cancer Diseases	51	20.8
12. Sight problems	51	20.8
13. Sickle Cells Anemia	48	19.6
14. Liver Problems	46	18.8
15. Heart Problems	44	17.9
16. Psychiatric Problems	44	17.9
17. Pneumonia	44	17.9
18. Stomach Ulcer	43	17.5
	55	22.4

**The respondents were required to list all illnesses for which they feel medical assistance must be sought.*

From the list of the health problems given by the respondents, ailments like malaria, typhoid fever, T.B, cholera and diabetes ranked top. These are the diseases among others that often affect the respondents, and should they occur they will feel threatened and seek medical assistance. The respondents were further asked to state where they seek medical help for diseases listed in Table 4.13 if and when they occur. Table 4.14 shows the responses.

TABLE 4.14 Sources Where Respondents Said They Would Seek for Medical Services When Diseases listed in Table 4.13 Occur.

INSTITUTION	FREQUENCY, N=237	PERCENTAGE
Government Hospital/Clinic	231	97.5
Private Hospital/Clinic	178	75.1
Private drug store	81	34.2
Drug hawkers	70	29.5
Friends and relations	68	28.1
Others (Spiritual prayer Traditional healing etc)	222	93.7
TOTAL		100.0

Missing cases = 8 (Did not answer this question)

**The respondents were required to list medical centres where they sought medical assistance is between 1986 and 1996.*

Table 4.14 shows that most respondents indicated that they seek assistance from more than one source for medical care. This is largely due to various different reasons like finance, beliefs, taste and preferences. However, a majority of the respondents (97.5 per cent) patronize government health institutions when they have health problems. This high patronage of governmental health centres is largely because consultation is still free in government owned health centres, but medication is paid for. Sometimes patients get prescription and buy elsewhere. A substantial proportion also patronize private health centres, others patronize drug stores and drug hawkers, and a few take solace in their relations and friends most of whom are medical staff who assist them with drugs. The table also reveals that a large proportion of respondents apart from patronizing modern

medical services also seek alternative means such as prayers, traditional means and self-medication when they do not acquire modern medical care.

In follow-up interviews with some respondents, it was revealed that in some cases respondents obtained prescriptions from health centres for the purchase of drugs and wait for salaries to be paid to buy the drugs. In spite of this some of them are unable to acquire the complete dosage for treatment. Referrals to other health institutions are similarly delayed or not followed up at all.

In this study the relationship between the salary grade level of public servants and the place of seeking medical treatment was analysed as indicated in Table 4.15.

TABLE 4.15: Salary Grade Level and Place for Seeking Medical Treatment

GRADE LEVEL	PLACE OF SEEKING MEDICAL TREATMENT			
	Govt. Hospital/ Clinic	Private Hospital/ Clinic	Other alternative sources	TOTALS N %
01 – 06	41 (47.1%)	19 (21.8%)	27 (21.1%)	87 100
07 – 12	80 (70.2%)	18 (15.8%)	16 (14.0%)	114 100
13 – 16	19 (52.8%)	12 (33.3%)	5(13.9%)	36 100
TOTALS	140 (50.1%)	49 (20.6%)	48 (20.3%)	237 100

Missing values = 8 (Did not answer this question)

$X^2 = 42$, df = 4, Significant 0.05 level.

Although all categories of public servants seek medical treatment from the same

sources, the chi-squire test in Table 4.15 indicates, that there is significant difference in the places of health seeking for public servants across the various salary grade levels. In a follow- up interview some senior public servants reported that they have better access to facilities in governmental health centres where they get better treatment in terms of reception, care during hospitalization which junior public servants do not enjoy. A glaring example is the preferential treatment accorded senior public servants in the New General Hospital Kaduna. While senior public servants are hospitalized in amenity wards with facilities like air conditioners, mosquito screens, private rooms, special diet, special attention, noise control mechanisms etc, the junior public servants are accommodated with other patients in the general wards which are usually overcrowded and lack the aforementioned amenities. In privately owned health centres however, such discriminatory practices are not prevalent. Where wards contain better facilities access to them is based on the patient's ability to pay for services required. Therefore, since both government and private health centres now charge fees, junior public servants prefer to patronize privately owned health centres where they are not discriminated against.

Some of the junior staff with whom in-depth interviews were held complained about the conduct of medical personnel in governmental health centres. They said that the nurses in particular are often hostile to patients. The general complaints about doctors is their engagements in private practice which makes it difficult for them to pay proper attention to patients. It was said that that in some cases, before doctors respond to their call duty, the patients would have had serious complication and died. Another dimension of general complaints is that doctors divert patients to their private clinics and diagnostic

centres where patients are exploited for economic gains. The respondents further complained that health staff in government health centres hawk drugs secretly to patients thus often blocking them from having access to governmental drugs which may be more genuine and cheaper.

The respondents who indicated that they were utilizing alternative sources of medical assistance were asked to state such alternative sources. The responses are presented in Table 4.16.

TABLE 4.16 Alternative Sources of Treatment Consequent Upon Non- Acquisition of Modern Medical Services

OPTION	FREQUENCY	PERCENTAGE
Prayers	120+	54.1
Traditional Healing Homes	58	26.1
Others (Self Medication)	28	12.6
Do Nothing	16	7.2
TOTALS	222	100.0

Missing cases = 23 (Did not answer this question)

Table 4.16 contains those respondents, who apart from utilizing modern medical services of any sort also acquire additional/alternative means of treatment. The results presented show that a large proportion of the respondents (54.1 per cent) rely on spiritual healing through prayers. This is followed by the patronage of traditional healing homes, 26.1 per cent; 12.6 per cent practise self-medication while 7.2 per cent resign to fate. The respondents who practise self-medication cut across the three cadres of the public servants.

It is noteworthy that a considerable proportion, 54 per cent of the respondents believe that their health needs could be taken care of through prayers alone or take medicine and still pray for the medicine to be effective for healing their illnesses. Those who practice self medication (12.6 per cent) said they usually buy drugs based on previous prescriptions for similar symptoms. In some instances even the cost of card and transportation scare many patients from patronizing modern medical centres. In follow -up interviews, it was revealed that occasionally some public servants resort to making appeals in electronic and print media, religious and tribal organizations for financial assistance to cater for their medical needs. Some public servants indicated that in some instances they have sold some of their personal property to obtain money for treating an illness in the family.

An analysis of the relationship between salary grade levels and the patronage of alternative means of medical treatment shows that public servants across board seek alternative means of treatment. However, a close look at the analysis shows that more public servants at lower and middle level of the salary grade levels (GL 01 - 12) patronize alternative means of treatment than the senior levels (see Table 4.17).

