IMPACT OF DEMOCRATIC GOVERNANCE ON SERVICE DELIVERY IN KATSINA AND BINDAWA LOCAL GOVERNMENT AREAS OF KATSINA STATE

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MARCH, 2018

DECLARATION

I declare that the work in this dissertation entitled "*Impact of Democratic Governance on Service Delivery in Katsina and Bindawa Local Government Areas of Katsina State"* has been carried out by me in the Department of Public Administration. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation was previously presented for another degree or diploma at this or any other institution.

Shehu SANI

Name of student	**signature**	**Date**

CERTIFICATION

This dissertation entitled IMPACT OF DEMOCRATIC GOVERNANCE ON SERVICE DELIVERY IN KATSINA AND BINDAWA LOCAL GOVERNMENT AREAS OF KATSINA STATE by shehu SANI meets the regulations governing the award of the degree of Master of Science in Public Administration of the Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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Dedication

This Dissertation Is Dedicated To My Elder Brother Alh. Ibrahim Sani Doro

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ABSTRACT

This study examines the impact of democratic governance on service delivery in Katsina State: with a focus on Katsina and Bindawa Local government from 2011 to 2016. The problem investigated is that; in spite of the institutional framework for efficient service delivery at both the state and local government levels; over 8 billion naira was spent on primary health care, water supply and basic education with the aim of boosting service delivery in the study area, some health facilities cannot operate for 24 hours, there is increased maternal mortality ratio, prevalence of malaria and other related diseases, shortage of portable drinking water. The story is almost the same in the basic education sector; as there are no adequate teachers, infrastructure and insignificant increased in the enrolment, retention and completion of basic education circle. The main objective of the study is to determine the impact of democratic governance on primary health care, basic education and portable drinking water in Katsina and Bindawa Local Government Areas. Data were generated from both primary and secondary sources. The instruments of the primary data used were questionnaire, interview and observation. While the secondary sources made use of project completion documents, financial records, files, staff inventory, laboratory and pharmacy record, medical records, store receipt and issued vouchers. Questionnaires were distributed to the sample of 362 respondents selected from the population of the study through a stratified purposive and simple random sampling. Regression analyses were used in testing the hypotheses. The findings reveals that there is inadequate manpower in basic education and primary health care sector, that there is increased maternal mortality rate, malaria and other related diseases, there is insignificant increase in the enrolment, retention and completion of basic education circle . There is also shortage of portable drinking water in Bindawa Local Government which is not an issue in

Katsina Local Government. It was recommended among other things that, there should be urgent and adequate provision of manpower in both primary healthcare and basic education, consistent creation of awareness for parents to send their children to schools and women for maternal care service and more provision for adequate sources of portable drinking water in Bindawa Local Government.

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LIST OF ABBREVIATIONS

ANC – Antenatal Care

CBDs – Community Based Organizations

CDAs – Community Development Associations

CGS – Conditional Grant Scheme

CHC – Comprehensive Health Centre

CHEW – Community Health Extension Workers

CHO – Community Health Officer.

DCU – Disease Control Unit

DFID – Department for International Development

DHC – District Health Committee

DRF – Drugs Revolving Funds

DSA – Dental Surgery Assistant.

DST – Dental Surgery Technician

DV – Dependent Variable

E.C – Executive Chairman

E.S – Education Secretary

ECCDE – Early Childhood Care Development Education

EHA – Environmental Health Assistant

EHO – Environmental Health Officers.

EHT – Environmental Health Technician

FFF – Family planning, food supplementation and female education

FMC - Federal Medical Centre

FMS – Free Medicare Scheme

GOBI – Growth Oral-rehydration, Breath feeding and Immunization

I.V – Independent Variable

JCHEW – Junior Community Health Extension Workers

KSPHCDA – Katsina State Primary Health Care Development Agency

KSUBEB – Katsina State Universal Basic Education

LGEA – Local Government Education Authority

LGSC – Local Government Service Commission

M and E – Monitoring and Evaluation.

MCHC – Material and child health clinic

MCHC2 - Maternal and child health care 2

MDG – Millennium Development Goals

MFLG – Ministry for Local Government

MOH – Ministry of Health

MP – Malaria Parasite

NCE – National Certificate of Education

NGOs – Non-governmental Organizations

NPHCDA – National Primary Health Care Development Agency

ORT – Oral Rehydration Therapy

PHC – Primary Health Care

PHCD – Primary Health Care Department

POE – Point of Entry

POU – Point of Use

PTA – Parents Teachers Association

RUWASA- Rural/Urban Water and Sanitation Authority.

SBMC – School Based Management Committee

SPHCDA – State Primary Health Care Development Agency

TRCN – Teachers Registration Council of Nigeria

UBE – Universal Basic Education

UNDP – United Nations Development Programme

UNESCO – United Nations Education Scientific and Cultural Organization

UNICEF – United Nations International Children Emergency funds

USAID – United State Agency for International Development

WATSAN- Water and Sanitation.

WASH—Water Sanitation and Health

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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

The post 1945 period has seen a very great extension of democratic government. Virtually most countries are now a democratic States. A high proportion of poorer countries in Asia, Eastern Europe, Africa and Latin America are also democracies although some clearly are not. Although, the downfall of soviet communism has not democratized the entire world, it has led to a significant increase in the number of democratic systems. Since the end of the cold war and subsequent re-emergence of the new world order, there was a significant resurgence of democratic government. This development is best due to hegemonic emergence of liberal democracy as the final human government.

Democracy as a system of government is now becoming a house hold name in Africa and Nigeria in particular. This is because, many African countries are now becoming democratic and indeed a republic, contrary to militarization of governmental structures in most of the African states particularly 60s to 90s (Madu *et'al* 2015). Perhaps this is as a result of its perceiving principle which is said to be the government that represents peoples' interest; that is the government of the people by the people and for the people. Nigeria is one of these countries that practices democracy and this was successfully enthroned in May 29, 1999; which ushered in the Fourth Republic. Since the return to democracy in May 1999, after almost three decades of military rule, the country has been faced with the complex challenges of national reconciliation, national reconstruction, socio-economic development and economic reform, and democratic consolidation. Even after holding the post transition elections (i.e. 2003, 2007, 2011 and

2015), Nigeria continues to grapple with these challenges and the citizenry is still anxious to enjoy the benefits of "democracy dividends" – adequate primary health care service, water spply, basic education and equal access to resources and power.

Besides the high hope that democracy would engender a democratic future in Katsina State, the optimism was also predicated on the rationalization that democracy stimulates development through adequate provision of goods and services. Such arguments constitute the central thesis of liberal democratic scholars (Olson 1993, Simbine 2000, in Suraj 2016) for these scholars democratic governance is the key link in the chain. This has been viewed as synonymous with sound "development management". The reasoning here seems to suggest that without democratic government being institutionalized, neither democracy nor development could be expected to take firm roots and last long.

Today, all societies seeks to organize and consolidate processes and structures that can ensure the greatest happiness of the society through adequate provision of goods and services and can by extension aggregate the diverse interest of the strata of the population in the process of development and consolidating development gains. No doubt, it is this drive that gave rise to movement to put in place the political administrative system that will best fast track this noble objective in Nigeria. A system that would allow for adequate provision of basic essentials of lives based on the demands and aspirations of the people, not only at the federal level but also at the grassroots, equal access to such resources and bridging all forms of inequalities, freedom, rule of law, participation, periodic election, competition and contestation among and between different interests. This political system is democracy. No doubt, democratic governance

is inevitably prerequisite to the overall development of national communities. To provide legal provision for the existence of democratic governance in Nigeria, section 1(2), of the 1999 constitution of the federal republic of nigeria states that; the federal republic of Nigeria shall not be governed, nor shall any person or group of persons take control of the government of Nigeria or any part there of, except in accordance with the provisions of this constitution. Section 14(1) also added that, the federal republic of Nigeria shall be a state base on the principles of democracy and social justice.

Democratic governance involves avenues for leadership through periodic election and provision of goods and services responsive and responsible to the people wishes. These values are closely associated with socio–economic development. Adequate provision of goods and services paves away for peace that is mostly needed for survival of democratic government; while service delivery in terms of education, water supply and health remains an essential attributes of a sovereign state in which the citizen are given the opportunities to pursue their safety and happiness.

To achieve better service delivery there is need for adequacy in the provision and distribution of goods and services (education, water supply and health) at the grassroots level in a country like Nigeria, Democratic governance is required at both three levels to facilitate such strategic and paramount role. The federal government is expected to provide institutional framework at the centre (NPHCDA, UBEC MWR) that provides logistics and other support. The state governments are to have SPHCDA, SUBEB and RUWASA for provision, supervision and regulation of basic education, primary health care and water supply. The local government being a government at the grass root which is closest to the people is expected to enhance the achievement of basic, protective, and

infrastructural facilities better than the federal government. This can be achieved through PHCD, WATSAN and LGEA at the local government level.

In the context of Katsina, and Bindawa Local Government areas of Katsina state, democratic governance exist with elected local government council representing the yearnings and aspirations of their constituencies. The local government through LGEA, PHCD, WATSAN and social welfare services department engage in the provision of basic education, water supply and primary health care, to mention but a few all in the art of meeting better service delivery. However, the issue is that, the provision of such services is one thing and their impact to the lives of the people is another thing.

Stemming from the foregoing, the work is aimed at studying democratic governance (at both State and local government level) and how it has impacted on the delivery of goods and services (education, water supply and health) taking Katsina and Bindawa Local Government Areas of Katsina State as a study area.

1.2 Statement of the Research Problem

Democratic Governance has installed development in Western Europe through its competition, contestation and participation. Diamond, (2009) believed that, the development in western society cannot be exonerated from the democratic governance that is functional in the area.

In Katsina State, Democratic Governance in the State has invested huge amount of resources with sole aim of improving the lives of the people. Between 2005 to 2009, the State Government established State Universal Basic Education Board (SUBEB), Rural Water Supply and Sanitation Authority (RUWASA) and State Primary Health Care Development Agency (SPHCDA) to ensure qualitative basic education, adequate portable

drinking water and sound primary health care services. These state agencies are working together with Local Government Education Authorities (LGEA), WATSAN and Primary Health Care Department at the Local Governments level. In addition to that institutional framework, between 2008 to 2011, about ₦4 billion has been spent in Katsina and Bindawa Local Government Areas with the aim of enhancing primary health care services, water supply and basic education (Sani, 2012). Moreover ₦4.3 billion was also spent on basic education, water supply and primary health care in Katsina and Bindawa Local Governments (Magaji 2015). Also about 25 primary health facilities were built in Katsina and Bindawa Local Government Areas. Between 2010 to 2015 many schools were built and renovated in the study area, and various training programmes were carried out all in the art of improving primary health care, water supply and basic education. There are also about 378 boreholes, 95 solar system and 414 other sources of water supply established by democratic governance in Katsina and Bindawa Local Government Areas of Katsina State, between 2011 to 2016. Moreover, the state and local governments has also spent over 612, 513, 345 for the maintenance of sources of portable drinking water between 2011 to 2016 (Magaji 2015, Saved the children 2015 Sani 2012 and Maigari 2015).

Inspite of all efforts by Democratic Governance to promote service delivery in Katsina and Bindawa Local Government Areas of Katsina State, empirical evidences, records and experiences showed that maternal mortality rate is still on the increase from 27% in 2011 to 36% in 2016, malaria and other related deseases are prevalent, some primary health centers are under staffed which make it impossible to run the facilities for 24 hours. Some staff are not qualified enough to use some tools in the health facilities

and some people have no access to health facility, some clinics have no laboratories and essential drugs are inadequate, if they exist at all (Katsina State Pprimary Health Care Development Agency, 2016). Maternal mortality ratio, child mortality ratio and less than five years mortality ratio has also been increasing (National Health Information System, 2016). The situation is almost the same in Basic Education sector, as many people have no access to primary schools, class rooms and furniture are in a bad condition, some classes have no blackboard, some students are receiving lessons under the shade of the tree, teaching aids are also inadequate and first aid drugs/tools are not even known in some schools. There is also assuming inadequate manpower in the schools and some of the available ones are not qualified enough to teach. The quality of primary education is assumed to be low and the enrolment, retention, transition and completion is also low (Maigari, 2015, Saved the Children, 2015, UNICEF, 2015). There is also total shortage of portable drinking water. Some communities have to travel for over 4 kilometers before they access water for domestic use. There is also the problem of drinking contaminated water that spreads cholera and other related deseases. Some pupils can not go to school due to the fact that they have to spend atleast 3 hours on the que before they fetch water for their parents (Save the children 2015, UNICEF 2015 and Maigari 2015).

Against this backdrop, the study seeks to find answers to the following questions

1.3 Research Questions

In view of the research problem identified above, the following were addressed in the course of this research.

i. What is the impact of democratic governance in the provision of primary health care services in Katsina and Bindawa local government areas?

ii. What is the impact of democratic governance in the provision of basic education in Katsina and Bindawa Local Government Areas?

iii. What is the impact of Democratic Governance in the provision of portable drinking water in Katsina and Bindawa Local Government Areas?

1.4 Objectives of the Study

The main objective of this study is to assess the impact of democratic governance on service delivery in Katsina and Bindawa Local Government Areas Katsina State. Specifically the study seeks to;

a. determine the impact of democratic governance in the provision of primary health care services in Katsina and Bindawa Local Government Areas.

b. determine the impact of democratic governance in the provision of basic education in Katsina and Bindawa Local Government Areas.

c. determine the impact of Democratic Governance in the provision of portable drinking water in Katsina and Biindawa Local Government Areas.

1.5 Hypotheses

The study based on the following hypotheses which are to be tested at the end of the research work:

1 HO1. There is no significant relationship between democratic governance and provision of primary health care services in Katsina and Bindawa Local Government Areas.

2 HO2. There is no significant relationship between democratic governance and provision of basic education in Katsina and Bindawa Local Government Areas.

3 HO3. There is no significant relationship between democratic governance and provision of portable drinking water in Katsina and Bindawa Local Government Areas.

1.6 Significance of the study

Studies conducted on democratic governance, service delivery and socio – economic development emphasizes more on the nexus of democracy and development. Some studies are meant to measure how democratic government has provided physical infrastructures which are essential for service delivery. The work of Yale 2012, Brama 2015, Desmond 2014, and Jamo 2013 can be an example. Others worked on democracy and development at state and National levels but unable to study democratic governance and its impact on service delivery at local government (grassroot) level. The work of Sani 2012, Suraj 2016, Nura 2015 and Jerome 2015 can also be an example. None of these works cover the areas of service delivery in respect to basic education, water resources and primary healthcare in the two study areas. It is in this light that this study seeks to bring to a limelight about the gap left by above researches as it attempts to assess the impact of democratic governance on service delivery through investigating the primary health care, water supply and basic education services delivery provided by democratic governance and their impact on the life of the people of Katsina and Bindawa Local Government Areas. The research also explores on nexus of democratic governance and service delivery by looking at Basic education, water supply and primary health care services at the grass root level, beyond the theoretical exploration. The research also exposes the impacts of health, water and education services provided by democratic governance on whether the services are beneficial to the people. By so doing, the research

adds to the literatue on the theory and provides another platform for further researches on democratic governance beyond the study area.

It further provides solutions to the problem of democratic governance which could be used to improve the quality of democratic governance, not only in the study areas but in the entire nation. It also useful in creating understanding about what democratic governance requires to achieving meaningful socio-economic development through better service delivery.

At the end, the study serves as a point of reference to the leaders of public institutions, in the federal, state and local governments respectively. It is also a worthwhile endeavor and beneficial to wide ranging beneficiaries such as politicians, organized labor groups, nongovernmental organizations (NGOs), self help/community development associations, scholars and students of administration, management and political science.

1.7 Scope and limitations of the Study

The research assesses the impact of democratic governance on service delivery in Katsina and Bindawa Local Government Areas of Katsina State. Katsina Local government was chosen as the urban local Government. This was based on the availability of infrastructure and commercial activities in the area. Bindawa local government was chosen as rural local government.

Service delivery on water supply, primary health care and Basic education were also chosen as integral part of socio-economic development. Emphasis was on public health facilities in terms of the adequacy of the facilities and manpower, laboratory services, maternal care services and provision of essential drugs. Although basic

education covers adult literacy and other special forms of education like Nomadic, Islamiyya/Quranic and special education, our focus was on primary education that affects majority of the population. As such emphasis was on public primary schools in terms of adequacy of the schools, manpower, classrooms, furniture and instructional materials. Water supply will be measured based on adequacy of the sources of drinking water, functioning of the sources of water, access to portable drinking water and adequacy of funds for treatment/mentenance of the sources of portable drinking water.

The study covers the period of six years i.e. 2011-2016. The choice of the period was necessitated by the fact that there was transition between the period and such transition involves different leaders and different political parties (Governor Ibrahim Shema of PDP 2011 to 2015 and Governor Aminu Bello Masari of APC 2015 date).

As part of the limitations, many of the respondents for focus group interview were public servants and thus reluctant to honour our interview because of the tight schedules and often fear of being implicated or accused of licking official information. Also the study is constrained by lack of access to data in the ministry for local government, department for budget and planning in the state, financial data in the L.G.E.As, financial data in the ministry of finance. There is also lack of access to some data on funds in the RUWASA. All efforts made to get such data in these organizations are abortive. However, the researcher followed other ways through backyard and accesses some data. Again, the study is constrained by a number of factors such as absence of official statistics on the health status and indicators of local communities in Katsina state.

1.8 Operational Definition of Concepts

Democracy; Democracy is operationally defined as the elected government of the people by the people and for the people that provides goods and services to the people at State and local government level.

Democratic governance; For the purpose of this work democratic governance is operationally defined as the government under civilian administration that provides goods and services responsive to the people wishes within the comfined of state and of local government.

Education service delivery: Primary education involves adequate provision of schools, furnitures, classrooms, qualitative and quantitative teachers, availability of instructional materials (teaching materials), and access to primary schools, enrolment, retention and completion.

Health Service Delivery: Health services involves adequate provision of health facilities, adequacy of health workers, availability of essential drugs, quality of health workers, adequacy of laboratory facilities, maternal care services and access to health facilities.

Portable Water supply: this involves adequate sources of drinking water, functioning of the sources, access to the sources, and funding for treatment/mentenance.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAME WORK

2.1 Introduction

This section will dwell on the literature review, empirical work and theoretical frame work. In the process, concept of democracy, origin and features of democracy were discussed. Concept of government, Democratic government, measurements and its tenets were also explored. Service delivery in terms of primary health, water supply and basic education were also discussed. Empirical studies related to the research will also be reviewed. Localism theory and democratic developmentalist state theory were employed as the theoretical framework.

2.2 Literature Review

2.2.1 Concept of Democracy

Democracy as a form of political organization, like other concepts of its caliber has not been easy to define without ideological equivocation. This makes democracy by Shafritz (1988) look like beauty, which is in the eyes of the beholder. The concept of democracy therefore, on its own has generated a lot of controversies, analytical disputations, ideological and philosophical camps.

This notwithstanding however, from a concrete perusal of the books that have been writen on it by scholars of repute, it is clear without equivocation that the word democracy has a Greek ancestry and had its first appearance in the fifth century B.C. The Greek historian, Herodotus had coined the word. Democratic ideas in antiquity combined two Greek words, "demo", meaning people and "Kratein" meaning ‘the rule of or by’. According to Dodo (2016) democracy is a people oriented government. This is because it has been defined by Abraham Lincoln as “Government of the people” (i.e the people are

involved in it), “for the people” (i.e it has the interest of the people and is run on behalf of the people) and “by the people” (i.e through the representatives of the people notably the legislatures).

Thus, the original meaning of democracy was the "rule of (by) the people" (Akindele, 1987, Enemuo, 1999, Mahajan, 2012 & Arora, 2014 in Sani 2016). At this time, Herodotus included among its specific features, "equality before the law and popular deliberations". Greek discussion of democracy was followed by Rome's contribution to democratic ideas and government in antiquity. The hallmark of this contribution was Rome's development of the "idea of constitutionalism" and her emphasis on laws as the system of norms binding on both the "rulers" and "ruled" (Akindele, 1987).

Drawing inspiration from this, democracy literally means the rule by the people. The idea of the people rule is thus, becoming imperative in any conceptualization of democracy (Owolabi, 1992 in Sani 2016). Although, literature established it that Greece was a stratified community whereby women, foreigners and slaves, who outnumbered the adult male citizens are disfranchised. Meanwhile, with the larger populations of contemporary nations, it is impossible to operate the type of direct democracy that obtained in Athens. The difficulty of transforming direct democracy into the complexity of modern world has made imperative to adopt its meaning. This eventually led to the adoption of indirect (representative government).