TABLE 4.17: Salary Grade Level and Patronage of Alternative Means of Treatment

Grade Level	Alternative Means of Treatment On Non Acquisition of Medical Care				
	Prayers	Traditional Healing Homes	Self Medication	Resigning to fate	TOTALS
01 – 06	33(54.1%)	22(36.1%)	1(1.6%)	5(8.2%)	61(100%)
07 – 12	35(39.3%)	26(29.2%)	12(13.5%)	10(18.0%)	89(100%)
13 – 16	7(41.2%)	6(35.3%)	3(17.6%)	1(5.9%)	17(100%)
TOTALS	75	44	5	16	177

**Missing cases = 45 (Some respondents did not indicate their GL and Alternative means of treatment)*

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Table 4.17 shows that there is generally a high patronage of alternative medical care by all categories of public servants although the middle cadre (53.3 per cent) and lower cadres (36.5 per cent) constitute the majority, while the upper cadre accounts for only 10.2 per cent. This is because alternative medicine is cheaper, readily available, affordable and devoid of cumbersome procedures to obtain.

The relationship between salary grade level and patronage of alternative means of treatment is also replicated when the relationship between real annual income and patronage of alternative means of treatment was analysed in Table 4.18. What this mean is that income is one of the main determinants of health in societies with a formal economic system.

4.18: Annual Income and Type of Alternative Means of Treatment Sought.

ANNUAL INCOME	TYPE OF ALTERNATIVE TREATMENT SOUGHT				
	Prayers	Traditional Healing Homes	Self-Medication	Resigning to fate	N=100%
N10,000 or less	18(48.6%)	14(37.8%)	4(10.8%)	4(10.8%)	37(100%)
N10,001 - 30,000	72(53.2%)	35(25.9%)	15(11.1%)	13(9.6%)	135(100%)
N30,001+	11(26.8%)	22(53.7%)	6(14.6%)	2(4.9%)	41(100%)

Another dimension of coping revealed by the respondents during the group interviews is that, the public servants have become more conscious of taking preventive measures for their health. This can be seen in the acceptance and practice of immunization, family planning and the baby friendly programme (i.e exclusive breast feeding of children for first six months of life). In fact, some of the female discussants who had prior to this period, not adopted family planning on religious and cultural grounds admitted that the impacts of the changing economic and subsequent changes in health policies have made them adopt family planning. The principles of exclusive breast feeding became a relief measure to some respondents because of the high costs of artificial baby food products.

4.4 CONCLUSION

The main findings presented in this chapter are that the costs of medication have risen too high for public servants in Kaduna and that they have difficulties in collecting refunds for expenses on health services such provision exist. Consequent upon this, many

public servants have resorted to alternative means of treatment as coping strategies to meet the shortfalls in acquisition of modern medical services.

It is important to state the shortfalls in medical supply for public servants is largely caused by the impact of induced changing health policies as result of changes in economic policies in the country. In other words, the state of the Nigerian health services and their distribution to the Nigerian public servants are influenced by the Nigerian political economy.

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CHAPTER FIVE

THE LIVING CONDITIONS OF PUBLIC SERVANTS

In this chapter, the living conditions, which for this thesis include housing, feeding patterns, transportation to place of work and other basic routine needs are analysed. For the purpose of this thesis, these variables also serve as indices for measuring the state of health of public servants.

5.1 Housing Conditions of Public Servants

Among the social services, shelter ranks very high in the policies of most governments in both the developed and developing nations. The respondents were asked to state whether they are tenants, squatters (i.e being accommodated by other people) or landlords. Table 5.1 shows the responses.

TABLE 5.1: Residential Status of Respondent

RESIDENTIAL STATUS	FREQUENCY	PERCENTAGE
Squatters (Accommodated by a relation or a friend)	23	9.8
Tenant (Privately rented accommodation)	131	56.0
Occupying government quarters	43	18.4
Landlord (personal House)	37	15.8
TOTAL	234	100.0

Missing cases = 11{Did not answer this question)

From Table 5.1, it can be seen that 56 per cent of the public servants are tenants occupying privately rented accommodation while 18.4 per cent occupy government quarters which are also paid for. Table 5.1 also shows that 9.8 per cent of the respondents are squatters. Squatters are people, who, because they are unable to rent private accommodation mostly due to financial constraints are accommodated by either relations or friends. A further analysis of the squatters shows that 15 (65.2 per cent) belong to the junior cadre, 5 (21.7 per cent) are in the middle cadre, while 3 (13.1 per cent) belong to the senior cadre.

The respondents were asked to state the number of people living with them as members of their household and the number of rooms in the houses they occupy irrespective of the type of house(flat, low-cost, compound etc). The responses indicate that the average number of occupants per bed room is 4 (four) persons. This is higher than the average allowable public health standard of 2(two) persons per standard bed room. The respondents' residential locations were also analysed. The analysis shows that the residence are spread all over the various sections of Kaduna metropolis, although a majority of them 183 (74.8 per cent)are living in the satellite and suburb sections like Television Village, Kurmin Gwari, Nassarawa etc, sixty - two (25.2 per cent) are living in the central area of the Kaduna metropolis, like Doka, Unguwa Rimi and Malali GRA, Gabasawa etc.

The findings of this research also indicate that 133 (55 per cent) have changed place of residence between 1986 and 1996 for various reasons as shown in Table 5.2

TABLE 5.2. Reasons for Change of Residence Between 1986 and 1996

REASONS	FREQUENCY	PERCENTAGE
Transfer from former station	54	40.6
New Appointment	9	6.8
High Cost of Tenancy	10	7.5
Need for Spacious Accommodation	17	12.7
Security Reasons	7	5.3
Poor Sanitary Conditions	3	2.3
To occupy a Personal House	8	6.0
Others (Ejection etc)	25	18.8
TOTAL	133	100.0

Missing cases = 112 (46.0%) (Have not changed Residence)

It is evident from Table 5.2 that most of the public servants have changed residence as a result of transfers. Nonetheless, other reasons such as high cost of rent, ejection and the need for more spacious accommodation were advanced. The change of residence from one rented accommodation to another has negative impact on public servants' meagre incomes. This appears most often in cases of transfers. The affected people are often required to pay rentals in advance for a year or two whereas they might have been paying on monthly basis in their former places of residence and those who are unable to pay are forced to squat. Furthermore, change of residence destabilizes families especially in respect of having to change schools for children and acquiring

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accommodation in slums with poor sanitary conditions in addition to being far away from the working place.

Some advantages are however experienced by those who change residence. The respondents were asked to state the advantages gained and inconveniences encountered as a result of the change of residence. Table 5.3 presents the advantages gained.

TABLE 5.3 Advantages Gained at New Residence by Those Who Changed House

ADVANTAGE	FREQUENCY	PERCENTAGE
Privacy/Convenience or comfort	72	55.0
More spacious accommodation	11	8.4
Peace	11	8.4
Security	10	7.6
Better Sanitary Condition	6	4.6
Electricity Supply	8	6.1
Water supply	5	3.8
Others	8	6.1
TOTAL	131	100.0

**A respondent could list more than one advantages*

In Table 5.3, it is evident that one of the outstanding advantages gained as in change of residence is privacy and convenience. Others include, spacious accommodation, peace, utility supplies and better sanitary conditions.

These stated advantages can be inferred to mean a certain degree of psychological satisfaction and comfort which are positive indices for good state of health. Similarly, the issue of overcrowding in some households is removed. However, there are in

conveniences as indicated in Table 5.4.

ABLE 5.4 Inconveniences Encountered by Respondents Because of Change of Residence

INCONVENIENCES	N=175	PERCENTAGE
Loss of better house /higher cost of tenancy	103	58.9
Loss of security	7	4.0
High cost of transportation to work	10	5.7
Loss of spacious accommodation	6	3.4
Poor sanitary conditions	12	6.9
Loss of good friends	25	14.2
Others (Changes of schools for children)	12	6.9
TOTAL	175	100.0

**A respondent could list more than one inconveniences that is why 133 respondents listed 175 in conveniences.*

Table 5.4 reveals that some of the respondents have encountered certain inconveniences as a result of the change of residence which include, loss of better housing, good friends, spacious accommodation, incurring higher cost of transportation, loss of good house at former location and higher cost of tenancy at new location, poor security etc. It is observed that high cost of transportation, loss of good spacious accommodation, loss of accommodation at former residence and high cost of tenancy at present location affect the public servants comfort.

Poor sanitary conditions at new locations have also been ranked high by the respondents. A typical unsanitary condition of a residential area in Kaduna suburb is like

Kurmin Gwari, Kakuri, Nasarawa, Kawo, Television, etc characterized by stagnant, muddy and dirty ponds and poor drainage. It is also characterized by indiscriminate disposal of liquid and solid wastes causing aesthetic and health problems. Such areas are breeding places for insects that cause diseases as observed in the course carrying out the research.

Due to the inflationary trends, in response to economic policies and measures, the charges for rent are very high. From the market survey conducted in 1996 involving estate agents, landlords and tenants, average rent for various categories of accommodation range from N3,600 – N80,000 per annum. The pre-SAP and post- SAP rates are presented in Table 5.5 for assorted house types in Kaduna.

TABLE 5.5: Mean Price List of Assorted Accommodation Units Based on Market Survey, 1996

Accommodation Type	Price Before SAP (Per Annum)	Price during SAP (Per annum)
Single Room	N960 - 1,200	3600 – 6000
Two Bed Room Flat	3600 – 5000	20,000 - 30,000
Three Bed Room Flat	7000 - 15,000	35,000 - 50,000
Four Bed Room Flat	10,000 - 20,000	50,000 - 80,000

The annual rent cost is far above most of the respondents' real annual incomes.

The rent subsidy given to public servants cannot match the tenancy cost. This is clearly evident from the responses in Table 5.6 where 50 per cent of the respondents indicated that rent subsidy is much lower than the actual amount paid as rent.

TABLE 5.6: Comparism of Rent Subsidy Paid to Public Servants With Actual Amount Paid For Rent Subsidy.

ASSESSMENT OF RENT SUBSIDY	FREQUENCY	PERCENTAGE
The rent subsidy is much higher than actual amount paid for rent	30	17.2
The rent subsidy is a little higher than actual amount paid for rent	20	1.5
The rent subsidy is about the same as actual amount paid for rent	21	12.1
The rent subsidy is a little lower than actual amount Paid for rent	16	9.2
The rent subsidy is much lower than actual amount paid for rent	87	50.0
TOTALS	174	100.0

Missing cases = 71 (Did not answer this question) includes those who do not rent)

Of the 30 respondents who indicated adequacy of rent subsidy 24(80.0 per cent) are middle and senior staff from Kaduna Polytechnic and from the Ministry of Health who are on an Enhanced Special Salary Structure (EUSS) their rent subsidies are far higher than the unified salary grade level operated in the mainstream civil service because some special professional allowances which are paid to other public servants.

For the 43 respondents who earlier indicated that they live in government quarters, (83.7

per cent) of them said they prefer their present occupation of government quarters to the payment of rent subsidy, while only 7 respondents (16.3 per cent) prefer the contrary. These seven are those occupying poorly maintained government quarters.

The respondents' attitudes about government official houses and rent subsidy are shown in Table 5.7

TABLE 5.7: Attitudes of Public Servants to the provision of Houses Instead of Rent subsidy

OPTION	FREQUENCY	PERCENTAGE
Very acceptable	139	60.2
Acceptable	46	20.0
Don't care either way	31	13.4
Unacceptable	8	3.4
Very Unacceptable	7	3.0
TOTALS	231	*100.0*

Missing cases = 14 (Did not answer this question)

In fact, data in Table 5.7 further substantiate the preference for government accommodation as it would be acceptable to 80.2 per cent of the respondents if government decided to provide accommodation and cancel rent subsidy. It is mostly the landlords who do not care either way as established during follow-up interviews.

Based on Kaduna State Ministry of Establishment's circular in 1995 on review of salaries and allowances, the rent subsidy for public officers ranges from N3,000 to N5,544 per annum for' GL 01-06, N8,700 to N21,576 for officers on GL 07 to 12 and N13,704 to N25,152 for officers on GL 13 to 16. These are illustrative of the meagre nature of rent subsidy compared with actual amount paid for renting houses (See table 5.5).

An examination of the physical conditions of the houses was made by asking the respondents to orally describe in terms of water supply, toilet facilities, drainage and access roads.

The results, showed that 198 (80.5 per cent) of the respondents have pipe borne water. However, 48 (19.5 per cent) of the respondents have only well water. The purity and quality of well water cannot be guaranteed and therefore, respondents who have such a facility could be more prone to water borne diseases. Most respondents enjoy pipe-borne water because most sections of the Kaduna metropolis have been linked with water pipe lines. For those who are utilizing well water it is discovered that most of them are living in the outskirts of Kaduna such as Nariya, Gonigora, Rafin Guza, Kurmin Gwari, Kakuri etc which are urban slums.

In terms of drainage, the analysis shows that 52.8 per cent of the respondents do not have good drainage facilities. Stagnant pools of water from bathrooms, kitchens and rain water are common sights as personally observed in areas like in Television Village, Nasarawa, Kurmin Gwari and Mekera Kakuri, Kawo etc.. Pit latrines are very common. These can affect water supply for those using wells. They also facilitate the breeding of insect borne diseases.