Representative democracy has been variously defined. In his book, Democracy, Burns (1935) in Magaji (2015) defined representative democracy as a system whereby " all (i.e. people) elected a few to do for them what they could not do together". On the

same token, John Stuart Mill concentrated a significant portion of his writing on representative democracy. While accepting the desirability of equal participation by everybody in the affairs of the government, he nevertheless claims that, it cannot be realized. Instead, he argued that representative government is the perfect form of government (Mill, 1962). But, he further argued that, for representative government to be democratic, it must be accompanied by universal adult suffrage, free elections, short terms of office and individual liberty. Without these things, any government will, in Mill's view, cease to be democratic.

According to Eric (1993) in Suraj (2016) democracy is perhaps the most "promiscuous" word in the world of public affairs. A term that can mean anything to anyone is in danger of losing its real value or original meaning (Andrew, 2002). However, democracy may be described as a system of government where the people exercise the governing power either directly or indirectly through representative periodically elected by them (Appadorai, 1974 in Gambo 2016). This definition implies that a state may be termed democratic if it provides institution for the expression and, in the final analysis, the supremacy of the popular will on basic questions of social direction and policy. However, the simple notion of the rule by the people does not and will not get us very far unless we understand the meaning of the people as defined in the original Greek. The Greek originally viewed the people to mean the poor, disadvantaged, or the many. Democracy is a political system in which all citizens have a right to play role in shaping government action – a mechanism often referred to as popular sovereignty (Shea, Green & Smith, 2009, Wilson & Dilulio, 2008 & Shively, 2012). Nwabuzo (1997) in Gambo (2016) also views democracy to be a political system in which the eligible people

in the society participate actively, not only in determining the mind of the people that govern them, but also participate actively in shaping the policy output of the government. Within this context, the best ideology, system or philosophy means nothing if it does not bring about justice, fair play and prosperity for all. This definition carries the import that democracy is based on the will of the people rather than on the whims of the elite or the few. Within this purview, democracy may be defined as political and economic empowerment of the majority of the ordinary people for effective participation in the decision that affects their lives, their individual and collective rights and the way in which their society is governed (Kwanashie, 2003 in Magaji 2015).

Agitation for democracy, as the best possible system of organizing human society, has become dominant among the social science scholars and political elites globally. Considering the available evidences from advanced democratic nations, democracy has the potential of reducing tension as well as improving citizens' welfare. Attempt to identify good or bad, democracy generates a lot of debates among both promoters and supporters of the system. Democracy by definition has become acceptable vision and mantra of those who struggle for freedom and better ways of life (Idowu, 2008 in Sani 2016). It has become global criteria to determine the kind of relationship that exist among the comity of nations (Omotola, 2008). This development paves way for African countries including Nigeria to embrace democracy with the aim of providing answers to political, economic, social and even cultural crisis which other regimes fail to address.

Historically, democracy is said to originate from the Ancient Athens some hundred years B.C and later adopted in Western Europe following the English Revolution of 1786, American war of revolution [1775-1783], French Revolution of 1789-1799 and

much later through colonial expansion to most of the Third world countries, and Eastern Europe following the collapse of Soviet Union in 1991.

As time goes by, especially after the Second World War, two dominant perspectives on democracy emerged. These are Western liberal democracy and socialist democracy. However, no matter how democracy is understood, interpreted and practiced, it has a generally agreed upon, philosophical justification premised on certain universally cherished human values and ideals. These are: Freedom, equality, and justice (Nnoli, 1986). Nevertheless, there is no single recipe for implementing these values in all societies. For instance, Rousseau in opposition to French monarchy among other obstacles to human freedom maintains that man is born free 'yet everywhere he is in chains (Rousseau, 1963). Locke similarly argued that man is by nature free, equal and independent'(Locke, 1952).

The American Declaration of independence is justified on similar ground:

> *We hold those truths to be self-evident, that all men are created equal, that they are endowed by their creator with certain inalienable rights that among these are life, liberty and pursuit of happiness (in Whisker, 1980:167).*

Democracy is a continuous process and struggle towards the actualization of these values. No country has ever attained the peak of this democratic historical evolution as warrant the Fukuyama End of History thesis (1993). Democracy is therefore, about a system of government which allows people to decide who should govern them through periodic elections and protect their cherished interests. The philosophy of democracy revolves around equality, freedom and justice. From the brief proceeding account, democracy is an ideal, a theory and aspiration partly associated with, or derived from man's perception of his exalted status as the most important creature on earth who has

been able to develop the capacity to exercise a measure of control over nature (even though he too is part of it). Thus, right from the word go, there was a disjuncture between this aspiration towards equality, freedom and justice and the reality on the ground, arising from economic, socio- historical constraints and other human behavioral and institutional imperfections among others. These constraint and imperfections frustrate the realization of democracy as an ideal – a condition and atmosphere perceived. For it, seems to be enmeshed in the dialectic of the alienated and subordinated social elements and forces Vis-a- Vis the privilege dominant social elements and forces. For no society can said to be democratic if large numbers are not involved in the process of government (Hoffman and Graham, 2006).

In Athens for example, and whose democratic experiment provides the social milieu for Aristotle assertion that "man is a political animal", the story of, and journey towards democracy kicked off and commence with the logic of exclusion – the very antithesis of democracy to the extent that it is inconsistent with the values of freedom, equality and justice, a point also made by Dahl in his reference to contemporary democracy (Gambo, 2016).

For if man in the generic sense is a political animal, as Aristotle claims, then, women slaves should have participated in the politics of Athenian society. Yet, they did not and could not because they were not allowed to participate. In short, Athenian democracy, was created by the revolt of organized peasants against the abusive power of an oligarchic elite for the peasants refusal to be submissive to the plutocratic policies that redistributed wealth upward-from the vast majority to the privileged few (Gana, 2005). But worse still, in the neighboring Sparta, democracy could not be imagined given the

numerical superiority of the slaves and the dependence of the economy on their labour power.

In this way, Niectzche (1978) develop his concept of original nihilism by which he mean resistance, through the experience of slaves and their oppression in ancient class societies, an outcome of the heightened sense of suffering caused by political subordination. As he writes: 'for it is the experience of being powerless against men, not against nature, that generates the most desperate embitterment against existence''(Warren, 1988).

This Democratic ideals and inclination is mirrored in the writings and polemics of the philosophers, notably Socrates, Pericles and Aristotle as opposed to Plato, Thrasymachus and Alcibiades among others. An example of the contestation for and against this democratic disposition or impulse can be seen in the writings of Pericles and Plato (both of Athens). Pericles submits that:

> *He who claims your indulgence as having acted for the good of the commonwealth must be shown to possess the spirit of the commonwealth. That spirit is a spirit of compassion for the helpless, and of resistance to the intimidation of the strong and powerful; it does not inspire brutal treatment of the populace and subservience to the potentates of the day (Gana, and Omelle, 2005:65).*

In contrast to this, Plato's disposition is totalitarian to the extent that an individual is stripped of any privacy or personal liberty in almost all matters. In his words:

> *The greatest principle of all is that no body, whether male or female, should be without a leader. Nor should the mind of anybody be habituated to letting him do anything at all on his own initiative; neither out of zeal, nor even playfully. But in war and in the midst of peace to his leader he shall direct his eye and follow him faithfully. And even in the smallest matter he should stand under leadership. For example, he gets up or moves, or washes, or takes his meals…only if he has been told to do so. In a word, he should teach his soul, by long*

habit, never to dream of acting independently, and to become utterly incapable of it (Popper, 1966:125).

Democratic disposition was not just a luxury among Philosophers, rather, it was indeed a movement for a more inclusive, open and representative social and political organization, a point equally made by Dahl (in a related context) when he state that' representative government resulted less from philosophical speculation than from a search for practical solutions to a fairly self-evident problem''(Britannica, 2009).

In most of the Third World, however, democracy is a product of colonialism and as such is conditioned by the exigencies and contradictions of colonialism and in particular the tension between the colonial economy and the self-acclaimed civilization mission of the colonizer. Through colonialism, liberal democracy was supposedly imposed on the colonies (Nigeria inclusive) by the colonial powers. This is in spite of the inherent contradiction of the economic base of liberal democracy – capital and super structural ideals of democracy. By the end of the Cold War this democracy had come to gain an upper hand over its socialist adversary, a period and experience described as the third wave of democratization or the end of history by Fukuyama. But what is this liberal democracy? For Held (1993), liberal democracy in its contemporary form includes, a cluster of rules and institutions permitting the broader participation of the majority of citizens in the selection of representatives who alone can make political decisions. And this cluster includes elected government; free and fair elections in which every citizens vote has an equal weight; a suffrage which embraces all citizens irrespective of distinction of race, religion, class, sex and so on; freedom of conscience, information and expression on all public matters broadly defined; the rights to all adults to oppose their government and stand for office; as well as associational autonomy-the right to form

independent associations including social movements, interest groups and political parties.

On their part, both Dahl and Ball (cited in Anifowose *et'al* 1999) focus on the minimal conditions for existence of liberal democracy. For the former, there must be meaningful and extensive competition among individuals and organized groups for, major position in government; a high inclusive level of political participation in the selection of leaders and policies through regular and fair elections, so that no major adult social group is excluded; and a level of civil political liberties, freedom of expression, press, etc Sufficient enough to ensure the integrity of political competition.

For the latter, liberal democracy is said to exist when there is more than one political party competing for political power; competition of power is open not secretive, and is based on established and accepted forms of procedure; entry and recruitment to positions of political power are relatively open and periodic elections based on universal franchise; Pressure groups are able to operate to influence government decisions; associations such as trade unions and other voluntary organizations are not subject to close government control; civil liberties such as freedom of speech, freedom from arbitrary arrest, are recognized and protected within the political system, and consequently, a substantial amount of independence and freedom from government control of the mass media, i.e. radio, television, newspapers; and some form of separation of powers, i.e. a representative assembly has form of control over the executive, and the judiciary is independent of both the executive and the legislature (it should be noted that what is more crucial and pronounced is not separation of power per se but a form of check and balance among the organs of government). Yet, however liberal democracy is

viewed, it is generally associated with acceptance of the sovereignty of the people (electorate), the supremacy of the law (rule of law), the existence of opposition (official and otherwise), multiparty periodic election, and liberty of the individual and popular participation. Thus, liberal democracy as a political order centered around certain civil and political rights whose existence and safety rest on the supremacy of the law of the land (rule of law) it is important to note that liberal democracy is less emphatic on equality than on freedom (by which it means freedom of the individual).

Historical researches have shown that some of the elements of democracy existed in other civilizations. For instance principles of accountability, consensus building and popular participation were common features of many pre-colonial systems of government in Africa. On this note Ake (1996:112) argued that:

> *Traditional African political systems were infused with democratic values. They were invariably patrimonial and consciousness was communal, everything was everybody's business…. Standards of accountability were even stricter than in Western societies, chiefs were answerable not only for their own actions but for natural catastrophes such as famine, epidemics, floods, and drought. In the event of such disaster's chiefs could be required to go into exile or asked to die.*

Therefore, it can be deduced from the above argument that the principles of democracy have universal relevance and multiple sources. Meanwhile, the failure of democracy few years after independence of most of African States is as result of fear that western countries will use democracy to pursue their economic interests (Enemuo, 1999 in Suraj 2016).

Democracy in a complex system society may be defined as a political system which supplies regular constitutional opportunities for changing the governing officials, and a social mechanism which permits the largest possible part of the population to

influence major decisions by choosing among contenders for political office (Lipset, 1983 in Sani 2012). As a consequence of free competition, political power is assumed to be widely distributed among various groups in democracies (Azeez, 2009 in Dodo 2016). Held (1993) defines democracy as a cluster of rules and institutions permitting the broader participation of the majority of citizens in the selection of representatives who alone can make political decisions. The cluster, according to him, include elected government, free and fair elections in which every citizen's vote has an equal weight, a suffrage which embraces all citizens irrespective of distributions of race, religions, class, sex and so on, freedom conscience, information and expression on all public matters broadly defined, the right to form independent associations including social movements, interest groups and political parties. Thus, it can be deduced that democracy is a system of government that has the potential of protecting and enhancing individual and group rights with the capacity of maximizing political order and socio-economic development (Oche, 2005). On that note these definitions share fundamental objective of "how to govern society in such a way that power actually belongs to all the people" (Osaghae, 1992).

2.2.2 Concept of Government

The root word of government is derived from the word of Latin "gubernare" and the old French word "governer" translated in the English word "govern". It is the state being directed or being acted on which now explains the meanings of government. It generally defined as the supreme authority of the State to formulate, administer and execute the fundamental laws of the land on the basis of the delivery of basic services, economic and social services for the common good and welfare of the society.

The government administration of the state on the supreme and sovereign power to rule with the people depends as to the forms of government being established by certain group of society. The political ruler has its significance in the government who will represent as the head of the state. It has to identify the derived sovereign power as to the administration of human freedom, social justice, liberty and constitutional rights of the people. Finally, the governmental administration of the state depends as to the political adoption on the scope of decentralization, autonomy or devolution along the formulation and the execution of the political decision in the society. Gourley (2010) has defined Government in the following perspectives:

a. It is the exercise of the political power and authority in the management of the affairs of government. The political power and authority defines the specific government activities that public officials must do as directed by their own development thrusts in the quality improvement of the society. The management functions discuss along the preparation of the development plans and agenda, the execution; enactment and the interpretation of the laws; the delivery of social and economic services; and other governmental services for general and common welfare.

b. It is the exercise of the sovereign power of the state to follow the established institutions and laws of the specific group of society. The sovereign power is conceptualize in the state is the enforcement of laws over the defined territory. The established institutions are those created by the government officials based on their political, cultural and economic ideologies that they thought would be the best way to deliver governmental services to the society.

c. It is a political unit governs by laws and customs of the particular group of society. This relates to the term use for government as a "political unit" designed to carry out specific tasks that relate to the laws and customs as the basis to provide development services to the society. This connected to the term political development on basis of governmental affairs of the state.

2.2.2.1 Characteristics/Functions of Government

Perrel (2013), Simpson (2014) and Huth (2010) provide characteristics/Functions of Government as follows;

a. ***Public Institutions****:* Public institutions, the institutions comprising the government of a political society, differ from the other institutions within the society. That is, the public, or governmental, institutions differ from the private institutions-institutions such as private business corporations, labor unions, private schools, religious organizations (except in societies characterized by the union of state and religion), and voluntary clubs and associations. Governmental, or public, institutions differ from private institutions in six ways: (1) the jurisdiction of a government extends to all members of the society, or community, of which it is the agent. (2) The government controls the use of physical force and coercion within the political society. (3) The government, if stable, is characterized by political legitimacy. (4) The decisions of the government are authoritative; (5) the decisions (a) are vested with the authority of the society for and in the name of which they are made and carried out and (b) are binding on all members of the society. (6) Every decision or action of the government is the legitimate concern of the general public.

b. ***Universality of the Government's Reach within Society***: A government, within the borders of its own society, is universal in its reach. That is, the jurisdiction, or authority, of the government extends to all persons and groups within the society. The authority of a private institution existing and operating in the Nigeria, for example, does not extend to all members of Nigerian society.

c. ***The Government's Control of the Use of Physical Force and Co****ercion*: The government reserves to itself a monopoly of control over employment of armed force and violence by the society and its members. The government has the legal right to utilize instruments of physical force and coercion, when deemed necessary, to preserve or restore domestic order or to compel obedience to the official decisions of government. In addition, it has ultimate authority to control and regulate the possession and use of such instruments by private citizens and groups. The government possesses the authority to decide who does and who does not legally go around armed within society. It has the power to decide if- and if so, under what conditions--private citizens shall be allowed to use armed force and violence.

d. ***The Government and Political Legitimacy****:* A stable government in a stable society is characterized by political legitimacy; that is, the government possesses legitimate political authority. The people making up the political believe that the government has the moral as well as the legal right to exercise political power over all subordinate parts of the society. The government is widely perceived by the citizenry to have the legitimate right to make and carry out decisions which apply to and are binding on all members of the society. Within the political society, there is the feeling, widespread and strongly held, that (1) the government itself is legitimate, (2) the office holders in the government

obtained their positions by legitimate means, (3) these government office holders possess legitimate authority to make binding decisions, and (4) the decisions themselves are legitimate and ought to be obeyed. Political legitimacy reflects the underlying consensus within society-the wide spread agreement on matters of fundamental importance to the society-which is indispensable to the long-term existence and operation of the government, including its ability to make and enforce binding decisions for the entire society.

e. ***Authoritative Decision making and Action by the Government****:* The decisions made and carried out by governmental offices and institutions are authoritative. The official decisions made and implemented by government for and in the name of the entire society are authoritative decisions. Governmental decisions are authoritative because they (1) are vested with the authority of the overall society for which they are made and enforced, (2) are binding on all members of the society, and (3) are accepted as binding by the vast majority of the society's members.

Compliance with the government's decisions is not voluntary; compliance is mandatory, or compulsory. The decisions of the government are not requests or recommendations; they are authoritative commands that must be obeyed. Standing behind these decisions are the instruments of physical force and coercion-the police, the military forces, the courts, and the prisons. The government, in other words, possesses the legitimate right to resort to-or threaten to resort to-armed force and violence, if necessary, to obtain citizens' obedience to its authoritative, binding decisions. One political observer has referred to the government as the "shotgun behind the door."

Also standing behind the decisions of government and making them authoritative are wide spread and strongly-held feelings that the decisions not only have to be obeyed in order to avoid punishment for disobedience but also should be obeyed because it is the moral as well as legal duty of citizens to comply with the laws of the political community. In other words, governmental decisions bear the force of legitimacy; they are considered to be legitimate by all or most members of the society. Because the decisions are widely accepted as legitimate, they bear a very high probability of compliance. It is highly probable that the decisions will be obeyed, with few, if any, members of the society challenging the right of the government to make the decisions or its capacity and will, to effectively enforce them.

f. ***The Government's Authoritative Allocation of Resources and Values***: The official decisions and actions of government help allocate society's relatively scarce resources. When the government makes and implements decisions that are binding on all members of the society, it authoritatively allocates resources and values for the society. That is, the decisions and actions of government have the effect of authoritatively distributing the benefits and costs of living in politically organized society.

The allocations made by government differ from those made by the institutions comprising the private sector of the economy. The private economic sector engages in a market allocation of resources and values, distributing society's resources and values-benefits and costs-by means of the market mechanism. In the market, millions of individuals, groups, and firms receive society's benefits, advantages, and rewards in

accordance with their ability and willingness to pay for them or provide satisfactory products and services in voluntary exchange.

In contrast, the government engages in a command, or authoritative, allocation of resources and values. The government accomplishes the allocation by making and enforcing official decisions which are binding on all members of the society. The government allocates resources and values through exercise of its legitimate authority to (1) lay and collect taxes, (2) borrow money on the credit of the general public, (3) appropriate and dispense funds from the public treasury, (4) regulate and restrict human behavior, and (5) generally, make and enforce laws and other government rules and regulations. In the exercise of this authority, the government authoritatively decides which individuals, groups, and firms within the society will receive more of the rewards, benefits, and advantages and which will bear more of the costs and burdens. In short, government allocates benefits and costs by means of public policy, while the private economy accomplishes the allocation through the voluntary, private decisions and actions of millions of individuals, groups, and firms in the market place.

In a predominantly capitalistic society, such as the U.S.A., the private economic sector allocates, by far, the greater proportion of society's resources and values. Government, however, allocates some very important resources and values. The benefits and the burdens--the rewards and deprivations--authoritatively distributed by government through decisions and actions on public policy affect the interests of many individuals, groups, and firms within society. In adopting and implementing income-tax policy, for example, the national government determines whether private savers and investors will

be rewarded or penalized, encouraging or discouraging savings and investment and thereby very importantly affecting the nation's rates of capital formation and real economic growth (i.e., economic growth with low inflation), which in turn decisively affect the economic well-being of virtually the entire population.

g. ***Governmental Activity and Public Concern***: The activities and functions of the government are the legitimate concern of the entire adult population comprising the political society. Anything the government does or fails to do is the business of the general public. Authoritative decision making and action by the government entails the expenditure of money from the public treasury. Every government policy adopted and carried out, every government program authorized, funded and implemented, involves spending tax money--money which the government demands and extracts from the members of the political society. Since the costs of government are borne by the taxpaying members of the community, the decisions and actions of the government, including its internal operations, are the business of the citizenry at large.