For the usage of toilet facilities in particular, the analysis shows that a majority of the respondents, 55.5 per cent use pit latrines. Some of the latrines are so much exposed that the wastes could leak into some wells and stagnant drainage. Pit latrines are breeding sites for flies which in turn contaminate foods and result in various illnesses like typhoid fever, cholera, hepatitis, enteric fevers, etc. A case in point is the outbreak of

cholera in 1996 in some parts of Kaduna town like Nasarawa, Kakuri, and Television Village during which 14 (5.7 per cent) public servants were among those affected (as retrieved from certified hospitals medical records in the Nasarawa General Hospital, Kaduna).

It was also discovered in the course of the study that 129 (60.6 per cent) respondents had dustbins, while the remaining 39.4 per cent did not have. In some of these environmentally poor areas, solid wastes are indiscriminately disposed of which create serious health problems to the inhabitants of the area.

5.2 Feeding Patterns of Public Servants

Among the basic needs of the human being, food ranks very high. Human beings nutritionally balanced foods to maintain good health. Poor food intake may result in under-nourishment and malnutrition with concomitant starvation, lowered resistance to infection, ill - health and premature death. The calorie shortfalls among under - fed and malnourished people are always high. The productivity of such undernourished and malnourished workers in terms of working years is grossly affected because of death.

The respondents were asked to state whether they and their families have regular and sufficient meals or not. The findings show that a large number of the respondents 184 (75.1 per cent) said they cannot afford three meals per day for their respective families. The general reason given for irregular meals is the economic predicament in the SAP period. The foregoing of meals is a coping strategy adopted by the public servants in view of economic realities. The relationship between level of income and the forgoing of various meals is presented in Table 5.8.

Table 5.8: Real Annual Income and Forgoing of Meals

Range of Real Annual Income	Forgoing of Some Meals		
	Yes	No	Total =N=
=N=10,000 or less (GL 01 – 06)	64 (88.0%)	9 (12.0%)	73 (100%)
=N= 10,001- 30,000 (GL 07 – 12)	77 (79.0%)	21 (21.0%)	98 (100%)
=N=30,0001 + (GL 13 – 17)	17 (57.0%)	13 (43.0%0	30 (100%)
TOTALS	158 (79.0%)	43 (221.0%)	201 (100%)

Missing cases 44 respondents (Did not indicate forgoing of meals).
X^2 *= 6 df = 2 Significant at 0.05 level*

Although all categories of public servants forgo some meals because they cannot afford three square meals a day. The data in Table 5.8 indicate that the level of real income of the public servants determines the incidence of forging of meals. The lower the real income of public servants, the higher the likelihood for their families to forego certain meals because of non-availability of food

Some of the respondents were asked during follow-up interviews to state what actually happen in situations where meals were forcely skipped. Some of the respondents asserted that lack of regular meals by their families have affected the performances of their children in school activities. Furthermore, such situations according to the respondents, have led to social vices like occasional stealing and pilfering of household property by their children in order to secure food. The data further shows that 67 (36.4 per cent) of the respondents of 35 years of age or older further stated that most of them have

developed stomach ulcers. Virtually all interviewees said that they suffer from psychological distress for inability to cater adequately for their families. Some respondents mostly the junior officers have also had to absent themselves from office while others have left office in search for food which resulted in queries and disciplinary measures. Some respondents revealed that in order to avoid irregular taking of meals, they buy food items on credit and accumulate debts pending the payment of their monthly salaries. The debts are even sometime more than the expected salary.

Apart from foregoing some meals most of the meals taken are substantially carbohydrates. In some cases there are variations. The reasons for the high consumption of carbohydrate foods are because carbohydrates foods are relatively cheaper than the high protein foods. In view of their meagre incomes, public servants resort to these cheaper foods even though these are less nutritious. Some respondents expressed dissatisfaction with the kind of food they eat. For instance, some claimed that they cannot afford protein foods, such as meat, fish, palm oil, and basic ingredients to improve the nutrients and flavour of their food.

Table 5.9 shows the most frequent types of food taken for breakfast by the respondents.

TABLE 5.9: Most Frequent Types of Food Taken For Breakfast By Respondents at the Time of Investigation

TYPE OF FOOD	FREQUENCY	PERCENTAGES
1. Tea only	26	10.6
2. Tea with bread	15	6.2
3. Papa/Akamu cake	66	26.9
4. Pap with bean cake	33	13.5
5. Rice and Beans	55	22.4
6. Fresh Tuwo/ Gari	6	2.4
7. Left over food	33	13.4
8. Others (Snacks and Vegetables)	11	5.3
TOTALS	245	100.0

From Table 5.9, the public servant's breakfast is most often made up of pap, with bean cake and previous days' food. These foods are relatively cheaper than tea, milk with bread. A sizeable number eat heavy foods like rice, beans, "gari", and "tuwo" and left over foods for breakfast. In standard dietary planning this is a deviation from the normal menu schedule for healthy growth. Breakfast menu should compose of fluid diets like beverages, milk, egg, fruits, sugar and bread.

Table 5.10 indicates the types of food usually taken for lunch by respondents as at the time of investigation.

TABLE 5.10 Most Frequent Types of Food Taken For Lunch by Respondnets as at the Time of Investigation

TYPE OF FOOD	FREQUENCY	PERCENTAGES
1. Tuwo/Gari	38	21.5
2. Rice and Beans	51	28.8
3. Moi-Moi	2	1.1
4.Yam Only	15	8.5
5. Beans Only	10	5.7
6. Rice Only	22	12.4
7. Gari Only	9	5.0
8. Pounded Yam	16	9.0
9. Others (Snacks vegetables	14	7.9
TOTALS	177	100.0

Missing cases = 68 (Did not answer this question because some forego meals)

From Table 5.10 most foods eaten as lunch are rice and beans, "tuwo" "gari" and rice, without meat and vegetables.

Table 5.11 shows the most frequent types of food taken for dinner by the respondents.

TABLE 5.11 Most Frequent Types of Food Taken For Dinner by Respondents as at the Time of Investigation

TYPE OF FOOD	FREQUENCY	PERCENTAGES
1. Tuwo	143	77.3
2. Yam	4	2.2
3. Rice	11	6.0
4. Pounded Yam	8	4.3
5. Beans	6	3.2
6. Gari	12	6.5
7. Others (Snacks and vegetables	1	0.5
TOTALS	185	100.0

Missing cases = 60 (Did not answer this question because some forego meals}

It can be seen in Tables 5.10 and 5.11 that items on menu for lunch and dinner are almost the same and that "tuwo" is significantly dominant for dinner. In concluding this section, it should be emphasized that the majority of the public servants do not take regular meals and that their meals are mostly made up of carbohydrate foods. Proteineous food are rarely taken.

5.3 Public Servants' Welfare

In Nigeria, some of the existing welfare schemes available to public servants include the following; medical care, meals and rent subsidies, and ; housing, transport, children's education, furniture and entertainment and personal effects (clothing) allowance(s) for higher public servants. For the purpose of this study some welfare schemes like medical care, meals, transport, housing and personal effects (Clothing rain coats, drivers' and messengers' uniform, booths etc) were considered crucial and were

subjects of investigations.

The respondents were asked to rank these welfare schemes, in order of preference as it affects them. The results are presented in Table 5.12 below.

TABLE 5.12 Welfare Assistance Preferred by Public Servants: First Choice Only Indicated

WELFARE	FIRST PRIORITY	PERCENTAGE
Feeding (Food) Allowance	82	33.7
Accommodation(Staff Quarters)	52	21.2
Transport Allowance	51	21.2
Medical Treatment/ Health Insurance	52	20.5
(Clothing) for Work	8	3.3
TOTAL	245	100.0

From the results, in Table 5.12, there is a high preference for food as first choice while accommodation, transport and health insurance ranked second; third and fourth respectively. The various reasons given by the respondents for their preference for food, include the fact that food is a daily basic need for human survival. Furthermore, because of the meagre income which they earn and coupled with high inflationary trends, their expenditure pattern are largely restricted to the food component to cater for themselves and their families. The present meal subsidies is too meagre to make any meaningful contribution to the food budget. Based on a Kaduna State Establishment circular in 1995 on review of salaries and allowances, the flat meal subsidy for all public officers irrespective of rank is N528.00 per annum. A further breakdown shows that the meal

subsidy is N44.00 per month and N1.45 per day. This is abysmally too meagre to secure a plate of food, even at a "bukateriat".(i.e is a road side popular eating place where meals are cheaper in comparison to standard restaurants).

Table 5.12 also shows that accommodation ranked next to food because shelter is another crucial basic need for workers and their families. Lack of accommodation affects the general well being of workers and in some cases leads to stress and frustration.

The transport component ranked third and this is because the public servants need transportation to their working places and back home. Furthermore, the increasing transport cost during this SAP period made the public servants pay more for transportation. Present transport subsidy is 5 per cent of the average of actual transport costs to and from work.

The medical allowance and health insurance ranked fourth due to the fact that the incidence of illness is not a daily affair in the life of the respondents and their families. But food, accommodation and transportation are daily basic necessities. Nevertheless, some respondents observed that although the incidence of illnesses are occasional, when they occur, a substantial amount of their income and in many cases even more than their incomes is required for medical treatment.

It is clear from Table 5.12 that the respondents have a reasonable preference for the welfare services except personal effects. It therefore, means that government has responsibility to adequately address these issues in order to improve on the general welfare of the public servants.

5.4 CONCLUSION

In this chapter the impact of changing health and economic policies on the living conditions of public servants such as housing,, feeding patterns, and social welfare schemes have been analysed. The findings show that public servants are differently affected in relation to their positions on the salary grade levels in the civil service. Those on lower grades are worse affected. They are more prone to transfers, during which they face difficulties in acquiring accommodation. It is also established that some junior public servants in particular live in unsanitary neighbourhoods. House rents are generally too high and the meagre rent subsidy cannot be sufficient to cater for them.

The findings also revealed that primary diets of most public servants comprise mostly carbohydrates and they forgo meals very often. Consequent upon these, the public servants prefer welfare schemes that centre on food, accommodation and medical services in that order. The findings also indicate that the differential impact of changing economic policies on public servant's feedings affect the junior and middle cadre staff more than the senior staff. Most of these are a reflection of the impact of changing economic policies on the Nigerian public servants; which is a product of a of the capitalist economic framework institutionalized and being perpetuated in Nigeria.

CHAPTER SIX

SUMMARY, DISCUSSION AND RECOMMENDATIONS

6.1 Introduction:

This study has set out to examine the impact of changing health and economic policies on the health and living conditions of public servants in Kaduna metropolis from 1986 to 1996. The summary of the findings is presented below.

6.2 Summary of the findings

The findings show that, most public servants in Kaduna no longer enjoy free medical care (70.7 per cent) because this has been withdrawn. Furthermore, for those who enjoy some form of medical subsidy (11.8 per cent), the amount is =N=500:00 per month and too little to cater for their medical needs. Other findings include the fact that public servants tend to seek medical services in both government (97.5 per cent) for low cadre and private (75.1 per cent for) high cadre. Thus more lower cadre public servants prefer Government owned health centres.

The cost of medical services are too high relative to the public servants' income. Closely related to this is the fact that the cost recovery schemes introduced by various tiers of Government have further compounded the problems of public servants who now pay directly for medical care at point of delivery.

With regards to living conditions, the findings show that, the rent subsidy which ranges from (=N=8,468:00 to =N=17, 424.00 per annum), paid by government to public servants, is not enough to secure good accommodation in areas of good sanitary conditions. Economic conditions have made housing rents very exhorbitant and beyond

the reach of most public servants particularly the middle and juniour public servants. Most of the junior and middle cadre staff are now living in unsanitary environments. This makes them susceptible to water, air and insect borne, communicable diseases.

The difficulties of acquiring adequate accommodation have forced some public servants especially those at the middle and lower levels to be squatters (9.8 per cent) in crowded houses with their attendant negative health implications. What is more, public servants' meals are essentially made up of carbohydrates which fall short of balanced diet. Most public servants (75.1 per cent) mostly of the lower and middle ranks lack regular meals owing to the fact that they cannot afford all meals. Apart from lack of regular meals, most public servants and their families purchase food stuffs on credit pending when salaries are paid.

One of the objectives of this study was to document health coping behaviours devised by public servants to cope with adverse changes. Due to the inability to acquire modern medical services, public servants, 206 (84.1 per cent) from the various salary grade levels and educational attainment seek alternative sources of medication for their health problems. These alternative sources include, prayers, traditional medicine and spiritual healing, and self-medication of various sorts. Those who practise self medical purchase un-prescribed drugs and local herbs which are consumed without medical supervision.

In some other circumstances apart from not buying complete doses of medication, some public servants have to delay the purchase of prescribed drugs until salaries are paid while others rely on friends and relations who assist them with assorted un-prescribed

drugs. The findings, show that some public servants out of absolute want and frustration resign to fate and allow the illness to run a natural course.

Although in most of the areas investigated, the impact of changing health policy on public servant cuts across salary grade levels, the middle and lower public level servants suffer more negative impact than senior public servants. The major areas of differential impact are summarized below.

The findings show that an aggregate of 150 (72.8 per cent) of public servants in the middle and lower cadres lack regular meals, squat, largely patronize alternative means of medication, and live in areas of very low environmental quality. Thus this group is more exposed to health risks than the corresponding figures 95(29.2 per cent) for senior public servants.