2.2.3 Concept of Democratic Governance

Democratic governance is a form of government in which all eligible citizens have an equal say in the decisions that affect their lives. It allows people to participate equally—either directly or through elected representatives—in the proposal, development, and creation of laws. It encompasses social, economic, and cultural conditions that enable the free and equal practice of political self-determination (Fortunato 2015).

Democratic governance is a government in a constitutional democracy, where the assembly of persons is given the authority to maintain a human level of cultural order. These persons, not being superior to their community, are not there to direct thinking or community attitudes. They are there to search for the truth of changing needs and to help maintain an informed society; to maintain the agreed Constitution and to avoid conflict with universal (established principles of) law. Their duties are to reflect, and put into effect, the thinking and desires of an informed electorate; to see that the community is kept truthfully informed (Warren, 2009). Politicians are ordinary people. If well chosen they may be expected to be better managers than the average; to maintain better moral standards and have wider or specialized experience. Nevertheless they are ordinary people no different from most and, in general, only a little more able than those they represent. To maintain order they need authority to make laws within limits defined by the Constitution. Maintenance of order is assumed to require police and armed services and, in addition, order also involves care of the financial system. Because money is the oil of industry it should be available in the needed amounts to enable human industry, free of commercial abuse, to run smoothly and in orderly manner (Gourley 2010).

Law, defense, information and finance are community basics but even here the power of parliament is not total. In particular laws, order and education are matters of community discipline before government design. Apart from the primal responsibility to see that the community is truthfully informed, the above are undoubtedly the main, if not the only, legitimate responsibilities of national government.

Today there may also seem a need to add health but given information and nutritious food, improving health may be best left to public intelligence and enterprise. Protected by democracy, individual responsibility and local social community can flourish. Neither the state (meaning the national government) nor private individuals should have direct control of finance, law, education, health or mass media. To achieve this wealth of freedom requires government as innate part of the general community – a true democracy – no other form of government gives effective community control. The state should have both responsibility and power to set limitations on services as necessary to restrain monopolizing or abuse by deceit as well as ensure common or unified systems, but restraints must be learned and authorized by the community.

According to Fortunato (2015), democratic governance contrasts two forms of government where power is either held by one, as in a monarchical government, or where power is held by a small number of individuals, as in an oligarchy or aristocratic government. Nevertheless, these oppositions, inherited from Greek philosophy, are now ambiguous because contemporary governments have mixed democratic, oligarchic, and monarchical elements. Several variants of democratic government exist, but there are two basic forms, both of which concern how the whole body of citizens executes its will: direct democratic and representative democratic government.

2.2.3.1 Pre-conditions for Democratic Governance

Democracy does indeed require important ancillary conditions to operate fruitfully and foster economic development. Where social life is fragmented and a culture of distrust diffuse, evidence shows that democratically elected bodies are less responsive

to public demands and politics takes on patron–client characteristics. Well-functioning democratic governance also requires voters to be informed about the political process and politicians' actions (Fritz, 2016). In places where the media does not facilitate access to unbiased information and where the rules and practices of information disclosure are not part of the political culture, elected officials are likely to be only partially accountable and serious moral hazard problems may arise. Education is likely to affect both the strength of social networks and access to information; it therefore represents a key pillar of democratic governance.

Education may also have a direct effect on the functioning of democratic institutions, since it empowers citizens to engage with government institutions and facilitates the negotiated resolution of social and economic disputes. Finally, inclusive and efficient democratic institutions also require a certain commonality of (economic) interests across the population. Economies heavily relying on natural resources whose rents are unevenly distributed are more likely to experience violent conflicts and, in turn, to develop a dysfunctional institutional setting after the transition to democracy. Again, education may play an important role here; modern economies in which a significant share of value added accrues to human capital development are less likely to be trapped in this institutional facet of the natural resource curse (UNDP 2013).

2.2.3.2 **Features of Democratic Governance**

UNDP (2012) and IDEA (2013) provides characteristics of democratic governance as inclusion of the public in the process of governmental elections, majority rule, establishment of basic human rights and free and fair elections**.** Democratic governance exist around the world and fall into the two categories of direct and

representative. Direct democratic governance allow citizens of legal voting age to establish rules and laws, while representative democracies use elected officials for rule-making.

Of the two types of democratic governance, representative democracies occur most frequently. While some countries feature one type of democratic governance, others contain elements of both. In the United States, for instance, elected officials make the majority of decisions affecting Americans. This is similar to Nigerian situation. Individual states, however, have provisions allowing for the recall of elected officials and for amending laws.

Democratic governance operate on the provision of majority rule, which states that laws enter into effect when approved by a large percentage of the population. Laws, however, protect the rights and freedoms of all citizens, including minorities. Democratic governance also allow for participation by a variety of groups, institutions and political parties. These ancillary groups operate independently of the central government, but have a participatory role, through the voices of citizens, in governmental actions and affairs. In contrast to democratic systems of government, authoritarian governments divert power into the hands of the central government.

The sovereign power is vested to the people through the exercise of suffrage .This is called the sovereign electorate as the people have the right to elect various governmental posts to carry out the political functions and responsibilities in the delivery of basic services. It also explain the political participation of the people whether it is democratic (with the advocacy of human freedom) or communistic (with the advocacy of

collective ownership and suppression of constitutional freedom) in its nature of governance.

There is political and administration of governmental affairs about its geographical and territorial jurisdiction. The government administration for the development programs and projects depends to the political platform of the national leader and the constitutional mandate on the branches of government. If the national government provides a centralized planning in all political affairs of the state then this is considered as unitary government. However, the local or federal government has also given the same political power in its territorial or geographical jurisdiction to administer the same governmental rights and privileges through autonomy and decentralization then it is federal in form.

2.2.4 Concept of Service Delivery

Service delivery is a common phrase used to describe the distribution of basic resources citizens depend on like health, education, water, electricity, sanitation infrastructure, land, and housing. Unfortunately, the government's delivery and upkeep of these resources is unreliable-greatly inconveniencing or endangering whole communities. In response, the number of "service delivery protests" or protests demanding better service delivery has become more popular in recent years. So popular, in fact, that the term "service delivery protest" has become a loosely used term by the media to define various types of protests.

Public services are those services provided by governments (local, municipal, or larger-scale) to the public. The need for services that no individual can or will pay for, but that benefit all by their presence, is one of the justifications for taxation. Examples of

such services are sewage, trash disposal and street cleaning. On a larger scale, public education and public health services (in countries that have them) are also public services. Public service delivery is the implementation of those services and making sure they reach those people and places they are intended to.

2.2.4.1 Primary Health Care Services

Primary healthcare (PHC) refers to essential health care that is based on scientifically sound and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. In other words, PHC is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy. PHC includes all areas that play a role in health, such as access to health services, environment and life style. Thus, primary healthcare and public health measures, taken together, may be considered as the cornerstones of universal health systems.

This ideal model of healthcare was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata, Kazakhstan in 1978 (known as the "Alma Ata Declaration"), and became a core concept of the World Health Organization's goal of *Health for all*. The Alma-Ata Conference mobilized a "Primary Health Care movement" of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the "politically, socially and economically unacceptable" health inequalities in all countries (*Cueto, 2004).*

2.2.4.1.1 Goals and principles of primary health care.

The overall goals of primary healthcare were identified by WHO (2014). These goals are five and are the best means of achieving better primary health care

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.

Behind these elements lies a series of basic principles identified in the Alma Ata Declaration that should be formulated in national policies in order to launch and sustain PHC as part of a comprehensive health system and in coordination with other sectors:

- Equitable distribution of health care – according to this principle, primary healthcare and other services to meet the main health problems in a community must be provided equally to all individuals irrespective of their gender, age, caste, color, urban/rural location and social class.
- Community participation – in order to make the fullest use of local, national and other available resources. Community participation was considered sustainable due to its grass roots nature and emphasis on self-sufficiency, as opposed to targeted (or vertical) approaches dependent on international development assistance.
- Health workforce development – comprehensive healthcare relies on adequate and distribution of trained physicians, nurses, allied health professions, community health

workers and others working as a health team and supported at the local and referral levels.

- Use of appropriate technology – medical technology should be provided that is accessible, affordable, feasible and culturally acceptable to the community. Examples of appropriate technology include refrigerators for vaccine cold storage. Less appropriate could include, in many settings, body scanners or heart-lung machines, which benefit only a small minority concentrated in urban areas. They are generally not accessible to the poor, but draw a large share of resources.
- Multi-sectional approach – recognition that health cannot be improved by intervention within just the formal health sector; other sectors are equally important in promoting the health and self-reliance of communities. These sectors include, at least: agriculture (e.g. food security); education; communication (e.g. concerning prevailing health problems and the methods of preventing and controlling them); housing; public works (e.g. ensuring an adequate supply of safe water and basic sanitation); rural development; industry; community organizations (including Panchayats or local governments, voluntary organizations, etc.).

In sum, PHC recognizes that healthcare is not a short-lived intervention, but an ongoing process of improving people's lives and alleviating the underlying socio economic conditions that contribute to poor health. The principles link health and development, advocating political interventions, rather than passive acceptance of economic conditions.

2.2.4.1.2 Approaches to primary healthcare

The primary health care approach has seen significant gains in health were applied even when adverse economic and political conditions prevail. Although the

declaration made at the Alma-Ata conference deemed to be convincing and plausible in specifying goals to PHC and achieving more effective strategies, it generated numerous criticisms and reactions worldwide. Many argued the declaration did not have clear targets, was too broad, and was not attainable because of the costs and aid needed. As a result, PHC approaches have evolved in different contexts to account for disparities in resources and local priority health problems; this is alternatively called the Selective Primary Health Care (SPHC) approach.

Selective PHC

After the year 1978 Alta Alma Conference, the Rockefeller Foundation held a conference in 1979 at its Bellagio conference center in Italy to address several concerns. Here, the idea of Selective Primary Health Care was introduced as a strategy to complement comprehensive PHC. It was based on a paper by Julia Walsh and Kenneth S. Warren (1979) entitled “Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries”. This new framework advocated a more economical feasible approach to PHC by only targeting specific areas of health, and choosing the most effective treatment plan in terms of cost and effectiveness. One of the foremost examples of SPHC is "GOBI" (growth monitoring, oral rehydration, breastfeeding, and immunization), focusing on combating the main diseases in developing nations.

Selective PHC approach consists of techniques known collectively under the acronym "GOBI-FFF". It focuses on severe population health problems in certain developing countries, where a few diseases are responsible for high rates of infant and child mortality. Health care planning is employed to see which diseases require most attention and, subsequently, which intervention can be most effectively applied as part of

primary care in a least-cost method. The targets and effects of Selective PHC are specific and measurable. The approach aims to prevent most health and nutrition problems before they begin:

- **G**rowth monitoring: the monitoring of how much infants grow within a period, with the goal to understand needs for better early nutrition.
- **O**ral rehydration therapy: to combat dehydration associated with diarrhea
- **B**reastfeeding
- **I**mmunization
- **F**amily planning (birth spacing)
- **F**emale education
- **F**ood supplementation: for example, iron and folic acid fortification/supplementation to prevent deficiencies in pregnant women.

2.2.4.2 Primary Education

Education presuppose the all round development of the child and the processes of equipping individual and society with the knowledge, skills, cognition, perspective and values required and, or expected to make for a meaningful life. Education entails all the processes of socialization and enculturation in the society. Education therefore evolves as human beings interacts with one another and with the environment and develops as the community Endeavour to meet her social economic and environmental challenges in their bid to make for a better life. Education is therefore, an important vehicle for national development; it can yield positive impact on a society if it is conditioned within the cultural and environmental context of such a society. It is imperative to observed that this idea indicates that there could be different perceptions and forms of education and those

forms that are alien to a particular society may be perceived erroneously as not being education or development in this situation the idea of a vocal and dominant culture may want to strategically assume superiority and subsume others perceptions.

Fundamentally, education is a veritable instrument for socio-economic development. Contemporary western technocrats have also presented education as an index of national development as reflected in the MDGs. But educational policies and goals indicate even as they derive from the national development ideology and or perspective which the social system seeks to attain, sustain, propagate, acculturate and projects. Education therefore may be an end but in itself a means to an end. The end of education is development. The educational processes of a society would be programmed and directed towards achieving what that society perceives as development. It then means that with an inappropriate estimation of development values, the educational system in such a society may be operating but without the desired result because the realities in the circumstance might have been at variance with the development expectation.

Western intellectualism as presented to Africa perceives education as the processes of engaging in schooling and school – related activities of the linear literacy and numeric and their associated intellectual activities, attitudes and behaviors. Kanu (2006) argued that no society is without some form of education. However, the popular western type of education was introduced into Africa societies by the Christian Missionaries which led to the subordination, if not total elimination of the traditional form of education. Indeed, it is universally evident that education is a heritage of all people and cultures, no matter their stages of development. Some tacit recognition of this fact is evident in such expression as Western education Oriental or Islamic education (Kanu, 2006).

Critically examining the concept of education, Kanu (2006) advanced the arguments that education is all the consciousness processes and activities both institutionalized and un – institutionalized organized and un – organized, graded and un- ungraded, literate and non – literate which are made to assist succeeding generation of members of societies to acquire the corpus of knowledge, values, attitudes, beliefs, mindset, skills, central tendencies, worldviews, and orientation - which are seen as representing the proper way of life in the given time and place. Durkheim (1956) the sociologist sees education as a means of organizing the individual self and the social self, into a discipline stable and meaningful unity. Education consists of a methodology socialization of the younger generation. It is the process by which the individual acquires the many physical, moral, social, capacities demanded of him by the group into which he is born and within which he must function (Swift, 1969).

Education is the process of all round development of the child equipping the individual with the expected approved knowledge, traits, skills, values and worldview that would make for a meaningful life and well being within the given society and epoch. It is essentially the systematic process of transmitting a people culture from one generation to the next generation as applicable within the epoch. Kanu (2006) affirms this when she expressed the view that education is "two aspects of the same reality, education being the instruments of culture and the goals of education is socio-economic development. Gracey (1999) also observed that education is an institution which serves society by socializing people into it through a formalized standardized procedure.

Education from the foregoing, therefore, is about the systematic transmission and development of the culture of a people as expected to make for a better living and societal

order. Education in this context aims at cultural development and is directed by the culture of the given society. Durkheim (1956) in Magaji (2015) argued that education is, above all, the means by which society perpetually recreates the conditions of its very existence. He contended that it is society as whole and each particular social milieu that determines the ideal that education realizes. Society can survive only if there exist among it members a sufficient degree of homogeneity, education perpetuates and reinforces this homogeneity by fixing in the child from the beginning the essential similarities that collectives life demands. Durkheim rightly advanced that education system can only be understood when we know for what society and for what social position the individuals are being educated. The educational system of a society must reflect the philosophy of that society and not operates in a vacuum. It should be based on the needs and cultural aspirations of the society for it to function properly.

Primary education, also called elementary education, is for children in kindergarten through sixth grade. Primary education provides students with a basic understanding of various subjects as well as the skills they will use throughout their lives. Schools offering Elementary Education degrees can also be found in these popular choices. According to Universal Basic Education Commission (UBEC) and UBE Act 2004, States supervise the curriculum, processes and every state government in Nigeria regulates primary education, universal basic education standards of elementary schools to ensure students receive a quality education regardless of the school they attend. Most states require children to receive a primary education to learn basic concepts. According to the United Nations Children's Fund (UNICEF), providing children with this education has many positive effects, including:

- Decreasing poverty
- Decreasing child mortality rates
- Encouraging gender equality
- Increasing environmental concern

Primary education provides students with fundamental skills that will be the foundation for the rest of their academic careers. Primary education institutions provide children with some of their first opportunities to meet people from different religions, races and socio economic statuses, as well as people with different disabilities. Therefore, elementary school teachers have a unique chance to teach children about tolerance and respect. Students are taught basic lifetime skills like reading, writing, spelling, interpersonal communication and concentration.

2.2.4.2.1 Primary Education Tools

Some primary education instructors teach several different subjects to a group of students, so they must constantly keep students engaged in learning. According to the U.S. Bureau of Labor Statistics (BLS, 2015), elementary school teachers use several different tools to teach children and keep their attentions including: games, books, movies, computers, artwork etc.

In order to achieve the goal by 2015, the United Nations estimates that all children at the official entry age for primary school would have had to be attending classes by 2009. This would depend on the duration of the primary level as well as how well the schools retain students until the end of the cycle. In half of the sub-Saharan African countries, however, "at least one in four children of primary-school age was out of school in 2008."

Also, not only is it important for children to be enrolled but countries will need to ensure that there are a sufficient amount of teachers and classrooms to meet the demand. As of 2010 and 2015, the number of new teachers needed in sub-Saharan Africa alone equals the current teaching force in the region (UNICEF, 2012).

The gender gap in the number of students not in school has also narrowed. Between 2005 and 2015, the number of girls not in school decreased from 57 percent to 53 percent globally. In some regions, however, there is a greater percentage; for example, in Northern Africa, 66 percent of "out-of-school children" are girls (Sani, 2012).

According to the United Nations, there are many things in the regions that have been accomplished. Although enrollment in the sub-Saharan area of Africa continues to be the lowest of all regions, by 2010 "it still increased by 18 percentage points—from 58 per cent to 76 per cent—between 2005 and 2015." There was also progress in both Southern Asia and Northern Africa, where both countries witnessed an increase in enrollment. Southern Asia increased by 11 percentage points and Northern Africa by 8 percentage points over the last decade (Suraj, 2016).

Also, major advances have been made even in some of the poorest countries, against the majority of them in the sub-Saharan region of Africa. With the abolition of primary school fees in Burundi, there was an increase in primary-school enrollment since 1999; it reached 99 percent in 2015 (Suraj, 2016). The United Republic of Tanzania experienced a similar outcome. The country doubled its enrollment ratio over the same period. Other regions in Latin America such as Guatemala and Nicaragua as well as Zambia in

Southern Africa "broke through the 90 percent towards greater access to primary education."

2.2.5 Concept of Portable Drinking Water

Availability and access to improved source of drinking water is a basic responsibility of government and indicator for human development. It bears direct relevance to health and well-being and is thus symbiotically linked to the achievement of Millennium Development Goals (MDGs). Traditional central treatment and piped distribution of drinking water in small communities for all uses, is becoming less achievable due to the costs of treating large volumes of water, installing and maintaining oversized distribution networks, managing leaks and system deterioration, and limited access to high quality water in some locations. Two-tiered systems, consisting of microbiologically safe piped water for general use supplemented by Point-of-Use or Point-of-Entry treatment or bottled water for drinking and cooking in each house, are a feasible and cost-effective alternative where specific chemical contaminants need to be avoided. These unconventional approaches require a willing community and access to qualified commercial support services for installation and management of the treatment devices or for providing safe bottled water.

Piped central distribution of good quality drinking water for public and home use was highly developed by the Romans more than two thousand years ago; however, the practice waned and then did not begin to change seriously until the 18th century. Significant improvements involving central filtration or disinfection were not added until the 19th and 20th centuries. Point-of-use supplemental treatment, using charcoal, settling, sand filtration, ceramic filtration, or boiling to improve palatability or safety has been

practiced for thousands of years and continues to the present. Supplemental treatment of centrally provided water for taste, softening, etc is widely practiced in the urban centres by consumer preference, but not for compliance with regulations until recently. The traditional concept of treating all of the water in the public water system to drinking water quality specifications is becoming less rational due to the increasing stringency of standards and guidelines, the costs of excess treatment for larger volumes of water, oversized distribution networks, distribution system deterioration and leaks, and reduced access to high quality water in many locations. Indeed, the public is increasingly opting for bottled water and supplemental treatment, because of their concerns for safety or their higher expectations. Less than 15 percent of the water produced in a public water system is used for drinking and cooking in the urban areas; about 25 percent is used for other human contact that requires high but not drinking water quality; about 75 percent is at the low quality end for toilet flushing, lawn irrigation, fire-fighting and other exterior uses (Cotruvo, 2012). However, in the rural areas, about 75 percent of water produced in a public water system is used for drinking and cooking purposes (Sani, 2012).

The time for considering alternative approaches to providing drinking water has come. Three broad categories of choices include: 1) Central remanufactured package technologies; 2) Two-Tiered: community-managed decentralized and supplemental treatment in the home (and other water access points such as schools and businesses) and bottled water; and 3) Dual distribution networks providing a small amount of high quality drinking water, and a larger quantity of lower quality (perhaps reprocessed waste water) for high volume lower quality uses.

The Nationl Safe Drinking Water Act (SDWA) Amendments of 1996 gave legal status to decentralized (point of-use or point-of-entry) technologies for compliance in public water supplies, in particular, as a potentially lower cost option in small water systems (Sani, 2012). Commercial POU or POE units have been tested to consensus standards, installed in millions of homes, and used by individual consumers for many years as POE water softeners, for POU taste and odor control and organic chemical removal, for reducing Total Dissolved Solids (TDS), fluoride, and other ions, and for filtration and disinfection.

More than 40 small-scale field studies and long-term applications of decentralized technologies in small communities in Nigeria have been conducted in the last 20 years, and more are underway. A significantly increased level of activity in developing newer technologies and lowering costs has occurred. Achieving compliance with several drinking water standards (e.g. organics and arsenic, radium, and other in organics) using decentralized strategies is feasible and cost-effective in practice in small systems (Suraj, 2015).

However, the costs and community operational details have not been fully determined, and neither have the size and local conditions that determine the upper bound range where decentralized strategies are no longer economically advantageous over central treatment options, or where they are no longer practical due to the logistics of managing a large number of treatment nodes. Communities will need significant assistance to help them make proper choices, training and assistance to carry them out.

Properly managed, decentralized strategies provide an opportunity to achieve safer drinking water than those communities might ever otherwise have had, and at

reasonable costs. The flexibility in small community environments, the availability of water service contractors, and the ease of installation and use of decentralized approaches are the best chance for providing safe drinking water for many small communities.

2.2.5.1 Main Source of Drinking Water

The source, which was availed during the greater part of the year, was recorded as the main source.

1 Tap water was bifurcated in two categories - Tap water from treated source and Tap water from un-treated source.

2 Well water was categorized as covered well and uncovered well

3 Other sources included Hand pump, Tube well/Borehole, spring, River/Canal, Tank/ Pond/Lake and Other sources.

2.2.5.2 Alternatives for Providing Safe Drinking Water in Small Water Systems.

According to UNICEF (2013), there are numerous strategies that could be envisioned for providing safe drinking water:

• **Central treatment and piped distribution**. This is the standard current method for supplying Community drinking water; a variant is when no treatment is applied. All of the water in the system must meet drinking water quality standards. It incorporates both conventional site-built systems and pre-engineered package systems.

• **Central treatment or untreated source water and piped distribution plus optional decentralized supplemental treatment at point-of-use or point-of-entry.** POU and POE are already common consumer choice options as many households have installed POU carbon filters under the sink to remove chlorine residuals or to improve other aesthetic characteristics. POE cationic water softening is common in hard water areas.

These treatments can often also remove regulated substances. The piped distributed water must meet microbial standards.

• **Central treatment or untreated source of water and piped distribution with community managed decentralized treatment at point-of-use or point-of-entry.** Frequently disinfection will be the only treatment centrally provided, especially in ground waters. Supplemental treatment applied at the delivery point in the home would remove selected contaminants to levels below drinking water standards. A small treatment unit would be installed under the kitchen sink and plumbed to a bypass from the cold water line to a new dedicated water tap installed above the sink. Connection to the refrigerator icemaker is also possible. The piped distributed water must meet microbial standards.

• **Bottled water plus piped distribution**. This additional hypothetical option would include piped distribution of water that did not meet all primary standards as well as supplemental community supplied bottled water. It is not currently acceptable for compliance in the United States and other western societies, but it can be used as a temporary measure during the terms of emergencies or variances or exemptions.

• **Dual distribution.** More than one quality of water is provided through separate distribution networks.

Variants include:

• Distribution of the highest quality water for all potable and human contact uses through a low Capacity network, and lower quality, yet biologically safe, water for interior non-human-contact Uses and exterior uses in a larger capacity network.

• Distribution of potable water for interior human contact uses and reprocessed waste water or other lower quality water for sanitary and exterior uses including lawn watering

and fire fighting. As current water distribution infrastructure approaches the end of its useful life, retrofits of dual networks should be expected because they can be cost effective, especially in water-limited areas.

2.2.6 Overview of Democratic Governance in Service Delivery

The 1999 constitution section 7(1) guarantees the system of democratically elected local government councils and tasks every state to ensure their existence under the law that makes local government subject largely to state statutes. The constitution listed the functions that are exclusive to local governments. Such as, provision and maintenance of cemeteries, slaughter slab, public convenience, collection of rate, issuance of petty licenses, naming of streets etc. The constitution also, stipulated that local governments shall participate in performing a number of functions concurrently with the state governments (FRN, 2000). These functions includes: provision and maintenance of primary education, health care, agriculture and natural resource among others.

This implies that local governments were established and recognized as a third tier of government responsible for participating in the delivery of most local public services like primary education, water supply and health along with the state and entitled to statutory federal allocation of 20% and state allocation of 10% from internally generated revenue. To add to this, the UBE Act 2004 has directed the establishment of local government education authorities (LGEAs) in each local government. The LGEAs is responsible for the day – to – day running and management of primary education at the local level with the support of SUBEB. Also, the current national health policy document 1996 revised 2004, Indicates that local governments are expected to be part of the implementers of PHC's policies with the federal government responsible for formulating

overall policy and for the monitoring and evaluating and state governments for providing logistical supports, funding and manpower regulation to the local government authorities such as procurement, personal training, financial assistance, planning and operation to quote:

> *"With general guidance, support and technical supervision of states health ministry's under the aegis of ministries of local governments. Local governments councils shall design and implement strategies to discharge the responsibilities assign to them under the constitution and to meet the health needs of the local community (NHP, 1996. 26)"*

Although the current 2011 amended constitution of Nigeria has placed primary education, water supply and health care in the concurrent legislative list, yet the extent of participation of local governments in the execution of these responsibilities has been enormous. In fact, proponent of the centralization are of the view that local government is in the better position among the three tiers of government to not only serve as a principle decision maker but a provider of most basic service like primary education and health care. Their argument is based on closeness and proximity to local community (Jica 2007 in Dalhatu 2015). In the same vein UNDP in 2004 shared the opinion that local government in Nigeria are immediate and more tangible environment for identifying local needs and articulating strategies for service delivery that are effective and sustainable than any other tier of government because of their proximity to local community.

However, some scholars like Linus (2014) and Khemani (2004) in Dalhatu (2015) are of the opinion that local government lack the management and the financial capacity to effectively promote provision of goods and services that can leads to socio-economic development. Their argument was based on legal frame work, local structure,

composition and the performance of local government authorities in recent time. This may be the reason why the state through SUBEB, SPHCDA, and RUWASA hijacked the manpower provision, determination of projects location, procurement, supervision and regulation of primary healthcare, water supply and basic education.

The survey carried out by USAID (2001) on the assessment of local government position and the performance in Nigeria notice that the current local governments legislation as entrenched in the 1999 constitution section 7(1) that guarantee the system of democratically elected local government council and then tasks each state to ensure their existence under state laws that provide for their establishment, structure, composition, finance and function, has reduced local government to babies of the states. In essence states are empowered to create, dissolve and even establish new local jurisdiction for local governments. And in exercising their powers over local governments, it was noticed that states has imposed administrative and political control that reduce the autonomy of the local government to effectively perform (Dalhatu, 2015).

The UNDP study on local government in 2004 further observed that many state governments have dissolve elected local government council on the pretext of non performance on the appointed care taker committees. Also many states have encroached on local revenues by making purchases on behalf of local governments, withheld state statutory allocations meant for local governments and took over constitutionally assigned local functions under the pretext that they were not effectively performed by the local governments.

To further support the above position, Abbas (2010) in Dalhatu (2015) maintains that the existing laws that guide the operation of local governments in Nigeria has created

a situation where by the state participate and dominate the access of local governments. He reiterates that local governments are reduced to an administrative unit of the state because of the joint account system that empowers the states to control local government's resources. Thus, this issue has manifested in an intricate control with no autonomy for local governments to manage local resources thereby frustrating the spirit enunciated in the decentralization of authority that is democratic government.

Dalhatu (2015) further observed that the current policy environment under which local government operate in Nigeria is somehow ambiguous, essentially because the constitution has identified local governments as third tier of government within the federal democratic system, and have spelled out both exclusive and concurrent functions and the certain amount of federal share is being allocated to the local government councils in order to discharge their duties effectively. Surprisingly, in the same constitution, section 8(1-4) the state is empowered to take total control of local governments affairs. This ambiguity have weakened the performance of local governments so much that many perceive it as an institution with assign responsibilities without corresponding authority and the autonomy to perform and function effectively.

2.3 Review of Empirical Studies

The issue of democratic governance has received much attention in the globe over the past decade. In fact, in recent times democratic governance has increasingly attracted the attention of many social scientists in many countries as a means of facilitating development projects that could yield positive transformation and improves the life of the people. Nigeria returned to democracy (fourth republic) in may 1999 at both federal,

state and local government level with the aim of facilitating developments programs that could touch the life of the people at all levels.

To ensure sound consolidation of democratic governance that would facilitate effective provision of goods and services that stimulates rapid socio-economic development, empirical studies were conducted by different scholars both academics and experts on the field. These researchers were geared towards unraveling the myths, investigating the problems associated with the services provided by democratic governance and its long run effects on the socio economic life of the people.

Przeworski (1990); and Przeworski and Lamungi (2007) used cross national study to compare regimes (both democracies and dictators) on their effect on socio-economic development; while Pel (1990) study compared Human Right Development Index (HRDI), educational development and gross domestic product (GDP) as an indicators for measuring socio-economic development among countries. Of course the studies have exposed some issues relevant to socio-economic development in countries, however there is little evidence of study with focus on poverty, unemployment, health and education and government expenditure on service delivery and human development index, foreign exchange rate (Naira per US dollar) and health performance.

Among the debated issues in recent years is whether link exists between democracy and development. Considerable number of scholars including, (Pel, 1999; Campos 1994; Jamo 2010) maintain the view that, there is causal link between democracy and development, while others including Sirowy and Linkels (1991); Bardhan (2002); Przeworski and Lamongi (2007) on the contrary maintained the opposite view. Two approaches according to Somolakae (2007) were observed, the first approach

utilizes by the scholars is the normative approach by exploring the possible link on the basis of what they know about democracy and development, and try to establish possible linkages between them. While the other approach is the use of case studies by trying to operationalize the concept of democracy and development, and examining the rate and character of development within the area under study and try to establish conclusion whether relationship or linear association exist between the two variables. Duncan *et'al* (2009) and Olarimoye, (2010) maintained that there is a clear relationship between political and economic change. However, there is limited hard evidence on the direction of causality, and the basic mechanisms through which politics affects growth and vice versa.

Ayuba (2015) conducted study on democratic governance and socio economic development in Nigeria looking at education, health and empowerment programmes using twelve states (two from each geo-political zone). Data were collected through questionnaire, interview and non participant observation. The data were analyzed using chi-square alongside tables and percentages. The study discovered that, democratic governance failed to deliver true development at the grass root level. This was buttressed by using the physical infrastructures before the fourth republic and during the fourth republic. He also discovered that party politics and party motivated programs are what characterized the democracy in the fourth republic. The findings went further to describe the democratic governance in Nigeria as too expensive as it failed to passion socio-economic development. The researcher uses Cost-Benefit Analysis (CBA) to measure the performances through input output ratio. However, this study is limited as it rely on physical infrastructures without looking at manpower provision in the area of study.

Pam, (2015), also conducted study on the Role of public bureaucracies under democratic governance in some selected federal institutions. Data were collected from the sample of 400 public officials and analyzed using chi-square. The findings showed that public bureaucracies are more effective during military era than during democracy. It was also discovered that public bureaucracies are characterized with indiscipline during democracy than under military. It was also found that democratic governance is weak in process of provision of social services and economic infrastructures that can enhance growth and development. This study is also limited as it relies on federal institutions only, neglecting the other levels of government that are more closer to the people interms of provision of goods and services

Diamond (2016) also conducted study on the relationship between democratic governance and socio economic development taken education, health and agriculture at grass root level. Data were collected and were analyzed using theoretical approach. The findings revealed that democracy is just a system that can make or mar development. The study found that development can be attained under different system of government which are not democratic. The findings showed that some countries like Libya, Saudi Arabia and Iran Republic have achieved high level of socio – economic development under non democratic government. While some countries under democratic regimes such as Niger Republic, Nigeria and Kenya were unable to accelerate the provision of goods and services that ensure socio political and economic development. It was concluded that, the nexus between democracy and development is neither positive, nor negative.

Suraj (2016) carried out a study on how democratic governance actualizes development through effective service delivery in local governments of Katsina State

using employment, water supply and education – using questionnaire on a sample of 384 respondents. Three hypotheses were tested using sample percentage and chi – square tools. The findings revealed that democratic government in Katsina State was very effective as it provide the physical socio – economic infrastructure. The study found that political participation, accountability and transparency are passioning in Katsina state. It was also found that, periodic election, rule of law and non partisan politics are very present in the state. This study is limited as the researcher used questionnaire only as a tool for data generation as it uses simple percentage only which will never shows the level of relationship.

Sani (2012) worked on the impact Democratic governance on infrastructural development with primary health care and primary education in some selected local governments in Katsina State. Data were collected from the sample of 120 respondents using questionnaire and observation. Simple percentage was used in analyzing the data. The finding showed that democratic governance in the state recorded credit in the provision of socio – economic infrastructure such as school, Health centers, Road, Electrification, mass transit, soft loans, training and capacity building, awareness and orientation programs, to mention just a few. The study found that there is high level of political participation in the state. However the study is limited in the sense that the sample size of 120 in a state with the projected population of 6.5 million was too small. Therefore sampling error must be too high because of the limited representation. More so, the used of simple percentage as a tool of analysis was insufficient in the sense that it was unable to measure the relationship. Likewise the use of physical infrastructure to quantify development can also be inadequate in the sense that true development must

touch the lives of the people. Therefore, the present of infrastructures is one thing and their impact to the lives of the people is another thing.

Mato and Jacob (2011) carried out a study on the Nexus of democracy and development In Nigeria. Data were collected and analyzed using theoretical approach. The finding revealed that there is no good governance that guarantees development which Nigerians Crave for. Unemployment, inequality poverty as well as all other indices of low/poor quality of life are experienced and present in this country. The study found that although Nigeria practices democracy, Nigeria is still under developed.

However, this work is constrained by its inability to generate empirical data that can be use to base the analysis. More so, there was no scope and specific sample in the course of the work. Therefore, theoretical literatures might be insufficient to conclude on the nexus of democracy and development.

Adoyi (2016) conducted study on the journey of democratic government in Nigeria and service delivery, a study of Katsina Local Government using a questionnaire on a sample of 108 respondents. Two hypotheses were tested using simple percentage and chi – square tools. The findings revealed that democratic governance in Katsina local government passion infrastructures in Katsina metropolis (Urban centre) than in other area (non urban areas/semi urban areas). It was noted that there was no balance (rural – urban) in the art of provision of goods and services. The study found that majority of the rural population are not touched in any way by the democratic values/principles such as transparency, accountability, rule of law and political participation are not functional in the state. The findings also showed that godfathers and prebendal politics are what characterized democratic administration in the state. However, this work is limited in the

sense that the sample size of 108 is too inadequate in the local government with the estimated population of over 338,000 thousands. This leads to sampling errors and affects the validity and reliability of the findings.

Omotola (2008) worked on democratization, Good Governance and Development in Africa: the Nigerian experience. It examines the nexus among the embattled trinity, using a contextual analysis of Nigerian experience under the fourth republic; but within a broader framework of African democratization hoodless. The study found that while democracy has been on course, it has not taken a firm root, because it has so far been pursued and predicated on alien institutions. The study found that democracy has arrived in Africa but without democratic governance. It was also argued that democracy is constrained by the ethno religious conflicts, party politics and high cost of governance which will never allow development to take place.

Idowu (2008) carried out a study on democracy, Human Rights and Development: the Nigerian experience. Data were collected and were analyzed using theoretical approach. The finding revealed that democratic governance in Nigeria is very much in theory rather than in practice. The study found that democracy does not passion development in the real sectors of the economy (macro economic indicator). The study also found that democracy does not attempt to promote human rights in practice. This study is also limited in the sense that it was unable to domesticate the study and it based on the secondary data only without any empirical study.

Braji (2011) worked on Nigeria: from democracy to Kakistocracy and implication for development. Data were collected and analysed using theoretical approach. The finding revealed that democracy in Nigeria is a transmution of military. The finding

explained that Nigerian democracy is a new form of military rule as they are the facilitators, architects and beneficiaries of the system (democracy). It is a new form of military investment in the area of governance. The finding also uses KaKi as a worst part of human element to demonstrate how democratic governance in Nigeria is spoiling the prospects for development. This study is limited as it relies on theoretical approach.

Jamo (2013) worked on the link between democracy and development in Nigeria relying on poverty reduction, employment generation, health care delivery, revenue and expenditure, good governance, Gross domestic product (GDP). Human right development index (HDI), foreign exchange rate as bases of analysis. The finding showed that there is no clear relationship between democracy and development in Nigerian context. It was lamented that, the first fourteen years of democratic dispensation in the country has in no way improved remarkable development. This study is limited as it was unable to domesticate the study and there were no primary data to support the findings of the study.

Madu *et'al* (2015) carried out a study on Democracy and Rural development in Nigeria's fourth Republic: challenges and prospects. The methodologies adopted in obtaining data for the research are content analysis, empirical and secondary. The study found that democratic performance to bringing the desired changes and development in Nigeria remained abysmal and insignificant. The study found that rural poverty, illiteracy and corruption in governance and policy inconsistency and implementation remain the major challenges on democracy to bringing the desired transformation and rural development in Nigeria. This study is also limited as it was unable to domesticate to a specific area.

Okeke and Chukwudi (2014) conducted a research on nexus between democracy and service delivery for sustainable development in katsina state local governments using critical mode of research and employing political economy framework as a theoretical framework for the study. It was argued that, the underpinning brand of democracy fully shows the tendencies of democratic capitalism, otherwise known as capitalist democracy. The Finding of the study highly support the thesis that, there is politics without progress in Nigeria. The study found that there is democracy without development in Nigeria. The study is also limited as it was unable to identify the methodology and tools of analysis for the work.

Oruonye (2013) conducted a research on Grass root democracy and the challenges of rural development in Nigeria taken Bali Local Government Area of Taraba state as a study area. Data were collected from oral interview and focus Group discussion (FGD) with stakeholders in grass root democracy. The result of the study findings shows that, the frequent interference and dissolution of local council officials by the state government and the joint account syndrome has eroded the performance of grass root democracy in providing socio – economic services in the country. The result of the study also shows that this has incapacitated the local government council in delivering social services to the rural dwellers. This study is limited as it lacks the secondary data to support the findings of the study.

From the above reviewed literature on democratic governance, service delivery and socio – economic development in Nigeria and their corresponding empirical studies, it is obvious that most researches on democratic governance, service delivery, rural development and socio – economic development were geared towards evaluating the

nexus of democracy and service delivery, relationship between democracy and physical infrastructures, democratization, good governance and socio-economic development. This tends to limits studies on impacts of democratic governance on service delivery and socio – economic development. This will go further to explore the extent to which democratic governance provides primary education, water supply and primary health care services to the people at the grass root level and the impacts of such services to the lives of the people. It is in light of the aforementioned gaps that this study seeks examine the impacts of democratic governance on service delivery in Katsina and Bindawa Local Government areas of Katsina sate from 2011 to 2016.

2.4 Theoretical Framework

Theory of localism was used as it deals with the needs to have strong institutions at the local level that will aid the provision of goods and services. It also provides the needs for local participation to support the provision and maintenance, based on the local needs.

2.4.1 Theory of localism adapted by Alexis de Tocqueville (1981)

Generally, localism supports local production and consumption of goods, local control of government, and promotion of local provision of goods and services, local culture and local identity. Localism can be contrasted with regionalism and centralized government, with its opposite being found in the unitary state. Localism can also refer to a systematic approach to organizing a national government so that local autonomy is retained rather than following the usual pattern of government and political power becoming centralized over time. The localist perspective like the traditional public administration has developed a forceful case for autonomous elected local authorities. In

the 20th century, localism drew heavily from the writings of Leopold Kohr (1989); Schumacher (1988); Wendell Berry (1969); Alexis de Tocqueville (1981) and Kirkpatrick Sale (1979), among others, Gambo (2016). More generally, localism draws on a wide range of movements and concerns, and it proposes that by re-localizing democratic and socio- economic relationships to the local level, social, economic and environmental problems will be more definable and solutions more easily created.