This study also examined specific Government health policies and measures in relation to the state of health of public servants and the following findings have emerged. Government in 1987, decided to cancel the policy of free medical services in Government owned health centres and introduced cost recovery schemes. Public servants were not exempted and had to fend for their medical needs at point of delivery. In effect most cannot meet their medical needs.

Nevertheless, the findings show to some degree that, the changing economic and health policies have led to the adoption of positive health habits by public servants, like family planning, availing themselves of immunization, exclusive breastfeeding, family food production and the exploring of sources for extra incomes to improve their financial stands. The respective benefits of the various behavioural measures adopted include

having few children to cater for, prevention of diseases on which money has to be expended for treatment, saving from buying infant formula and increase in income from other economic activities.

6.3 Discussion of the findings

This sub-section discusses the findings of the study. The subject matter of this study emerges from the fact that Kaduna state government withdrew free medical care provided for public servants at the onset of SAP. This is explained by the fact the SAP adjustment policies affected the funding of the health sector and other social services. Apart from this, in order to sustain the health sector and to avoid its total collapse, revenue generating strategies were adopted by government through various cost recovery schemes. These policies partly commercialized the government health centres. It could be argued here that the changing health policies, resorted to measures to generate funds from health services from the Nigerian public, including the public servants whose legitimate incomes are theoretically static (there is a restriction on them to engage in other economic ventures).

Given these circumstances, it can be remarked that most public servants have unmet health needs because their legitimate salaries cannot meet their families medical needs. Going by these findings, it can be generalized that most Nigerians in the middle and lower segments of the economy are incapable of acquiring the necessary medical services for themselves and families. The public servants resorted to various coping behaviours in order to handle their health problems. The findings show that, most public servants now go traditional healers, spiritual healing institutions, divine prayers etc,

because these alternative means of treatment are cheaper, accessible and readily available. They require little or no funding. However, some of these alternative means of treatment are a potential danger to the patients because most of them are not scientifically tested and are not regulated.

Beside this, different dimensions of self-medication have been reported by public servants and this is largely due to inadequate financial resources to pay for care at approved medical health centres. Self-medication has its attendant dangers. A more disturbing coping behaviour is the issue of some public servants, who, failing to acquire modern medical services resign to fate, to allow the illness run a natural course of either recovery deformiy or death. This is an indication of resignation and desperation. It is therefore obvious that economic status affects the acquisition of modern medical services public servants. The higher one's economic status, the higher the likely hood of obtaining *conventional medical care.*

The findings of this study also pointed to the fact that most public servants are not provided with housing accommodation and this has forced many of them to live in environmentally hazardous areas, injurious to health. This is explained by the fact that government is unable to provide accommodation due to lean financial resources and expanding demands on government to meet up various tasks. What is more, rent subsidy provided to public servants is grossly inadequate to cater for their accommodation needs. This situation has further led public servants particularly at the middle and lower cadres to become squatters. Under normal economic conditions, no public servant should be a squatter except temporarily during cases of transfer and fresh appointments. Squatting

results in over-crowding, restrictions and fast spread of epidemic and other communicable diseases. Most public servants in Kaduna metropolis therefore live under environmentally poor conditions which exposes them to the danger of communicable diseases and epidemics capable of jeopardizing their health. A case in focus is the outbreak of cholera in 1996 in some parts of Kaduna slums like Nassarawa, Kakuri, Television village where some of the junior public servants reside. According to medical records at the Gwamna Awan General Hospital, Nassarawa, 14 of those affected by the cholera epidemic were public servants.

In addition to the unsanitary conditions there is poor food intake by junior and middle cadre public servants in particular. This is simply because their incomes are too low to acquire adequate food in contrast to their better paid senior counterparts. The state of health of low income groups in Nigeria whose incomes were already over stretched by the inflation which accompanied the economic crisis and SAP were more adversely affected by the new health policies than the higher socio- economic groups, the positive effects of family planning breastfeeding and innovations at income generation schemes not withstanding.

At the onset, the political economic perspective was adopted as a theoretical framework for this study. It is assumed that the capitalist mode of production in Nigeria determines largely the performance of the health sector and the distribution of health services to various groups including Nigeria's public servants. In Nigeria, Government is the main employer of labour and government determines who gets what. In other words, the wages, rewards, benefits and privileges, health and welfare schemes which

accrue to the workers are determined by Government. The workers on the other hand only sell their labour power to government with little or no contribution to decision making on their conditions of services. In this light, some public servants have no choice but to remain on the low paying jobs.

The relationship between the government and its employees is therefore that of dominance / subservience as seen in government's unilateral withdrawal of free medical care for public servants. As observed by Waitzkin,1983, Turshen,1977, Lewis, 1953 the causes and treatment of diseases, distribution and acquisition of health services are largely ideological, political and economic rather than bio-medical. This position is also held by Navarro (1976), Ake (1981) Alubo,(1995), who see the poor econmic and material conditions in which people live in Nigeria and their concomitant deprivations as major causes of morbidity and mortality.

This study has revealed increasing difficulties in the acquisition of medical services by public servants due the withdrawal of free medical services by their employer. Ensuing inflationary trends lowered the financial capacity of juniour public servants in particular to obtain medical services. Those who could not afford modern medical treatment either sought alternative means of treatment in the traditional sector, spiritual healing or adopted one form of self - medication or the other including resigning oneself to fate.

The findings of this study are similar to that of Russell and Gibson (1997) in which they established that the introduction of cost recovery schemes like user fees in twenty six low- and middle –income countries(e.g in Cameroon ,Ghana, Egypt, Iran, Chile,

Mexico, Bangladesh, Nepal, Thailand Fiji etc) in the face of increasing economic difficulties, led to very low utilization of medical services because patients could not afford high operational costs. Similarly Ejembi and Bandipo (1989), report that the Ahmadu Ballo University Teaching Hospital (ABUTH) experienced a drastic reduction in the utilization of medical services when it introduced user fee charges during Nigerian economic crisis.

The provision of medical services on the capitalist principles of profit making in Nigeria puts the civil servant at a particular disadvantage. First of all, the public servants' salaries are fixed and they are restricted in engaging in private practice to augment their income. To crown it all, there is a limit to which civil servants can demand for improvements in their conditions of service in the face of a large number of unemployed, if less experience citizens, who are willing to take up the jobs. In fact, in most instances it is government which either decides to displace, retire, terminate, retrench or replace labour at its discretion as reported by Schram (1981), Navarro (1976), Oculi (1981) and Ake (1981), an example of such is the recent mass retrenchment of public servants tagged "rationalization" in Nigeria.

The aggregate position of this study, based on the findings, is that, the quality of life of various classes of public servants in Kaduna is generally poor. The measures adopted by government, meal and rent subsidies are too meagre to make a significant impact on food and housing needs respectively. This has made public servants adopt unorthodox means of meeting their medical, housing and nutritional needs. Government on the other hand, has not paid any special attention to these crucial needs. This means

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that government may be more interested in the public servants' labour power and accords less priority to their welfare. This action of government is akin to capitalist practices where labour is perceived as an instrument to have tasks performed while the welfare of the instrument is of little or no consequence if it can be conveniently replaced. In Nigeria there are many unemployed people to fill vacancies especially at the lower levels in which case government often takes, advantage of the circumstance to neglect the welfare of its employees because they can be replaced at will.

6.4 Recommendations

Based on the findings of this study, the following recommendations are made to address the welfare of public servants in Kaduna.

(1) The government should rescind its decision on the withdrawal of free medical treatment for public servants particularly in governmental health centres or in the alternative, a realistic health insurance scheme should be provided for all public servants.

(2) Government should explore the possibility of either providing quarters (government owned or rented) for all public servants, or, in the alternative provide an enhanced rent subsidy to enable public servants acquire descent accommodation.

(3) Government should assist public servants through mortgage housing loans to acquire personal housing accommodation for use while on active service and after retirement from service.

(4) Government should either set up commodity food stores or provide soft

agricultural loans for basic subsistence agriculture aimed at ensuring a stable food supply for public servants.

In conclusion, it should be noted that although the recommendations are specifically for public servants other Nigerian citizens can benefit from the findings and recommendations.

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APPENDIX – I

QUESTIONAIRE SCHEDULE

Respondent No .....

Place .....

Date .....

Time .....

QUESTIONAIRE ON THE "THE IMPACT OF CHANGING HEALTH POLICY ON NIGERIAN WORKERS: A CASE STUDY OF KADUNA METROPOLIS.

Introduction

The purpose of this questionnaire is to help ascertain the effects of the Nigerian economic crisis and government adjustment policies on the health of the working class, particularly public servants. The information sought is purely for academic exercise and consumption. Confidential treatment of the information supplied is assured. To fully guarantee anonymity of respondents, identity is not required.

Your anticipated cooperation is kindly acknowledged.

KASU M. IBRAHIM LIBRARY

Thank you immensely.

Kajang, D. R.

Department of Sociology

A.B.U. Zaria

July, 1999

SECTION ONE

Background Characteristics

1. Place of Work:
   a. Ministry .....
   b. Parastatals/Board .....
   c. Local Government .....
2. Occupation or job title of worker .....
3. Sex:
   a. Male .....
   b. Female .....
4. Age .....
5. Marital Status .....
   a. Single .....
   b. Married .....
   c. Divorced .....
   d. Separated .....
   e. Widowed .....
   f. Unwed Mother .....
   g. Unwed father .....
6. If married male
   Number of wives .....
7. Total number of people currently living in your house .....

8. What is your highest level of formal educational attainment?
   a. No formal education .....
   b. Quaranic education only .....
   c. Primary education .....
   d. Post – Primary/Secondary .....
   e. Polytechnic .....
   f. University .....
   g. Other .....

SECTION TWO

Employment and Income

9. How long have you been working in this establishment ?
..... years/Months

10. What is your Grade Level (GL) or Salary scale ?
.....

11. Do you have other sources of income apart from salary ?
Yes ..... No.....

12. If your answer to QII is yes, state these other sources of extra income ?
.....
.....

13 When did you start doing the supplementary work for earning extra income ?
.....

13. Adding any extra income you may earn, and or subtracting any loans you may be repaying which of the following most accurately reflects your annual income ? Tick as appropriate :-

Less than	-	#10,000.00 .....
#10,000.00	-	#20,000.00 .....
#21,000.00	-	#30,000.00 .....
#31,000.00	-	#40,000.00 .....
#41,000.00	-	#50,000,00 .....
#51,000.00	-	#60,000.00 .....
#61,000.00	-	#70,000.00 .....
#71,000.00	-	#80,000.00 .....
#81,000.00	-	#90,000.00 .....
#91,000.00		and above .....

15a. How many members of your household apart from you are employed ?
.....

15b. If some of your household members are employed how much per annum do they contribute to the up keep of the household ? .....

15c. How many potentially employable members of your household are unemployed?
.....

16. How would you classify yourself ? Tick as appropriate.
(a) A poor worker .....
(b) A middle class worker .....
(c) A wealthy or rich worker .....

17. Why do you classify yourself this way ?
.....
.....

SECTION THREE

Medical and Health Services

18. Which of the following health services does your establishment provide? Tick as appropriate :-
    a. Free medical care .....
    b. Payment of medical allowance .....
    c. Credit facilities for medical care .....
    d. Other specify .....
    e. None .....
19. If your employer provides medical allowance, how much are you paid monthly? .....
20. How adequate is the amount provided by your employer?
    (a) Very adequate .....
    (b) Just adequate .....
    (c) Inadequate .....
    (d) Grossly inadequate .....

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21. Specify the health problems for which you believe it is necessary to seek medical assistance
    (1) ..... (2) ..... (3) .....
    (4)..... (5) ..... (6) .....
22. Do you utilize medical services whenever problems in Q21 arise ?
    Yes ..... No ..... Never .....
23. Where do you and your family members most often go for treatment when sick?
    (a) Government Hospital/Clinic .....
    (b) Private Hospital/Clinic .....
    (c) Private Drugs Stores .....
    (d) Drug Hawkers .....
    (e) Friends/Relatives .....
    (f) Others Specify .....
24. Which of the following best reflects the way you seek treatment since 1986 ? Tick as appropriate :-
    (a) Relying more on modern than traditional medicine .....
    (b) Relying more on traditional than modern medicine .....
    (c) Reliance on spiritual or divine healing through prayer .....
    (d) Receiving treatment simultaneously from orthodox doctors, traditional healers and spiritualist .....
    (e) Self medication .....
    (f) Other specify .....
25. If you are unable to acquire modern medical services as regularly as you need such services how do you cope with your health problems ?.
    (a) Utilizing spiritual healing centres such as

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(i) Churches .....
(ii) Mosques .....
(iii) Shrines .....

(b) Utilizing traditional healing homes .....
(c) Do nothing .....
(d) Others specify .....

26. In which of the following Health Centres do you receive more prompt attention when you go for medical care?

		Yes	No
(a)	Government Health Centre	.....	.....
(b)	Private Health Centres	.....	.....

27. Are you aware of the cost recovery scheme introduced in the Government Health Centres ? Yes ..... No .....

28. If yes, mention the source of information .....
.....
.....
.....

29. If the answer to question 28 is yes do you feel Government is right in introducing this scheme ? Yes ..... No.....

30. Give reasons for your answer to question 29
.....

31. Which of the following statements are true reflections of your views: relative to your income:

(a)	Cost of medical services are too high	.....	.....
(b)	Cost of medical services are fairly high	.....	.....
(c)	Cost of medical services are moderate	.....	.....
(d)	Cost of medical services are very low	.....	.....