Localism has received numerous contributions by various scholars and political activists who subscribe to the idea of democratizing the local entities, empowering the local government resourcefully and giving them the capacity to execute their duties which will affect socio-economic development from the various localities outwardly to the entire nation. Long before it became known as the principle of subsidiarity, Tocqueville wrote: In order to understand the consequences of this division, it is necessary to make a short distinction between the affairs of the Democratic Governance. There are some objects which are national by their very nature, that is to say, which affect the nation as a body, and can only be entrusted to the man or the assembly of men who most completely represent the entire nation. Amongst these may be reckoned war and diplomacy. There are other objects which are provincial by their very nature, that is to say, which only affect certain localities, and which can only be properly treated in that locality. Lastly, there are certain objects of a mixed nature, which are national in as much as they affect all the citizens who compose the nation, and which are provincial in as much as it is not necessary that the nation itself should provide for them all (Tocqueville in Gambo, 2016).

Localism advocates the adoption of a new management style. The characteristics of the new management involve a commitment of openness, learning and innovation. A new management style is required if the challenge of service delivery change is to be met (Boyte, 2004). The theory of localism is one which supports a devolved model of government that is focused on the delivery of better services to citizens, stronger democracy and ensuring that the right incentives for balanced economic growth are in place. Localism is aligned with the goal of achieving local democracy, empowering community through provision of health, education and water supply (Malcom, in Sani, 2016).

One of the main goals of the localism theory is to create effective "subsidiaries" at the local levels that can handle the responsibility of democratic governance as well as the provision of social services. The tenets of localism go against the centralisation of power at a federal level of government, arguing on the view that effective provision of goods and services will be achieved when local entities are prioritised due to their closeness to the people.

The relevance of this theory to this study lies in the understanding that for effective provision of goods and services, the local entities must be prioritised and empowered with efficient manpower and material resources which are required for adequate provision of goods and services and socio-economic development of the localities. Support has been given to the notion of devolution and a fundamental shift of power to councils, communities, neighborhoods and individuals. Empowered local people coming together to take more responsibilities for their community through

community development organizations and local councils is a tried, tested and trusted model of grassroots neighborhood action (Chater, 2010 in Pronk 2012).

Prioritising the effectiveness of these CDAs and local councils under the local government system in Nigeria will bring about adequate/efficient and effective provision of goods and services that can lead to socio-economic development in the various parts of the country. Neill (2010) opined that; if you want people to feel like they have a stake in the services given to them, that they are really connected to what is going on, then you give people closer to their homes a real say over what happens there, and the power to make a difference. This is what localism is all about, which amounts to trusting them to decide their own fate. The theory of localism is based on prioritising local entities and encouraging local participation in the provision of goods and services and support which will help channel the efforts of the local people towards development. However, councils are uniquely placed to develop the necessary strategic approach and take the lead in bringing various organizations (PHC, WATSAN and LGEA) together because they have the democratic legitimacy of having been elected by their communities. The local government in Nigeria is broadly considered as a significant apparatus for service delivery.

2.4.3 Revlevance of the Theory to the Study

Localism theory provides the need for decentralization as a mechanism for providing services to the people at the grassroots level. This can be seen in this study as there is National Primary Health Care Development Agency, Universal Basic Education Commission and River Basin Development Authorities as the national level to provide guidelines and enabling laws for the adequate provision of goods and services. At the

state level, there is also SPHDC, SUBEB and RUWASA to regulate and supervise the services provision. At the local level, there is PHCD, LGEA and WATSAN to execute the service provision responsive to the local wishes. Likewise, in terms of participation of people into their provision of goods and services, there is community participation through SBMC and PTA in the basic education sector. There is also DHC, VHC and WCA that participate actively in the provision of primary healthcare and water supply.

Localism theory also provides the need for the provision of goods and services through the institution of local government as the closest to the people. It also portrait the need to provides services responsive to the local wishes. The local institutions are the likely agent that could ensure the effective provision of goods and services. It also provides the room for local people to take part in the choice of political leadership otherwise known as democratic governance.

Localism theory is also relevant to this study as it emphasizes on the need to have elected representatives that provides goods and services responsive to the wishes of the people. This has been seen in the study areas as there are elected councilors that represents the needs and yearnings of the entire polity. The councilors are fully engaged in the policy making and taken part in the execution of some projects. There are supervisory councilors for WATSAN, PHC and ESSD departments. The issue of creation of effective subsidiaries was seen in this study as it shows the presence of state and local governments, PHCD, WATSAN, LGEA and NGOs to aid the provision of goods and services. The new management style were also seen in the study areas as there are various training programmes organized by federal, state and local governments as a means for capacity development.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This section will discuss the detail of the research methodology adopted in the study. It discussed the research design, population and sample size of the study, sampling techniques, sources of data collection, methods and instruments of data collection and methods of data presentation and analysis. It also gives an insight of the statistical tools used for testing the hypotheses.

3.2 Research Design

The study adopts qualitative and quantitative research design. This allows the researcher to collect data from sampled population through the use of focus group interview and questionnaire administration. The sample was selected to represent the characteristics of the population and the sample size was chosen using Krejcie and Morgan (1970). This provides the researcher with the opportunity to generalize the findings of the study for the whole population.

3.3 Population of the Study

The population of this study comprises the people of the two study areas (i.e. Katsina and Bindawa Local Government Areas). Multi stage categorization of local government (rural – urban criteria) was used and arrived at this selection. This can be seen below

Table 3.1: Population of the study

Urban/Rural	Local Governments Selected	Population of the Selected Local Governments
Urban	Katsina Local Government	338,000
Rural	Bindawa Local Government	152,356
Total	2	490,356

Source: National Bureau for Statistics, Census 2006

3.4 Sample Size

The sample size for the study is 382, Krejcie and Morgan (1970**)** table was used in arriving at sample size. For proportional representation of the two local governments, simple percentage was used to select the sample size from each local government in relation to its proportion in the population. This is represented in the following table:

Table 3.2: Sample Size and Proportional Distribution

Local Government	**Population**	**Sample Size**	**Percentage**
Katsina	338000	264	69%
Bindawa	152,356	118	31%
Total	**490,356**	**382**	**100%**

Source: Field Survey 2017

3.5 Sampling Technique

For the purpose of this study stratified purposive sampling was used for the staff of Primary Health Care, WATSAN and Local Government Education Authorities (LGEAs) of the two local governments, Political Wards and community organizations that provide similar services. This was due to the fact that it accommodates both qualitative and quantitative research. Stratified purposive sampling technique was used to select the sample from each departments and political wards. Having selected the sample size from each department, accidental random sampling was used on the general public

3.6. Source of Data

Data for the study was collected from both primary and the secondary sources details of which are presented below.

3.6.1 Sources of Primary Data

The primary sources of data used for this study are the administration of questionnaire, observation and the conduct of focus group interview to elicit respondents'

opinion in appreciating the impact of democratic governance on service delivery. This involves the entire people of Katsina and Bindawa local government, officials in the SUBEB, RUWASA, KSPHCDA, PHCD, WATSAN, LGEA and CDAs.

3.6.2 Sources of Secondary Data

The secondary sources of information for this research are textbooks, newspapers, government gazettes, seminar papers, articles and reports, from the Two Local Governments. Information from dissertations, thesis, published and unpublished materials was used and acknowledged accordingly. Files, annual estimates, store received and store issued voucher, medical records, action plans and staff inventory were also used.

3.7 Methods and Instruments of Data Collection

For the purpose of this research, three instruments were used.

3.7.1 Questionnaire

The questionnaire was structured using open and closed ended. Likert scale of agreement was used and recognized the degree of intensity in the respondents' feelings and perceptions. This is for easy coding, tabulation and subsequent analysis. Questionnaire was administered to the beneficiaries of primary health care, water resources and basic education in the political wards, PTA, SBMC, WDC, DHC, WCA and CDA members.

Table 3.3 Distribution of Questionnaire in Katsina and Bindawa Local Governments.

S/N	Katsina local Government	Questionnaire administered	Bindawa Local govt	Questionnaire administered
1.	Wakilin Gabas I	20	Bindawa	9
2.	Wakilin Gabas II	20	Doro	9
3.	Wakilin Kudu I	20	Tama	9
4.	Wakilin Kudu II	20	Shibdawa	9
5.	Wakilin Kudu III	20	Dallaje	9

6.	Shinkafi A	20	Jibawa/R.Bade	9
7.	Shinkafi B	20	Kamri	9
8.	Wakilin Arewa A	20	Baure	9
9.	Wakilin Arewa B	20	Yangora	9
10.	Wakilin Yamma I	20	Giremawa	9
11.	Wakiin Yamma II	20	Gaiwa	9
12.	Kangiwa	20	-	-
13.	PTA/SBMC Members	6	PTA/SBMC Members	4
14.	WDC/CDA Members	6	WDC/CDA Members	3
15.	WCA	4	WCA	2
16	Total	254	Total	108

Source: field survey 2017.

i. Interview

Interview was conducted with the aid of checklist with the officials of the local government, PHC coordinators and unit heads, education secretaries and unit heads, medical/health staff in the facilities, teachers in the schools, people in the Facilities, Officials of SUBEB, officials of KSPHCDA, officials of RUWASA, WCA, CDAs, DHCs, PTA and SBMC, NUT, MHW chairmen of the two local governments.

Table 3.4 Distribution of Interview

Status / Position	**Katsina Local Government**	**Bindawa Local Government**	**Tot al**
Officials of SPHCDA			1
Officials of SUBEB			1
Officials of RUWASA			1
In charge of CHCs & PHCs And some staff	1	1	2
Headmasters and Teachers	1	1	2
SBMC, PTA, NUT & CDA Chairman	1	1	2
MHW, DHC, WDC & CDA Chairman	1	1	2
People in the clinic	2	2	4
Officials of PHCD	1	1	2
Management of the local government	1	1	2
Officials of WATSAN	**1**	**1**	**2**
Officials of LGEA	**1**	**1**	**2**
WCA		**1**	**1**
Total	**10**	**11**	**24**

Source: Researcher field survey 2017

3.8 Method of Data Analysis

The study employed two analytical methods to present and analyze the responses from questionnaires and interview also to test the hypotheses. First descriptive statistical tools were used for describing and summarizing the data derived from the research questionnaires. Using tabulation, frequency distribution and percentages for easy analysis and describe the characteristics of the data in the table so as to determine the relationships in addressing the research questions and hypotheses. The second method is the use of inferential statistics tools. This enabled the study to draw inferences on the sample population of the study. Regression analysis of a parametric statistics was used to measure the degree or level of the effects of independent variables (IV) on the dependent variables (DV) to test hypotheses. This is based on the fact that, the researcher will be able to predict the degree of effects of the IV or predictor variables on the DV or criterion variable.

Qualitative data was analyzed using thematic method which involves coding the groups and the issues. Gibson (2006) sees thematic analysis as an approach dealing with data that involves the creation and application of 'codes' to data. The 'data' being analysed might take any number of forms. It can be an interview transcript, field notes, policy documents, photographs, or video footage. There is also a clear link between this type of analysis and grounded theory, as the latter clearly lays out a framework for carrying out this type of code-related analysis.

Thematic analysis can be use to represent a picture of reality through systematically sorting the text to identify topics that are well integrated into hierarchical order of themes through the processes of de-contextualization and re-contextualization.

3.9 Measurements of Variables

Service delivery was measured in basic education, water supply and primary health care.

Primary health care was measured by using the followings;

1. Number of health facilities.
2. Adequacy of health workers.
3. Competency of health workers
4. Essential drugs in the health facilities.
5. Laboratories.
6. Functional maternities
7. Adequacy of the funding.

Primary education will be measured by using the followings;

1. Number of primary schools.
2. Adequacy of teaching staff.
3. Competency of teachers.
4. Adequacy and conduciveness of the classrooms.
5. Adequacy of furniture /Teaching and learning aids.
6. Adequacy of funding.

Water supply will be measured by using the following

1. Adequacy of the sources of water supply
2. Functioning of the sources water supply
3. Access to the sources of water supply
4. Funding for treatment and maintenece of sources of water supply

CHAPTER FOUR

OVERVIEW OF PRIMARY HEALTHCARE, WATER SUPPLY AND BASIC EDUCATION SERVICE DELIVERY IN KATSINA STATE

4.1 Introduction

This chapter discusses the capacity and funding requirements of primary health care and basic education in Nigeria. Overview on the background of Katsina state has been discussed and activities of primary health care and primary education in the state has also been presented. Activities of Katsina and Bindawa local governments and local education authorities on primary health care and primary education have been reported. Finally organizational structure, departmentalization and staff strength of the two local governments have been presented.

4.2 The UBE Funding Structure

It is important to note that the UBE as an intervention programme is a funding arrangement of the federal government to provide financial and technical assistance to states and local government in support of their effort to deliver basic education. The programme is partly financed through the 2% of the Consolidated Revenue Funds (CRF) of the federal government. This amount translated into N24.30 billion in year 2005 when it was first released and later rose to N30 billion in 2006 (Dalhatu, 2015). The sharing formula and components of the CRF directed that:

i. 70% of the UBE fund is given to the 36 states and FCT on equality basis as matching grant.
ii. 14% is to be shared to states to correct educational imbalance within and between states.

iii. 5% to states that are doing very well in the implementation of the UBE programme as incentive.

iv. 5% dedicated to school feeding and health programme.

v. 2% to address issues of special needs education specifically physical and mentally challenged children.

vi. 2% for monitoring the implementation of the programme.

vii. 2% as UBE commission's implementation fund. (Tahir, 2007 in Dalhatu, 2015)

However, the criteria for assessing the 70% matching grant fund by the states is predicated on a number of conditions. These are:

i. Enactment of the State Universal Basic Education law in compliance with section 12(1) of the UBE Act 2004;

ii. Establishment of State Universal Basic Education Board (SUBEB) in each state with appointment of principal officers to manage the Board and implement the programme.

iii. Opening of a separate Bank Account with the Central Bank titled "UBE matching grant account" with executive chairman of the board and senior seasoned civil servant in the board as signatories to the account;

iv. Lodgment of states counterpart contribution of 50% of the same amount; and

v. Development and submission of state action plan to UBEC for negation and eventual approval.

In utilizing the funds, the state should assign the following percentage to the following level of basic education;

i.	Pre-primary education	5%
ii.	Primary Education	60%
iii.	Junior Secondary Education	35%
		100%

And further allocate each of this level to be utilized on the following major components of the UBE programme:

i.	Infrastructural development	70%
ii.	Provision of instructional materials	15%
iii.	Teacher professional development	15% (Tahir, 2007 in Dalhatu, 2015)

Indeed, the UBE programme offers a unique opportunity for state governments to access funds for the development of basic education in their respective states.

4.2.1 Capacity Requirements for the Implementation of Basic Education Programmes in Nigeria.

The UBE Act 2004 has provided that the UBEC should set out minimum standard for basic education delivery throughout Nigeria in line with the National Policy on Education and the directive of the National Council on Education. A standard that established the Norms and requirements the UBE programme should work towards achieving. The standards would result in producing an environment that is child friendly and conducive to teaching and learning and produce the desired learning outcomes for the achievement of UBE goals. There are three types of standard namely, Resources

standards, process standards and performance standards in the operational implementation of the UBE programme.

Resource Standards; UBEC (2010) has spilt out the minimum Human, Infrastructure and Logistic requirements for the implementation of basic education in Nigeria. These are;

i. Distance and proximity measures in locating a school maintain that schools should be located in such a way that the average number of pupils does not walk more than 2m to get to the nearest school.

ii. School classification; public primary schools are classified into three types, Rural/small schools with less than 200 pupils enrolled but a minimum of 60 pupils, Semi urban Schools with not more than 1000 pupils. The last one is the Urban Schools with more than 1000 pupils enrolled.

iii. For management purposes the minimum and maximum desirable school size for Rural Schools should be between 1 to 2 streams of 240 and 480 pupils. And semi Urban Schools should be between 3 to 4 streams of 720 to 960, while the minimum and maximum size for Urban Schools should be between 5 to 6 streams of 1200 to 1440 pupils' enrolment respectively.

iv. The functional requirements of schools of various sizes are presented in a table 4.1 below.

v. School should not be located immediately close to the market squares or religious centers to avoid the spillover effect of such facilities during school hours unless there is absolutely no alternative.

vi. The maximum number of pupils per classroom is 20 for pre-primary, 40 for primary and 35 pupils for secondary schools respectively.

vii. The mandatory Pupil-Teacher Ratio is 20:1, 40:1 and 35:1 for pre-primary, primary and secondary schools respectively (UBEC, 2010 in Dalhatu, 2015).

Table 4.1: Functional Requirements of a Primary School by UBEC Standards

Requirements	Rural School		Semi urban School		Urban School	
No. of Streams	1	2	3	4	5	6
Maximum enrolment	240	480	720	960	1200	1440
Classroom actual Requirement	6	12	18	24	30	36
Laboratories	-	1	1	1	1	2
Workshops	-	1	1	1	1	2
Libraries	-	-	1	1	1	2
Toilet separate for males and females	6	12	18	24	30	36
Headmasters/principal's office	1	1	1	1	1	1
Asst. Headmaster's/ Principal's Office	-	-	1	1	1	1
General office	-	-	-	1	1	1
Staff Room	-	-	-	1	1	1
Store	1	1	1	1	1	1
First-Aid Box/Sick Bay	1	1	1	1	1	1

Sources: UPE Standard Guidelines, FMOE, Lagos, (1975) reviewed 2002 and adopted by UBEC as preferred capabilities/sizes of public schools.

4.2.1.1 Process Standards: These are aspects that affect policy guidelines and regulations governing the operation for the basic education programme. Some of these policy requirements are:

i. The maximum number of weeks per year for all levels pre-primary, primary and secondary schools are 39 weeks' mandatory, 45 weeks optimal and 42 weeks' ideal.

ii. The entry age per standard specification for Pre-Primary is between 1 – 3 years of age, 6 years for Primary and 12 years for JSS on completion of primary education.

iii. The curriculum most adopts 9 compulsory subjects for Primary School and minimum of 10 compulsory subjects for Junior Secondary Schools.

iv. Transition of pupils within the curriculum and from class to class shall be based on competency – Based Continuous Assessment (CA).

v. Complete disarticulation of the JSS from SSS for effective administration and application of the UBE Intervention Funds is necessary.

vi. Accelerated Girl-Child Education and other disadvantage groups' Initiative (AGCI) is mandatory (UBEB, 2010).

4.2.1.2 Performance Standards: These are aspects that affect the quality of teaching and learning. Some of the standard specifications that affect quality of instructions and learning outcomes are;

i. Teachers minimum entry qualification into the basic education sector is NCE registered with the TRCN as professional teacher.

ii. The minimum Routine monitoring/supervision by SUBEB shall be twice a term, LGEA thrice a term and that of community and school continuous exercise.

iii. Quality Assurance department shall be created at UBEC, SUBEB and LGEA Levels to monitor the quality of teaching and learning procedures and outcomes.

iv. Assessment of Learning Achievement based on pupils' performance in core subjects and life skills using cognitive and non-cognitive test should be conducted by SUBEB and LGEA annually.

v. Each SUBEB and LGEA should have strategic plan for action derived from State Education Sector Plan together with a Short term plans targeted areas to fast-track the achievement of EFA (UBEB, 2010).

The local Education Authorities are responsible for the management of primary Education services throughout the state. Local education authorities are now called local

government education authority (LGEA) in line with the UBE policy guideline. LGEA is further sub-divided into six departments/units:

1. Personnel department.
2. Planning, research and statistics (PRS).
3. Academic services.
4. Finance and supply.
5. Quality assurance.
6. Social Mobilization.

4.3 Capacity Requirements for the Implementation of Primary Health Care Programmes

The National Primary Health Care Development Agency (NPHCDA) has set out Minimum Standards in the areas of health infrastructure, human and financial resources as well as the provision of essential drugs and equipment for primary health facilities in Nigeria. The NPHCDA sees the Minimum Standards as a robust system that is fundamental to the effective functioning of any health and therefore an essential element for the delivery of quality health care. The policy document defines a set of Minimum Standards in the following areas:

i. Health infrastructure: Types/Levels of PHC facilities including recommended infrastructure dimensions, furniture and equipment.
ii. Human resources for Health: Minimum recommended staff number and cadre for each type of health facility.
iii. Service provision: Recommended minimum PHC services for each facility type including the minimum requirement of medical equipment and essential drugs (From

the National essential Drugs list) required to achieve these services (NPHCDA, 2013).

The overall goal of the manual is to set uniform standard for the various levels of health facilities and the Minimum Standards for PHC structures, systems, staffing and equipment as basic capacity requirement for PHC service delivery at Local Government Level. In order to improve access and quality of services the minimum standard focuses on PHC infrastructure and management; human resources; service provision and essential drugs. Health facilities are either static or mobile in structures; these health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered. Many terminologies have been used over the years including dispensaries, health clinics, health centres, primary health centres, maternities, health posts and comprehensive health centres (Dalhatu, 2015). However based on the Ward Health System approved by the NPHCDA, the three recognized primary health facility types are: Health Posts; Primary Health Clinics and Primary Health Care Centres.

Health Posts: The Health Posts are supposed to provide health care services at neighborhood and village level, serving an estimated population of not more than 500 people. The infrastructural requirement of the Health Post include among other thing:

i. Building and Premises requirements such as; two rooms with cross ventilation, functional doors and netted windows and the walls and roof must be in good condition; Functional separate male and female toilet facilities with water supply within the premises; Availability of a clean water source; Be connected to the

national grid and other regular alternative power source; Have a sanitary waste collection point and a waste disposal site; be clearly signposted – visible from both entry and exist points; Be fenced with gate and generator houses (NPHCDA, 2013).

ii. Furnishing requirement include among other 2 Benches, 2 Chairs, 2 Cupboards, 1 Examination couch, 1 Screen, 1 Stove, 1 Wash hand basin and, 1 writing table.

Medical equipment requirements are: 2 Dressing forceps, 1Fetoscope, 2Geo Style Vaccine Carrier (GSVC), Ice Packs – 4 per GSVC, 1injection safety box, 2Kidney dish, 1 set of ORT Demonstration Equipment (Cup, jug, wash basin, towel, bucket, standard beer or/and soft drink bottle), 2 scissors, 1 Solar Refrigerator, 2 Sphygmomanometer, 2Stethoscope, 1Tape rule, 1 Thermometer and 1 Weighing scale (NPHCDA, 2013: P12).

Personnel requirements: The minimum standard manual recognized the following category of health staff, these are; Community Health Officer (CHO), Nurse/Midwife, Community Health Extension Worker (CHEW), and Junior Community Health Extension Worker (JCHEW). The manual proposed that a Health Post should be headed by at least a JCHEW, who supervises Community Resource Persons (CORPS) working within the community. CORPS is a trained Community Volunteers including, TBA, VHW and other community based service providers that have been duly trained and are recognized by the LGA.

Service requirements: The types of recommended services to be provided by the Health Post are as follows:

i. Health education and promotion services on prevailing health issues and problems of the local community.

ii. Collect data in respect to Health Management Information System and sent to M&E unit of the PHC department.

iii. Routine home visit and community outreach to identify health issues affecting the community.

iv. Provide maternal, newborn and child care (routine price, ante and post-natal care to pregnant women).

v. Family planning counselling services and dispensing of condoms to prevent unwanted pregnancy.

vi. Promotion of proper nutrition and food education through health education.

vii. Participating in immunization campaigns and immunization trend fellow up.

viii. Participate in mobilizing the local community on the prevention and misconception of HIV/AIDS.

ix. Sensitize the community on the contact tracing, prevention and misconception of tuberculosis.

x. Prevention and treatment of malaria particularly among women and children.

xi. Provide curative care services on minor diseases and injuries.

xii. Maintain the Essential Drugs Funding System within the community.

xiii. Promotion of personal and community hygiene.

xiv. Advice and counsel community on mental health prevention of drugs and substance abuse (NPHCDA, 2013: P25 - 27).

Other requirements of the Health Post include recommended hours of operation from 9:00am - 4:00pm (open for at least 8 hours every day). The managerial system provided that the Health Post is to be co-managed with the Village Development Committee

(VDC) who represents the community in the planning, implementation and monitoring of the services rendered by the Health Post.

Primary Health Clinic: This is the second type of PHC facility that is expected to offer services to a group of neighborhoods and villages with an estimated population of 2,000 –5,000 people. The manual proposed for the Infrastructural requirements that the building and premises of the Primary Health Clinic should be a detached building with at least 5 rooms, Walls and roof must be in good condition with functional doors and netted windows, functional separate male and female toilet facilities with water supply within the premises, availability of a clean water source: at least motorized borehole, connected to the national grid and other regular alternative power source, have a sanitary waste collection point, have a waste disposal site, clearly signposted – visible from both entry and exit points, fenced with gate and generator houses and staff accommodation provided within the premises (2 bedroom apartments). The manual recommends that the building must have sufficient rooms and space to accommodate: Client observation area, consulting area, delivery room, first stage room, injection and dressing area, lying-in ward (4 beds), pharmacy section, record section, staff station, store, toilet facilities (or VIP Toilet), waiting/reception area. Other furnishing requirements include among other 8 benches, 10 chairs, 2 cupboards, curtains for windows and doors, 1 delivery bed, 2 examination couch, 4 observation beds, 2 screens, 2 wash hand basins, 1-wheel chair, 3 writing table. (NPHCDA, 2013: P, 28). On the other hand, the medical requirements include the following listed in figure 4.2 below.

Figure 4.2: List of Medical Requirements Recommended in PHC Clinics.

Adult weighing scale – 2	Ambo bag – 1	Artery forceps – 2
Baby weighing scale – 1	Bed pan – 4	Bed sheets, 2 per bed
Clinical thermometers – 2	Cold boxes – 1	Cord clamps
Curtains	1 per window	Cusco speculum – 2
Disposable (facemask, gloves etc) 1 pack each	Multisite test kits – 1 pack of 100	Dissecting forceps
Dressing trolley -	Enema kits – 2	Episiotomy scissors
Foetal stethoscope 2	Instrument tray - 2	Kidney dishes – 4
Kidney dish – 2	Lanterns, Buckets	Needle holding forceps– 2
Refrigerator – 1	Scissors – 2	Sims speculum
Solar Refrigerator	Sphygmomanometer – 2	Stadiometer
Stethoscope – 2	Sterilization equipment - 1	Stove
Suction machine or (mucus extractors) 1	ORT Demonstration equipment - 1 set	Tape rule
Urinary catheter 2 of each size	Ice Packs – 4 per GSVC	Geo Style Vaccine Carriers (GSVC)

Source: (NPHCDA, 2013: P, 33).

Personnel requirement for the Primary Health Clinic include 2 Midwife or Nurse Midwife, 2 CHEW, 4 JCHEW (they must work with the standing order). Other supporting staff includes 2 Health Attendant/Assistant and 2 Security personnel. This staffs are to provide all the services provided by the Health Post in a more in-depth manner and even attend to some cases of referral from the Health Post. The facility should run 24 hours services and a complete Essential Drugs list is to be utilized at this level.

Primary Health Care Centers. The Primary Health Care Centre is supposed to be located in every political ward to service an estimated population of 10,000 to 20,000 people. The building and premises infrastructural requirements include in addition to all the requirements for Primary Health Clinic, a detached building of at least 13 rooms. The building should have sufficient rooms and space to accommodate; waiting/Reception areas for Child welfare, Antenatal care (ANC), Health Education and Oral Rehydration

Therapy (ORT) corner; Staff Station; 2 consulting rooms; Adolescent health service room; Pharmacy & Dispensing unit; 2 delivery room; Maternity/lying-in section; In-patient ward section; Laboratory; Medical records area; Injection/ Dressing area; Minor procedures room; Food demonstration area; Kitchen; Store; Toilet facilities (Male and Female). Again, the premises should be fenced and have a waste disposal site with staff quarters or accommodation within the community provided. The premises should be connected to the national grid and provided with alternate power sources.

The centre should be well furnished with all the basic equipment that will make the place look like a PHC centre. In terms of medical requirements, the center should have the following sections; female ward, infant and child welfare unit, first stage room, labor room, antenatal interview room, laboratory, dressing and injection room, staff room, male ward, family planning section consulting cubicle, nutrition and sterilization section, cleaning and utilization facilities. In these sections/units, the manual have described basic items required in each of this section/unit ranging from 14 items to 61 items depending on the section/unit in question.

Personnel and service requirements: The minimum standard manual deed recommends the following number and category of health staff for a PHC Center. These are: 1 Medical officer if available, 1 CHO (must work with standing order), 4 Nurse/Midwife, 3 Chew (must work with standing order), 1 Environmental Officer, 1 Medical records officer and, 1 Laboratory Technician. Other support staff includes 2 Health Attendant/Assistant, 2 Security personnel and 1 General maintenance staff (NPHCDA, 2013). These health personnel are to provide the following PHC services:

i. Health education and promotion services.

ii. Health management information system services

iii. Routine home visit and community outreach.

iv. Family planning services

v. Promotion of proper nutrition and food education services.

vi. Immunization services.

vii. HIV/AIDS counselling, testing and treatment services.

viii. Tuberculosis diagnosis, tracing and management services

ix. Malaria treatment services.

x. Curative care services

xi. Maintaining the essential drugs management system

xii. Promotion of water and sanitation services

xiii. Advice and treatment of oral health services

xiv. Identification, counselling, management and prevention of community mental health.

xv. Effecting referrals for all cases above the other two levels (health Post and PHC Clinic).

xvi. Provide basic laboratory services.

xvii. Provide counselling and supporting to Adolescent Health

xviii. Monitor and supervise Health Clinic and Health Post under their jurisdiction (NPHCDA, 2013: P 48 - 51).

Other requirements include: an Ambulance Vehicle, a bicycle, communication facility (1 Mobile phone or Communication Radio). 2 sets of computers, access to internet

services, 1 motorcycle or small motor boat for riverine area. In addition, the centre shall be open for service 24 hours.

The local government councils are responsible for the management of primary health care services and facilities throughout the state. The department of health in the local governments are now called PHC department in line with the primary health care policy guideline and the department is further sub divided into seven units to effectively handle all the components of the PHC at local level. These units include;

i. Medical unit,
ii. Disease Control unit,
iii. Essential Drugs unit,
iv. Maternal and Child/Reproductive Health unit,
v. Monitoring and Evaluation/Disease Surveillance & Notification unit,
vi. National Programme on Immunization unit and
vii. Social Mobilization/ Health Education unit.

For effective monitoring and control, each of these units is manned by an assistant PHC coordinator who shall be a senior health officer on grade level 14 and above with a minimum qualification of a Diploma or Community Health Officer (CHO). The Maternal & Health Care unit handles all matters on family planning, reproductive and child health. The unit controls the activities of all health facilities in the local government.

4.4 **Overview of Katsina State**

Katsina is a city (formerly a city-state), and a Local Government Area in northern Nigeria, and is the capital of Katsina State. Katsina is located some 260 kilometres

(160 mi) east of the city of Sokoto, and 135 kilometres (84 mi) northwest of Kano, close to the border with Niger. Katsina has a total area of 24,192 km^2 (9,341 sq mi) and ranked as 17th of 36 States. It has a total population of 6,483,429 according to 2006 Population census. It has density of 160/km^2 (420/sq mi). The state was established on 23rd September, 1989. Katsina State has 34 local governments.The city is the centre of an agricultural region producing groundnuts, cotton, hides, millet and guinea corn, and also has mills for producing peanut oil and steel. The city is largely Muslim and the population of the city is mainly from the Fulani and Hausa ethnic groups.

The Katsina Royal Palace 'GidanKorau' is a huge complex located in the centre of the ancient city. It is a symbol of culture, history and traditions of 'Katsinawa'. According to historical account, it was built in 1348 AD by MuhammaduKorau who is believed to be the first Muslim King of Katsina. This explains why it is traditionally known as 'GidanKorau' (House of Korau). It is one of the oldest and among the first generation Palaces in Hausaland. The rest are that of Daura, Kano and Zazzau. The Palace was encircled with a rampart 'Ganuwar Gidan Sarki' (which is now extinct). The main gate which leads to the Palace is known as 'KofarSoro', while the gate at the backyard is called 'KofarBai' (now extinct). The Emir's residential quarters which is the epicenter of the Palace, is a large compound built in the typical Hausa traditional architecture. The current Emir of Katsina is AlhajiAbdulmuminiKabirUsman.

Surrounded by city walls 21 kilometres (13 mi) in length, Katsina is believed to have been founded circa 1100. In pre-Islamic times, Katsina's semi-divine ruler was known as the *Sarki*, who faced a summary death-sentence if found to be ruling incompetently.

From the 17th to the 18th century, Katsina was the commercial heart of Hausaland and became the largest of the seven Hausa city-states. Katsina was conquered by the Fulani during the Fulani War in 1807. In 1903, the Emir, Abubakardan Ibrahim, accepted British rule, which continued until Nigerian independence from Britain in 1960.

During sub-Saharan trade, the city of Katsina was known to be one of the most vibrant and strong commercial centres, and was believed to be the strongest with the Hausa kingdoms in terms of commerce, trade and craft. The German explorer Friedrich Hornemann reached Katsina, the first Westerner to do so, at the beginning of the 19th century. The city's history of western-style education dates back to the early 1950s, when the first middle school in all of northern Nigeria was established. There are now several institutions of higher learning, including three universities: Federal University Dutsinma, Umaru Musa Yar'adua University and the private Katsina University. There are also tertiary hospitals such as Federal Medical Centre, orthopedic hospital etc. The city of Katsina is also home to a famous 18th-century mosque featuring the Gobarau Minaret, a 15-metre (50 ft) tower made from mud and palm branches. The Hausa-Fulani are the largest ethnic group. The state is predominantly Muslim, and Gobarau Minaret is an important building. Sharia is valid in the entire state. The Church of Nigeria has a Diocese of Katsina. The Redeemed Christian Church of God and the Roman Catholic Church are fairly present in the state.

Reports have shown that the State has a population of 6,483,429 million people which are spread within 34 local government Areas of the State. Out of which 3,474,758 million are males (53.6%) and 3,008,671 millions are females (46.4) (NBS, 2009). This indicates

a gender ratio of 105 male for 100 female. The National Bureau of Statistics gives the percentage distribution of the population by age group where 5 – 14 years age bracket received the highest percentage of 34.8, even higher than the National average of 28.2%, followed by 15 -29 years age bracket that received 24.3% while between 0 – 4 years age group recorded 12.7% (NBS, 2009). The two age groups 0 – 4 and 5 – 14 years fall within the basic education and primary healthcare category and thus recorded a combined total of 48% of the population, which is almost half of the entire population of the state.

4.4.1 Primary Health Care Sector in Katsina State

Katsina state has 1698 Health Facilities. This comprises 1 tertiary hospital,20 general hospitals, 30 comprehensive health centers (CHC), 144 primary health centers (PHC), 201 maternal and child health centres, 1059 health clinic,130 dispensaries, 61 health post and 52 private hospitals (KSPHCDA, 2016). The federal medical centre is solely under federal government, the general hospitals are directly under Katsina state ministry of health, The CHCs are managed (structures and equipments) by the KSPHCDA while staffing by KSLGSC. Other health facilities (PHC, MCHC, HC, HP) are co-managed by the state and local governments.

Katsina state government in partnership with NGOs and NPHCDA have built/renovated 201, health facilities in 2011, 264 in 2012, 239 in 2013, 248 in 2014, 161 in 2015, and 102 in 2016 respectively. NPHCDA had also renovated 4 health facilities in 2011, 6 in 2012, 2 in 2013, 3 in 2014, 2 in 2015 and 4 in 2016. Data for the cost of renovation and buildings are not assessable in both the Ministry for Local Government and Department of Budget and Planning. However, most of the projects are co-funded

either through conditional grant scheme or between the partners (i.e federal, state, local government and NGOs) (KSMFLG, 2017).

In terms of manpower, there are 9310 health workers in the state. This comprises 28 resident doctors, 24 nonresident doctors, 171 nurses, 89 midwives, 120 registed nurses and midwives, 124 Community Health Officers (CHOs), 1685 Community Health Extension Workers (CHEW), 947 (JCHEW), 280 Environmental Health Officers (EHOs), 431 Environmental Health Assistants (EHA), 77 pharm technicians, 30 pharm assistants, 27 lab scientists, 111 lab technicians, 132lab assistants, 17 X-ray technicians, 10 X-ray assistants, 121 dental surgery technicians, 130 dental surgery assistants, 23 nutritionists, 69 medical records, 2360 health attendant and 2304 others (KSPHCDA, 2016).

In addition to that, the state have received the total of 384 midwives and CHEWs from the midwives service scheme and SURE-P from 2009 to 2014 (i.e. 96 each batch). In the first quarter of 2017, 57 midwives were received from NPHCDA under the mandatory services of midwives. However, the number of midwives and CHEWs reduced from 384 to 214 as of February 2017. Also the KSPHCDA had received a total of 449 N-POWER staff from the federal government (Though, only 291 are medical practitioners). As of February 2017, there are 9310 medical staff (under katsina state government and ministry for local government), 271 midwives and CHEWs from NPHCDA (though now belong to katsina state government on casual bases), and 291 N-POWER staff (i.e. total of 9872 medical and health workers), (KSMOH, 2017).

In terms of capacity development, KSPHCDA and MFLG had organized 6 programmes for 340 local government health workers (10 from each local government) in 2011, 14 programmes in 2012 with 170 participants, 9 programmes in 2013 with 284 participants, 4 programmes in 2014 with 170 participants, 6 programmes in 2015 with 170 participants, 3 programmes in 2016 with 340 participants, and 2 programmes as at February 2017 with 136 participants. The participants are mostly in charge of CHCs, PHCs, MCHCs, Laboratory, pharmacy and maternities, (KSPHCDA, 2017).

With regards to laboratory equipments katsina state government through KSPHCDA provides laboratory consumables to CHC, MCHC, PHC, (though on request). Such consumables includes ACU-check, widal kit, blood bags, giving sets, field stains, anti A, B, and D SERA, determine, pt strip, AC-check strip, VDRL strip, grams iodine, crystal violet, cotton wool, glass slide, industrial container, Jik, malarial RDT, capillary tubes, e.t.c (some are free, others are at affordable price) (CRRIV, 2016).

In terms of essential drugs, katsina state government in conjunction with ministry for local government provide essential drugs (mostly from the list of national essential drugs) to the health facilities across the state. The supply of such drugs is quarterly (i.e. 4 times in a year). The drugs are mostly 71 categories, which are based on the needs of tertiary, secondary and primary health centers. In addition to that, there is a provision for almajiri drugs which is giving to the almajiris quarterly. There is also mobile ambulance operation in the 34 local governments of the state. The drugs for such mobile ambulance are 36 categories and it’s issued quarterly (Katsina state medical store, 2016).

Katsina state government supplied drugs on free Medicare scheme worth 60,000,000, Epid control and management 30,000,000, child health week 6,400,000; mobile ambulance drugs 18,000,000, almajiri free Medicarescheme 4,200,000 all in 2010. The state government has been spending such amounts on the above programmes every year, with the exception of 2013 where 8,200,000 were spent on epid control and management and in 2016, the free Medicare scheme dropped by 50% (i.e. from 60,000,000 to 30,000,000). The total cost of drugs supplied on free Medicare scheme between 2010 to 2016 stood at 390,000,000. For the Epid control and management, the state supplied drugs worth 26,200,000 between 2010 to 2016. Between 2010 to 2016 the state supplied drugs for child health week worth 44,800,000. Between 2010 to 2016, 108,000,000 were spent on mobile ambulance drugs. For the almajiri FMS, 25,200,000 were spent between 2010 to 2016. Cost of family planning commodities are not available as they use to come from the society for family health. Data on subsidy for DRF is not also available in the MOH. The grand total for the supply of drugs and consumables between 2010 to 2016 stood at 594,200,000 (KTSPHCDA, 2016 and MOH, 2016).

About maternal care services, there are maternities in all the general hospitals, CHC, MCHC, PHC and some HC. There are midwives, Nurses and CHWEs who take care of maternal issues. The state also provides free ANC and PNC drugs and services for the polity. Data on the quantity and amount spent on such consumables maternal tools and drugs is not available in KSPHCDA, MOH, HSMB and MFLG. Likewise data on the annual estimates on primary health for the years under study is not available /assessable.

A part from the commitment by government, there are also NGOs such as UNICEF, GLOBAL FUND, CHAI, MCHC2, WHO, Doctors without borders, save the

children, IHVN, USAID, DFID etc that provides training, drugs and consumables and other support for the primary health care services in the state.

The less than 5 mortality rate (per 1000) stood at 36.8% in 2011, 37.9% in 2012, and 37.7% in 2013, and rose to 47.4%in 2014. It dropped to 35.3% in 2015 and rose to 36.2% in 2016.The maternal mortality ratio (MMR per 100,000 deliveries), stood at 1198.7 in 2011, 1181.2 in 2012, and dropped to 918.2 in 2013. It is also rose to1149.8 in 2014 and dropped to 590 in 2015. Also it rose to 634.8 in 2016. Infant mortality rate (IMR per 1000) stood at 31.6 in 2011, 29.5 in 2012, 27.2 in 2013, 25.9 in 2014, 18.3 in 2015 and rose to 21.9 in 2016. Moreover, it was noted that, malaria, diarreoe, malnutrition, diabetes and hypertention has been in the rapid increases in the state. For instance the percentage of people reported to have malaria in 2011 was 31%. However, by December, 2016, it stood at 59.8% (NHIS2, 2016). Likewise, the percentage of children repoted with acute malnutrition in 2012 was 20.4%. However, by December, 2016, it rose to 39.7%. In the same vein, the percentage of children reported with diarreoe in 2012 was 19.6%. However by December, 2016, it rose to 43.8% (Save the children, 2016 and NHIS2, 2016).