32. What is your own general assessment of the following aspect of medical facilities/services in governmental health centres in Kaduna State these days ? Tick as appropriate for each item.

Medical services **Degree of Adequacy**

		V. Adequate	Adequate	Inadequate	G. Inadequate
(a)	Availability of Doctors	----------	----------	----------	----------
(b)	Availability of Nurses	----------	----------	----------	----------
(c)	Availability of Equipment	----------	----------	----------	----------
(d)	Prescription	----------	----------	----------	----------
(e)	Facilities for admission For in – patients	----------	----------	----------	----------
(f)	Out – patient facilities	----------	----------	----------	----------
(g)	Availability of Drugs	----------	----------	----------	----------
(h)	Treatment/Medication	----------	----------	----------	----------
(i)	Follow – up/ check- ups	----------	----------	----------	----------
(j)	Referral to better/higher Health centres	----------	----------	----------	----------
(k)	Behaviour of medical personnel	----------	----------	----------	----------
(i)	Prompt attention	----------	----------	----------	----------

33. How do you assess the Human relation of the Medical personnel? Tick as appropriate

(a) Very good .....
(b) Good .....
(c) Fair .....
(d) Poor .....
(e) Very poor .....

SECTION FOUR

Living conditions.

34. In which section of Kaduna town are you residing now?
.....

35. When did you start living there ? .....

36. What is your residence status in your present home?
    (a) Squatter (Leaving with Relation or Friend) .....
    (b) Tenant .....
    (c) Landlord .....

37. Have you changed place of residence between 1986 to 1996 ?
    Yes ..... No .....

38. If yes, state places you moved from/and to:
    (a) From ..... to .....Year .....
    (b) From ..... to ..... Year .....
    (c) From ..... to ..... Year .....
    (d) From ..... to ..... Year .....

39. State why you have moved .....
.....
.....

40 If you have changed residence between 1986 – 1996 what type of house were you residing in before movement?
    Type (a) Compound ..... (b) Flat ..... (c) Low cost .....
    No. of rooms .....
    No. of occupants .....

41. What type of house do you live in now ?
    Type (a) Compound .....(b)Flat .....(c) Low cost .....
    No. of rooms .....
    No. of occupants .....

42. State the privileges/conveniences you gained at your new residence .....
.....

43. State the inconveniences incurred because of your change of residence
:.....
.....
.

44. If your organization decides to cancel housing allowance and provides houses instead how will you feel ?
    (a) Very happy indeed .....
    (b) Happy .....
    (c) Sad .....
    (d) Very sad .....
    (e) Don't care either way .....

45. Which of the following statements is true about rent subsidy paid to you and the amount you pay for rent if you are a tenant ? Tick as appropriate.

(a) The rent subsidy is much higher than actual amount paid for rent .....
(b) The rent subsidy is a little higher than the amount paid for rent .....
(c) The rent subsidy is about the same as amount paid for rent .....
(d) The rent subsidy is a little lower than the amount paid for rent .....
(e) The rent subsidy is much lower than the amount paid for rent .....

46. State below if you have the following facilities in your residence.

	Facilities	**Yes**	**No**
(a)	Water system toilet	----------	----------
(b)	Pit latrine	----------	----------
(c)	Bathroom	----------	----------
(d)	Pipe borne water	----------	----------
(e)	Well water	----------	----------
(f)	Electricity supply	----------	----------
(g)	Adequate room spaces	----------	----------
(h)	Physical state of house Still in good repair	----------	----------
(i)	Ever working drainage	----------	----------
(j)	Dustbin	----------	----------
(k)	Good access road to house	----------	----------

47. Assuming the government intends to render assistance to civil servants in the following areas, indicate in order of priority 1 to 5 the degree of attention you want the government to pay to the following welfare schemes. (Where 1 = most important 2 = quite important 3 = just important 4 = less important and 5 = least important).

Type of welfare Assistance	Rank order Importance
Transport	.....
Feeding (Food)	.....
Medical (Health Insurance)	.....
Accommodation	.....
Personal effect (Clothing etc)	.....

48a. What do you usually take for break fast ? .....

(b) What do you usually take for lunch ? .....

(d) What do you usually take for dinner ? .....

49. Do you or any other of your family ever forego some meals ? If yes; How often ? .....; Why ?.....

.....

.....

.....

50. How regularly do take the following type of food ?

Type of food	Frequency			
	Daily	Once a week	Sometimes	Not at all
Milk	.....	.....	.....	.....
Meat or Egg	.....	.....	.....	.....
Beans	.....	.....	.....	.....
Grains	.....	.....	.....	.....
Bread	.....	.....	.....	.....
Vegetable	.....	.....	.....	.....

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APPENDIX II

Department of Sociology,
Ahmadu Bello University,
Zaria.

July, 1996

.....

.....

Dear Sir/Madam,

INTERVIEW SCHEDULE FOR HEALTH MANAGERS.

I am presently conducting a research on the topic: "THE IMPACT OF CHANGING HEALTH POLICY ON NIGERIAN WORKERS: ACASE STUDY OF KADUNA METROPOLIS"; as part of the requirements for award of MSc Degree in Sociology of the Ahmadu Bello University, Zaria.

2. In view of the above, I hereby request you to grant me an official interview on a date and time suitable to you.

3. Before the interview date, it will be important for you to consider providing the researcher information in the following areas:

   (a) What has been the basic health policies of the Kaduna State Government for Public Servants since the introduction of SAP in 1986?

(b) What was the rationale for the introduction of cost recovery scheme (i.e the DRF, payment for all services except consultation fee etc) in the Government Health Centres in Kaduna State?

(c) Were the Public Servants informed of the cost recovery scheme (e.g DRF, payment for Laboratory Investigations ect). If Yes, how were they informed and what was their reaction? If No, what informed the decision not to inform them?

(d) Most Public Servants hold the view that cost of medical services is too high in governmental health centres in Kaduna, what is your view about this?

(e) What will you say about the proliferation of drugs stores, private clinics and quackery in the state ?

(f) Despite the introduction of the cost recovery scheme particularly the Drug Revolving Fund Scheme in Governmental Health Centres we are still faced with the problem of out of stock (O/S) syndrome on drugs and even diagnostic materials particularly in the laboratories and X-Ray units etc, what do you think is responsible for this?

(g) In what areas would you like to see improvements with regard to the curative and preventive health programmes run by the Ministry of Health for the welfare of the people in Kaduna State particularly civil servants.

(h) Suggest possible solutions to Public Servants' health problems in the state civil service in terms of medical allowances, health credit scheme, free medical care etc.

4. Your response will enhance the success of this research.

Yours Faithfully,

Kajang, D.R.

(Researcher)

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