4.4.2 Basic Education Sector in Katsina State

There are 2,231 public primary schools with 13,622 classrooms in katsina state. There are 8704 classrooms in good condition (i.e. 65%) and the remaining 36% (4918) are not in a good condition and they do not have a good blackboard. There are 1,477,255 pupils under public primary schools and 71,902 in pre-primary school in Katsina State. There are also 19,435 teachers in the state. The pupil/teacher ratio is

(1,477,255/19435=76:1) 76:1. The pupils/classroom ratio is 114:1 and the percentage of public primary schools with no source of water is 64% (i.e. 8718); pupils/Toilet ratio is 161:1 and the percentage of primary schools with no health facilities is 31% (i.e. 4228). The percentage of classrooms without good blackboard is 36% (i.e. 4918) (SUBEB, profile of Katsina LGAs: key indicators 2016).

With regards to manpower, there is 19435 teaching staff under SUBEB, Katsina state. These comprise different category ranging from Grade II teachers to Msc/Med teachers. In addition to that, there is about 1942 casual staff teaching in the primary schools. Also there is about 1049 N- Power staff received from the federal government. In addition to that there are about 3024 federal teachers (though some have dropped from the programme) in Katsina State teaching in primary schools under Federal Teachers Scheme. The federal teachers were received in four different batches i.e First batch 1000, second batch 1000 Third batch 600 and fourth batch 424 (FTS, 2016, PRS office 2016, staff inventory 2017).

Katsina State Government, in conjunction with the UBE through intervention fund has constructed/renovated many schools. This construction and renovation have costs over Ten Billions, thirty three millions, Two hundred and seventy one thousand, two hundred and ten Naira (10,033,271,210.78) from 2010 to 2015. This comprises the rehabilitation of 492 schools, construction of 548 classes, 621 toilets, 3 storey buildings, 211 offices, 242 stores and electrification of 31 schools worth 1,132,179.891 in 2010. Also in 2011, 1,560,318,685 were spent on renovation of 301 schools, construction of 429 classes, 178 toilets, 4 storey buildings, 193 stores and electrification of 29 schools. In the same vein, the intervention fund spent in 2012 on rehabilitation of 611 schools,

construction of 783 classes, 209 toilets, 289 stores, 189 offices and electrification of 29 schools was 1,601, 179,216. In 2013 the amount spent on construction of 794 classes, renovation of 409 schools, 211 toilets, 189 stores, 230 offices and 7 storey buildings was 1,733,497,734. However, the amount spent in 2014 on construction of 389 classes, renovation of 295 schools, 4 storey buildings, 94 offices, 219 toilets and electrification of 29 schools was 1,544,192,915. In 2015, the capital spending on construction of 298 classes, 345 toilets, 212 offices and renovation of 392 schools was 1,495,993,668. This goes to shows that there is a high level of commitment in terms of provision and construction/rehabilitation of schools (SUBEB project documents 2010, 2011, 2012, 2013, 2014 and 2015).

About the provision of furniture for pupils and teachers, One Billion, Fifty four million, three hundred and ninety six thousand, two hundred and three Naira (i.e. 1,054,396,203) was spent between 2010 to 2016. This involves the supply of 2989 three sitter for pupils and 682 teachers furniture worth 51,125,000. In 2010, 175,530,000 was spent on construction of 4721 three sitter pupils furniture and 498 teacher furniture. In 2011, 4689 pupil furniture and 1089 teachers furniture was supplied at the cost of 144,409,000. In 2012, 6456 pupils furniture and 1432 teachers furniture was constructed at the cost of 230,987,637. In 2013, 5083 pupils furniture and 1405 teachers furniture was constructed at the cost of 230,507,456. In 2014, 4983 pupils furniture and 948 teachers furniture was supplied at the cost of 221,837,110. In 2015, 2968 pupils furniture and 895 teacher furniture was constructed at the cost of 213,827,894 respectively (SUBEB, project document 2010 to 2015).

Withregards to games facilities, 9,762,940 was spent in 2012 and 20,339,460 was also spent on games facilities in 2013. Also in terms of generator, Borehole and others

145,781,583 was spent in 2014 for procurement of 28 gasoline generator, 41 boreholes, and other facilities. More so, 35,070,246 were also spent for procurement of 9 gasoline generator, 29 boreholes, and 1 project van in 2015.

In terms of provision of books, the state government had supplied 184,000 copies of text books for English and mathematics in 2010. In 2011, there was supply of 682,893 copies delivered by UBEC and Assorted Novels that worth 65,984 copies. In 2012, UBEC delivered 1,349,980 copies of Text books on English, Mathematics, Science and social studies. In 2013, there was a delivery of library materials from UBEC with 60,500 copies. In 2014, there was also a supply of text books on mathematics, English and social studies worth 138,999 copies. In 2015, there was also a delivery of 66,930 copies of Text books and library materials from UBEC. Also in 2013, SUBEB distributed 695,712 copies of books on Basic Science, Technical and Social studies. Likewise in 2015, SUBEB distributed 14000 copies of Text books on English, Mathematics, socials Studies, Basic Science and my world words and my figures (SUBEB, S.R.V and S.I.V 2010 to 2015, KTS/SUBEB/OFF/396/Vol.I/67.2017, KTS/SUBEB/ADM/5/396/Vol.I/80).

In terms of capacity development, SUBEB had organized In house teacher development programmes in 2013 with the 1,360 participants (40 from each LGEA). Also in 2014, the same programmes was also organized by SUBEB and attended by 1,360 participants. SUBEB had also organized various programmes for Normadic schools. There was also distribution of school uniforms to Normadic primary schools in which 1389 pupils were benefitted from the programme hold on 09/09/2015. SUBEB had also organized at least 2 sports activities every year. This involves inter schools competition; inter zonal and senatorial competitions (SUBEB, DAS, 2016). SUBEB had

also provides learning materials to teachers/pupils with special needs, seminar for the same pupil/teacher with special needs, awarded scholarship to such pupils and provides different kinds of support to such pupils/teachers with special needs. (SUBEB,DAS various reports- 2011 to 2016).

Katsina state annual estimates on Basic Education stood at 3,363,675,924 for capital expenditure in 2012. Recurrent expenditure (i.e. over head and salaries) stood at 17,990,644,039 for 2012. The capital expenditure for 2013 was 3,228,295,509 while recurrent expenditure for 2013 stood at 16,205,210,418. For the year 2014, the capital expenditure was 3, 741, 125, 061, whereas recurrent expenditure was 17,812,005,131. Capital expenditure for the year 2015 stood as 2,761,534,245 while recurrent expenditure for 2015 was 18,606,923,195. While for 2016, the capital expenditure was 3,603,124,465, while recurrent expenditure for 2016 was 19,530,818,226. For the recurrent expenditure, the local government provides 100% of the salaries for LGEA staff and overhead while the state government provides 100% of the salaries of SUBEB officials and overhead (SUBEB Annual Estimates 2012 to 2016).

4.4.3 Portable Water Supply in Katsina State

There is commitment to provide Portable water supply in Katsina State. Katsina state Government through Ministry of Water Resources and Rural Water Supply Authority has provides 2857 sources of drinking water between 2010 to 2016. This involves 2550 boreholes, 302 solar system and 5 treament sources (RUWASA 2016). In addition to that the State through MFLG, RUWASA and MWR has spent over 480,000,000 for the mentenance of such plants, boreholes and solar system. In addition to that there is also support from the senators, house of representative members and some

philantrophers that provides 195 boreholes and solar system through constituency projects. Moreover, there is also intervention from Sokoto River Basin Development Authorities that provides 34 sources of treatment water plants (Magaji, 2016).

Katsina state government through RUWASA has supplied borehole equipments such as G1 pipes 28000, complete cylinder 15,000, connecting Rod 19840, complete head 6209, spindle 2704, Rubber cup 46,000, Bearing 14,927, Foot valve 11209, Chalk valve 17896, Stander 4160, Spoot 16261, and chain 8604 "between 2011 to 2016 respectively (RUWASA, 2016). In the same vein the state have procured the facilities for electrified summer such as 2104 complete SQ Pump, 14211, 110mm cable wire, 2018 safety rod, 1409 borehole cover, 14961 PVC pipe, 14961 PVC gum, 986 PVC pipe, 2301 screen casing, 149 complete chain, 2708 starter, 49 Generator and 169 blinding casing all between 2011 to 2016 (SRV, 2016).

4.5 Katsina Local Government in Context.

The local government area of Katsina is an area of 142 km^2, with a population of 338,000 at the 2006 census. The local government has 12 political wards; Wakilin Gabas 1, Wakilin Gabas 2, Wakilin Kudu 1, Wakilin Kudu 2, wakilin Kudu 3, Shinkafi A. Shinkafi B, Wakilin arewa A, Wakilin arewa B, Wakilin Yamma 1, Wakilin Yamma 2 and Kangiwa. The local government shared border with jibia and kaita at the north, Batsari and batagarawa at the west, Rimi and Batagarawa at the south and Mani and Batagarawa at the east. Farming, petty trading and public service are the major occupation of the people of Katsina local government.

4.5.1 Primary Health Care in Katsina Local Government

Katsina local government has fifty three 53 health facilities. These include 1 FMC, 3 General Hospital, I CHC, 15 MCHC, 10 HC, 3 Dispensaries and 20 private Hospitals. The FMC is managed by Federal Government, General Hospitals are also managed by Hospital Service Management Board (HSMB), 1 CHC and 4 MCHCs are managed by KSPHCD and the 20 private Hospitals are managed privately. The remaining 24 Health facilities are directly under PHC department of Katsina local government (KLG, PHCD, 2016). There are also three 3 equipped laboratory under of katsina local government, 6 equipped pharmacist and 13 maternities under PHCD in katsina local government.

In terms of manpower (i.e. Health workers) there are 323 workers in the Health facilities. This include 1 Nurse, 5 Midwifes 7 CHOs, 64 CHEW, 21 JCHEW, 39 EHO, 2 Pharmacist, 1 lab scientist, 2 lab technicians, 1 Lab Assistant, 1 DST, 2 DSAs, 1 Nutrition, 1 medical record, 48 Health Attendants, and 103 others (i.e. N-power, Sure-p, Casual, and social welfare staff (KLG, PHCD 2016). Katsina local government has sent 14 staff for training in 2011, 8 in 2012, 3 in 2013, 3 in 2014, 5 in 2015 and 6 in 2016 respectively.

With regards to essential drugs, the local government had supplied drugs worth 651,201 in 2011, 695, 500, in 2012, 600,000 in 2013, 600,000 in 2014 and 600,000 in 2015. There was no supply in 2016. The local government also received drugs worth 2,515,958 from MCHC2 in 2014/2015.The local government also supplied laboratory consumables worth 200,000 in 2011, 200,000 in 2012, 219,000 in 2013 and 251,000 in 2014 (KLGPHCD, 2016). As at 2016, under 5 mortality rate per 1000 stood at 33.4,

maternal mortality ratio per 100,000 deliveries stood at 621.4, and infant mortality rate per 1000 stood at 18.2 (M&E, PHCD, KTLG 2016).

The annual estimates of katsina local government for 2010 is 186,626,968 personnel cost, 20,580,000 overhead cost, 17,000,000 capital expenditure, the total for 2010 stood at 220,626,968. For 2011 it stood at personnel cost 186,626,968, over head cost, 20,588,000 and capital expenditure 141,510,000. The total for 2011 stood at 348,725,968. For 2012 it stood at 232,369,532. For 2013 personnel cost was 252,587,100, the total for 2013 stood at 393,293,100. For the year 2014, personnel cost was 326,112,914, overhead cost was 8,000,000 and capital expenditure was 67,206,000. The total for 2014 stood as 401,318914. For 2015, personnel cost was 204,508,977, overhead cost was 8000.000 and capital expenditure was 25,000,000 the total for 2015 stood as 237,508,977 (Treasury dept, KTLG, 2016).

4.5.2 Basic Education in Katsina Local Government

There are 48 public primary schools with 790 classrooms. There are 11% (i.e. 87) of the classrooms that does not have a good blackboard and are not in a good condition in katsina local government. The enrolment as at 2016 stood at 89,507 while enrolment in pre primary schools stood at 5,711, pupils classrooms ratio stood at 121:1 and the percentage of primary schools with no source of water stood at 25% (i.e. 12). Pupils' toilet ratio stood at 228:1, while the percentage of primary schools without health facilities is 10% (i.e 5). The number of teachers in katsina local government education authority (LGEA) is 1,212. The pupils teacher ratio is 89,507/121 = 74:1 (SUBEB, profiles of LGEA 2016). The distribution of teachers in terms of their qualification is that OND 201, HND10, NCE 905, Bsc/BA.Ed 73 and others 8 (KTLGEA, 2016).

The enrolment in primary schools has been increasing from 63500 in 2011, 69,250 in 2012, 72,860 in 2013, 75,112 in 2014, 79,688 in 2015, and 84,621 in 2016 with 89,507 in 2017 respectively. The completion is also increasing from 2010 with 7882, 2011 with 9080, 2012 with 9800, 2013 with 9904, 2014 with 10,240, 2015 with 10,380 and 2016 with 12,230 respectively (KTLGEA, Quality Assurance dept, 2017).

In terms of structure, between 2010 to 2016, 2 new primary schools were built and 33 were renovated. There is also approval for the construction of another three new primary schools and renovation of four primary schools (KTLGEA, 2017). With regards to text books, katsina LGEA have received 18,000 copies of books on English, 18,000 copies of Mathematics books, 18,000 copies of social studies books, 18,000 copies of Basic Science Books, 7000 copies of ECCDE Books all from the SUBEB from 2011 to 2015. In addition to that katsina LGEA have received 395,000 copies of books on English, mathematics, social studies. Science and ECCDE from UBEC between 2012 to 2015 (KTLGEA, 2017). Katsina LGEA have also received 20,000 cartoons of chalk 10,000 registers, 8000 diaries, 5000 admission registers, 200 foot balls, 100 hand balls, 100 ropes for jumping, 3000 mathematics sets between 2011 to 2015 (KTLGEA, 2017).

There are also training programmes attended by over 104 staffs of KTLGEA from 2011 to 2016. In the same vein some staffs have benefitted from the in-service training scholarship of the current administration that pays 100% of the registration fees and other allowances. The local government also is supporting the LGEA in terms of provision of books, furniture, renovation of schools and teaching and learning aids. There are also philantrophers and politicians that donated some books and other facilities to Katsina

LGEA (KTLGEA 2017). The number of school children out of school is 38,588 and the literacy rate stood at 63% (NDS, 2016).

4.5.3 Portable Drinking Water in Katsina Local Government

There are 648 boreholes, 102 electrified solar and about 847 covered wells in Katsina local government. In addition to that, there are 621 registered private boreholes in the local government (KTLG, 2016). According to the information available, KTLG through WATSAN department had procured/received borehole and electrified summer equipments from NGOs, state government and philantrophers worth 68 million naira between 2011 to 2016 electrified summer equipments involves PVC pipe, PVC tank, PVC gum, Reducer, coplen chain, blinding casing, screen casing, panel solar, safety rope, starter, complete SQ pump etc. The boreholes equipment includes spladers, chain, foot valve, chalk valve, complete head, connecting rod, spindles and rubber cup. In addition to that, there is interventions form various community organizations in terms of provision and maintenance of such sources of water (KTLG, 2016).

4.6 Bindawa Local Government in Context.

In terms of the political features the projected population is about 152,356 people, and land area of 26 square kilometers. The people of Bindawa local government area are law abiding and peace loving people. The local government has Hausa Fulani as the major tribes with 99% of the inhabitants as Muslim by religion. Prior to the creation of Bindawa local government, Bindawa town was under the jurisdiction of Mani Local Government Area in Katsina state. Bindawa local government was created in 1989 by the former head of state General Ibrahim B. Babangida. It is located 21 kilometers south of

the state capital. Bindiawa local government shared boundary with Ingawa local government to the east, Kankia Local Government to the south, Mani Local Government to the North and Rimi, and Charanchi Local Governments to the west. The local government comprises of two districts namely: Bindawa and Doro with a total of 21 village Head areas. They are as follows: Bindawa, Shibdawa, Kamri, Gaiwa, Tama Dailaje, Rinjin Baushi, Faru, Jibawa, Rugar barde, Gwanza, Kyarmanya, Daye, Doro, Mazanya, Aisawa, Baure, Giremawa, Tuwaru, Yangora and Kura. With regards to the economic features, from the data available in the council, the people of Bindawa local government engaged in farming, livestock rearing, crafts and petty trading as their major occupations. Bindawa local government currently plays a significant role in the production of the following foods and cash crops: Millet, Corn, Beans, Cotton, Maize, groundnut Rice and cassava. In some areas, rivers are present for irrigation purposes. As such, the local government scoring a shining example in dry season farming in response to the successive governments particularly the present government clarion call to help boost food production in the state and the country at large. Similarly, the local government is blessed with excellent communication system made up of good network roads that links it with all parts of the state. At present, the local government has a total of 74 primary schools in the area with about 44787 pupils and a number of 508 teaching staff and 218 non-teaching staff. In addition to that, the local government has 10 post primary schools out of which 4 are owned and managed by the local communities of Doro, Dallaje, Giremawa and Tama respectively. So also there are 68 health facilities with 76 health workers in the local government.

4.6.1 Primary Health Care Sector in Bindawa Local Government

Bindawa local government has 68 health facilities. This ranges from 1 CHC, 5 PHC, 7 MCHCs, 29 HCs, 25 Dispensaries and 1 Health Post. In terms of manpower, there are 248 workers in the health facilities. These includes 1 Residential Doctor, 1 Non Residential Doctor, 1 Registered Nurse, 1 Midwife, 1 RN and MW, 7 CHO, 55 CHEW, 34 JCHEW, 7 EHO, 9 EHA, 5 pharm Tech, 4 lab Tech, 3 lab Assistant, 1 DST, 1 DSA, 1 Nutritionist, 95 Health Attendants and 21 Others (BDLG, PHCD, 2017).

Bindawa local government has sent 40 staffs for training between 2011 to 2016. This involves 9 in 2011, 7 in 2012, 11 in 2013, 4 in 2014, 4 in 2015 and 5 in 2016. With regards to essential drugs, the local government has supplied drugs worth 450,000 in 2011, 480,000 in 2012, 250,000 in 2013, and 300,000 in 2014. There is no supply in 2015 and 2016 respectively. The local government also built/renovated 6 health facilities in 2011, 5 health facilities in 2012, 7 health facilities in 2014 and 4 in 2015 (BDLG, PHCD, 2017). As at 2016, the under 5 mortality rate per 1000 stood at 41.4, maternal mortality ratio per 100,000 deliveries stood at 648.2 and infant mortality rate per 1000 stood at 24.6 (NHIS2, 2016). The percentage of people reported to have malaria in 2012 was 28%. However, as at 2016, it stood at 46%. Bindawa Local Government Annual Estimates on Primary Health Care for 2011 is 197,626,968 personnel cost, 16,581,000. For 2012 it stood at 228,000,000, for the year 2013 it was 229,158,000. For 2014 it was 218,149,428, for 2015 it stood at 219,421,413 and for 2016, it was not available for the researcher.

4.6.2 Basic Education Sector in Bindawa Local Government

There are 69 public primary schools and 5 annex schools with 393 classes. Enrolment in public primary schools stood at 43,514 while the enrolment in pre-primary

schools in Bindawa LGEA stood at 4,056. Pupils classroom ratio stood at 121:1, percentage of public primary schools with no source of water is 58% (i.e. 40) while pupils/toilet ratio is 177:1. The percentage of schools with no health facilities is 20% (14) while the percentage of classrooms without good blackboard is 32% (i.e. 22). There are 503 teachers in Bindawa LGEA and the pupils teacher ratio is 43514/503 (i.e. 87:1) (SUBEB key indicators 2016). The distribution teachers in terms of qualification is that; OND 64, NCE 370, Grade II 19, HND 2, Bsc/Bed 31, others 17 (BDLGEA 2016). The enrolment in primary schools has been increasing from 2011 to 2017.

In terms of structure SUBEB renovated 3 schools at the cost of 165,101,722 Naira in 2010. In 2011, 4 schools were renovated at the cost of 17,580,000. In 2012, 4 schools were also renovated at the cost of 14,315,455 Naira. In 2013, 4 schools were renovated at the cost of 23,830,908. In 2014, 5 schools were also renovated at the cost of 34,299,844 (BDLGEA, PRS dept, 2016). In addition to that, Bindawa local government have renovated 7 schools in 2011 at the cost of 18,186, 226 Naira. Also in 2013, 3 schools were also renovated at the cost of 13,553,088 Naira. In 2014, UBEC alone renovated 2 schools at a cost of 60,000,000 Naira (BDLGEA, 2016).

About furniture, LGEA Bindawa has received over 6500 three sitters furniture from SUBEB between 2011 to 2016. In addition to that, Bindawa local government council had donated furniture for 5 schools at the cost of 4,258,577 Naira in 2011. Moreover, the local government had also donated furniture to 12 schools at the cost of 11,200,000. Also in 2016, 2180 three sitters' furniture was received from SUBEB (the furniture is for 5 primary schools). Currently there are 7465 three sitters for pupils but only 4502 are in good condition, there are also 200 teachers' furniture, but only 148 are

in good condition (BDLGEA 2017). There are also 3 library shelves and all are in good condition. Also there are 10 cardboards but only 6 are in good condition. With regards to Text Books, the LGEA have received Books on English 30,000, Mathematics 30,000, Basic Science 15550, Nigerian Language 10,000, Social Studies 15,000, Civic education 5000, Arabic 10,000, Agric 545, PHE 5000, and ICT 450 copies from SUBEB/UBEC respectively (LGEA, Quality Assurance dept, 2016).

With regards to instructional materials, the LGEA have received 400 packets of chalk, 250 Charts, 2 Maps, 220 Chalk boards, 35 computers and 40,000 nine years basic education curriculum copies (LGEA, Quality Assurance dept, 2016). Bindawa local government education authority have also received 41 casual staff from the local government, 18 N-Power teachers from the federal government and 8 casual staff (teachers) from the philanthropists.

4.6.3 Portable Drinking Water in Bindawa Local Government

Bindawa local government had also received/procured borehole and electrified summer equipments as follows; Complete cylinder/409, connecting rod 1198, complete heads, complete head 147, spindle 21, rubber cup 162, bearing 1121, foot valve, 1113, chalk valve 1162, slander 89, spout 167, chain 1603, complete SQ pump 69, 110mm cable 1906, borehole cover 98, PVC pipe 2341, PVC tank 62, PVC gum 29, reducer 132, coplen chain 129, starter 51, safety ropes 56, blinding casing 49, generator 41, panel solar 146, and screen casing 141 between 2011 to 2016 (BDLG 2016, SRV 2016 and WATSAN 2016).

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS

5.1 Introductions

This section deals with the presentation and analysis of the data collected. It has presented the qualitative and quantitative analysis of the data and used these to test the hypotheses. For relevant data, focus was placed on the objectives of the study, the critical variables of the hypotheses and the theoretical framework guiding the study. The data analyzed in this section came from the use of the questionnaire, personal observation, focus group interviews and secondary materials that have direct bearing with the subjects matter of this study. For clarity of focus, this chapter is divided into six sections. For the first section, is the introduction and the second section is the summary of data collected. The third section presents and analyzed the result of focus group interview using thematic method of qualitative data analysis. The fourth section presents and analyzed the quantitative data as well as test of hypotheses, the fifth section compare between rural and urban areas of study and sixth section is the summary of major findings

5.2 Summary of Questionnaire Administered

On the whole, 362 questionnaires were administered in the two local governments under study. Out of which 330 representing 91.4% of the total questionnaire administered were returned. Therefore, 330 formed the basis of our analysis and interpretation, which were considered sufficient for valid conclusions (Tabachnick and Figell, 2007, Ringim, 2012 and Dalhatu 2015). The data collection period took about three month (i.e. November 2016 to January, 2017).

Table 5.1: Questionnaire Administration.

S/N	Katsina LG	No. Issued	No. Returned	Bindawa LG	No. Issued	No. Returned
1.	Wakilin Gabas I	20	18	Bindawa	9	8
2.	Wakilin Gabas II	20	19	Doro	9	8
3.	Wakilin Kudu I	20	19	Tama	9	8
4.	Wakilin Kudu II	20	18	Shibdawa	9	8
5.	Wakilin Kudu III	20	19	Dallaje	9	7
6.	Shinkafi A	20	18	Jibawa/R.bade	9	6
7.	Shinkafi B	20	16	Kamri	9	8
8.	Wakilin Arewa A	20	19	Gaiwa	9	8
9.	Wakilin Arewa B	20	19	Baure	9	9
10.	SWakilin Yamma I	20	18	Yangora	9	9
11.	WakilinYamma II	20	16	Giremawa	9	8
12.	Kangiwa	20	19			
13.	PTA/SBMC Members	6	6	PTA/SBMC	3	3
14.	DHC/CDA Members	6	6	DHC/CDA	3	3
15	WCA	4	4	WCA	3	3
16	Total	256	234		108	96

Source: Field Survey, 2017

From the table 5.1 above, out of 330 (100%) returned questionnaires, Katsina local government has the highest frequency of 234 representing 70.9% of the total returned questionnaires. Bindawa local government has 96 representing 29.1% of the returned questionnaires.

Table 5.2: Distribution Interview

S/N	Persons/Depts	Katsina local govt	Bindawa local govt	Total
1.	SUBEB officials	-	-	1
2.	KSPHCDA officials	-	-	1
3.	Management of the local govt	1	1	2
4.	Director PHC and unit heads	1	1	2
5.	Education sect and unit heads	1	1	2
6.	I/C of health facilities	1	1	2
7.	Headmasters/Teachers	1	1	2
8.	NUT,SBMC ,PTA and CDA	1	1	2
9.	MHW,DHC,WDC and CDA	1	1	2
10.	Patients in CHC and PHCs	2	2	4
11.	Officials of RUWASA			1
12.	Official of WATSAN	1	1	2
13.	Officials of WCA		1	1
14.	TOTAL	10	11	24

Source: Research Survey, 2017.

The above table shows that, focus group interview was conducted with the officials of SUBEB, RUWASA, KSPHCDA and the management of each local government. Also focus group interview was conducted with the directors of the PHC department and unit heads in each local government, WATSAN, Education secretaries and their sectionals heads in each LGEA. Likewise the study conducted focus group interview with the chairmen of NUT, SBMC, PTA and CDAs in each local government. Chairmen of MHW, DHC, WDC, WCA and CDA were also part of the people interviewed in each local government. The study also conducted the focus group interview with some patients in the CHCs and PHCs in each local government.

5.3 Data Presentation, Analysis and Test of Hypotheses.

Here data were presented both from focus group interview and questionnaires, analyzed and then hypotheses were tested. Qualitative data were presented and analyzed using thematic method.

5.3.1 Qualitative Data analysis.

Another way of achieving the objectives of this study is through conducting an in-depth focus group interview with major stakeholders involved. The purpose of conducting focus group interview is to allow researcher to have detailed picture about respondent's belief on the major challenges of primary healthcare, basic education and water supply. Interview was targeted towards answering research questions in terms of problems and prospects of basic education, primary healthcare and water supply.

The thematic analytical process involves the initial preparation of data for analysis, then read the original text and identify items that are of relevance through first reading of the text and re-read the text to annotes any text in the margin, sort relevant items into proto-

themes, assess the pro-themes and try initial definitions, re-assess the text thoroughly and carefully for related incidents of data for each pro-theme, arrange and construct the final form of each theme, and finally report each theme as summarized in Table.

Table 5.3: Coding the Respondents

S/N	Codes	Group
1.	FGD 1	Officials Of SPHCDA
2.	FGD 2	Officials Of The Local Governments
3.	FGD 3	Officials Of PHC Department
4.	FGD 4	MHW, DHC, CDA, WDC and CDA.
5.	FGD 5	In charge Of Health Facilities
6.	FGD 6	Patients In CHC
7.	FGD 7	Patient In PHC
8.	FGD 8	Officials Of SUBEB
9.	FGD 9	Officials Of LGEA
10.	FGD 10	PTA, SBMC, NUT and CDA.
11.	FGD 11	Headmasters And Teachers
12	FGD12	Officials of RUWASA
13	FGD13	Officials of WATSAN
14	FGD14	Officials of WCA

Source: field survey, 2017.

From the above table, it can be seen that respondents are categorized into codes ranging from FGD1 to FGD14. FGD stands for focused group discussion.

Table 5.4 Themes on Research Question (Primary Healthcare)

From the table below, it can be seen that primary healthcare is a theme with a subtheme represented by codes. The subtheme ranges from PHC 1 to PHC 8.

S/N	Codes	Themes
1.	PHC 1	Adequacy Of Health Facility
2.	PHC 2	Adequacy Of Manpower
3.	PHC 3	Competency Of Health Workers
4.	PHC 4	Essential Drugs
5.	PHC 5	Laboratory Service
6.	PHC 6	Maternal Care Service
7.	PHC 7	Adequate Funding
8.	PHC 8	Challenges of PHC

Source: field survey, 2017.

Theme One: Adequacy Of Primary Health Care: One of the basic requirements of primary healthcare services is the health facilities. The NPHCDA Act 2013 requires that there should be health post for the minimum population of 200, PHC for 750 people and PHCC for 1400 and above. On this note, FGD 1, FGD 2, FGD 3, and FGD 7 were quoted saying that…

> "There is total gap. The situation is devastating. There are more than required health facilities in the state. There are about 1698 health facilities in the entire state. However the staff strength is the major challenge (i.e. 9310). The standard of CHC is 70 staffs we need 2240 staffs for CHC only. Moreover, there are some PHC centers managed by only three permanent health workers. Some PHCs does not have maternity, laboratory, pharmacy etc. due to inadequate staff. In fact this is the major challenge of primary health care in the state (PHC1)".

The issue of adequacy of health workers is another serious drawback for primary health care service delivery. On this note, FGD5, FGD6 and FGD7 Was quoted saying that;

> The staffs are not really adequate. However, they are really trying as they spend the whole day moving from one unit to another. But they need other staff to assist them. Sometimes they are too aggressive, but may be is because of the nature of the work and the staff are inadequate for the work. Maternity and laboratory are suffering from such shortage of staff. These really affect the patients as we stays sometimes for three to four hours (3 – 4) before they attend to us. Sometimes they are busy in the ward, maternity or OPD (PHC 2).

Also on the same issue, FGD1, FGD2 and FGD3 reveal that;

> The staffs are inadequate. There are 165 technical staff and 28 non technical staff (i.e. 165 + 28 = 193). There is total shortage of staff in all cadres. Some health facilities are managed only by 2 technical staff. The facilities are not operating 24 hours. They operate mainly morning and evening with the exception of CHC, (PHC 2).

The issue of competency of health workers is a serious drawback for primary healthcare service delivery. FGD1 Was quoted saying that

> This is part of major problems of primary health care. There are about 32 CHC provided by the SPHCDA. The staffs of four corner clinics are under SPHCDA.

> However, the rest of the staffs are not competent enough and inadequate. The agency is a supervisory body and use to notice such problems, but there is nothing we can do. The arrangement does not help matters at all. There are some of them that display professionalism and passion. However, there are also others that cannot be relevant in any ways. Some does not know their primary work; some are not up to date while some are not committed at all (PHC3).

On the same issue (IS 3), FGD6 and FGD7 say that;

> The staffs are not much but they are trying to do their best. They give us time and attend to us even at night. There is a doctor in the OPD and sometime he work in maternity, they normally conduct good deliveries. Likewise they have been doing this work for over 12 years; therefore they are really competent in terms of delivering the best. The only place that have problem of competency is laboratory and sometimes maternity. This is because they are mostly casual, Sure-P, and N-Power (PHC 3).

About essential drugs (PHC 4), FGD1, FGD2, FGD3 and FGD5 reveal that;

> There are really supplied of essential drugs. The drugs come from the state government or NGOs (e.g. MCHC). The only gap is that some drugs are not required at all. This is because it is a push method were by the facilities are not to provide the category of drugs required. Very few PHCs have laboratory and they are not fully functional, but all the CHCs have functional laboratory, and maternity.

On the same issue, FGD4, FGD6 and FGD7 say that;

> Actually there are drugs for ANC and other maternal issues. Also there are drugs for malaria, cough TB and other problems (though not always). Only ANC drugs are sometimes free, though others too are at cheaper price and affordable to us. The drugs are usually from WDC, CDA and NGOs. The officials hardly give us drugs, they are selling it. We are really unsatisfied with the situation. Even the drugs that are said to be free, are no longer giving to anybody (PHC 4).

In the same vein, FGD7 and FGD4 were quoted saying that;

> They gave us drugs whenever we came for ANC or R.I sometimes they gave ACT and paracetamol at affordable price. Some facilities provide drugs during immunization only. There are also other consumables from some donor agencies (PHC4).

PHC5: There is need for adequate provision of laboratory consumables in order to help primary health care service delivery. On that note, FGD1, FGD2 FGD3 reveals that;

> There is provision for laboratory consumables for CHC only. They are really functional in terms of that. The local governments should have been responsible for laboratory consumables for PHC and others facilities but they are not doing it. The staffs are also inadequate and incompetent as they are mostly fresh graduate of college of health science and they lack the technical competency to deliver effective services. They are also casual, sure – p and Npower staff, the local government does not have laboratory officers that could provide effective services.

On the same issue, FGD4, FGD5, FGD6 and FGD7 reveal that;

> The laboratory services are the problems. There is only one staff and if he closed, he will hardly come back. We only have problems with the inadequate staffs in the laboratory and their staffs. There are serious problems with laboratory services. Mostly, the services are not reliable at all. Sometimes it is casual staff and attendants, that are conducting the investigations and they charge exorbitantly. We do not have sufficient laboratories and they provide limited services (PHC5).

PHC 6, on this issue the FGD1, FGD2, FGD3, and FGD5 reveals that:

> There are functional maternities in CHC and some PHCs. They are really operating 24 hours; they are competent in providing maternal care services. There is only problem in terms of inadequate tools required to conduct safe delivery. There are also problems in terms of midwives that will conduct the delivery. Most of the staffs MSS staffs are more of CHEWs than Midwives. There are challenges for lack of doctors that could help in extreme situation. The women too are not helping matters in terms of compliance to primary health care advices. The essential drugs required for ANC are sometimes inadequate (PHC 6).

However, on the same issue FGD 6 and FGD 7 reveal that;

> The maternity is functional in some facilities. It operates 24 hours. Just last week, we brought my sister around 2:30 am and they are on duty. They conducted a safe delivery. However, sometime there is congestion in the maternity. The staffs are not adequate enough to attend to all maternal cases. In some instance (complication) they have a doctor (Youth corper) to attend to it.

PHC 7; in response to this FGD 1, FGD 2, FGD 3 and FGD 5 reveals that;

> KSPHCDA is only operating fully at the state. The funding of its activities is directly from the state government. There are some interventions from other level of government (federal) and National and International NGOs. There is adequate funding in terms of structures, manpower development and personnel cost. Almost all the stakeholders are relatively trying. The only issue is that no provision made for procurement of manpower. The current administration also suspended the running

cost of the health facilities. The allocation for FMS and other services have also been reduces by 50%.

In the same vein FGD5 reveal that;

> There is serious drawback in terms of funding of personnel cost. The salary has been reduces by about 30% and the running cost were also withdrawn. The ANC drugs and other tools required for maternal care services were no longer sufficient. The costs of some services in laboratory have also increase due to withdrawn of government provision in such areas (PHC 7).

The issue of challenges of primary health care is a serious drawback for primary health care service delivery. FGD1, FGD2, FGD3 and FGD4 Was quoted saying that

> There are many challenges. This range from poor Human attitude which involves illiteracy, belief in superstition and there is also problems in terms of the low level of awareness. There are also problems in term of fragmentation of primary health care. The human resource is also another problem. The non indigene dominated the sector and they are frequently leaving the state. The training institutions are not adequate and capacitated enough to provide for the requirement. Inadequate number of staffs is also another problem; there is no recruitment in the PHC department of the local government for ten (10) years. Therefore as many are leaving the service for many reasons, there must be wide gap, particularly with growing populations (PHC 8).

On the same issue FGD 6 and FGD 7 was quoted saying that;

> There is need for adequate manpower, adequate provision for laboratory consumables, essential drugs and changes in attitudes of the health workers towards patient (PHC 8)

Table 5.5 Themes on Research Question (Basic Education)

From the table below, it can be seen that basic education is a theme with a subtheme represented by code ranging from BE 1 to BE 7.

1.	BE 1	Adequacy of schools	
2.	BE 2	Adequate Teaching Staff	
3.	BE 3	Competency Of The Teachers	
4.	BE 4	Adequate instructional materials	
5.	BE 5	Adequate Furniture	
6.	BE 6	Adequate Funding	
7.	BE 7	Challenges of Basic Education	

Source: field survey, 2017.

Education is also essential in terms of service delivery. To actualize the UBE objectives, adequate provision of schools, teachers, furniture, classrooms, instructional materials and funds is very essential. BE1, on this issue the FGD 8, reveal that;

> The number of schools is relatively adequate. There are about 2000 primary schools in the state. The most important thing is the condition of the schools and teachers. Some schools needs renovation. There is also need for more classes in the schools. Likewise, the distribution of the schools is also another problem (BE1).

On the same issue FGD 9 and FGD 10 reveal that;

> The schools are inadequate and cannot properly contain the pupils. There are 50 schools (but 2 are not really existing) with the total number of pupils is 89,568. Therefore the schools are not adequate for containing the pupils. The schools are inadequate. There is need for at least 10 schools with about 200 classes. This will help to enroll the pupils appropriately and accommodate them. There is need for more schools to meet the UBE 2004 act requirement (BE1).

BE2 on this issue, FGD 9, FGD 10, and FGD 11 reveal that;

> The teachers are too inadequate. There are some schools with over 1600 pupils with 14 teachers (1600/14=114) which mean each teacher is to manage 114 pupils (114:1). Although there are some schools like Modoji primary school with 785 pupils and 18 teachers (i.e. 785/18 = 43.6). Therefore, there is unequal distribution of teachers by the LGEA.
>
> The teachers are not up to 50% of the requirement of the UBE 2004 Act. There are about 90,000 students with less than 1100 teaching staff. Therefore, teachers are not sufficient at all. Some schools like Shinkafi model primary school has over 3000 pupils with only 28 teachers (i.e. 3000/28 = 107) per teacher. The teachers are not adequate at all. Some schools are managed by two teachers only. The teachers are not sufficient to provide the basic for the pupils. The teachers are not enjoying the work. This is because of the stress of managing over 100 pupils per teacher sometimes where there are female teachers who usually go on maternity leave; there are usually only 3 teachers per school (e.g Santar kuka, Kirya and Kaura Primary schools).

On the same issue FGD 8 reveals that;

> There is need for over 20,000 teachers to meet the UBE requirement of 40:1, although we received huge number of N-Power teachers from the federal government, but there is still need for more teachers (BE2).

BE3, in response to this FGD 8, FGD 9 FGD 10 and FGD 11 reveal that;

> There is need for more competent teachers to provide sound education. However, the quality of teachers is outstanding in the sense that over 90% of the teachers have the minimum requirement by UBE act 2004. The quality of teachers is relatively fair. Although some of them need more training and some are qualified but they are not punctual (BE3).

BE4, on this issue FGD 10 and FGD 11 reveal that;

> There is nothing like adequacy of furniture in the LGEA katsina. There are some schools where pupils are taking their lessons on the floor, some furniture are even broken which injured the pupils. Although some schools like Modoji primary schools have adequate furniture including the plastic chairs. There is total inadequacy of furnitures in the schools some students in school like Dan Masani Bala and Rafin dadi are taken their lesson on the floor. Even where they have furniture some of them are broken and cannot be used by the pupils. The SBMC and PTA in conjunction with welders association have achieved in renovating about 2000 numbers of furniture. The furnitures are in bad condition and insufficient classes like in Aisawa, Daye, Kirya etc. most of the primary schools does not have sufficient chairs. There are general insufficient furnitures for both teachers and pupils, but, this administration had started making provision of furniture. Some had already arrived to school (BE4).

BE5, on this issue the FGD 10 and FGD 11 reveal that;

> The teaching and learning aids are relatively sufficient but, there are no laboratory equipments at all. Some schools do not even have laboratories. Although charts on mathematics and science are inadequate, but they are sufficient for other subjects
>
> There is relatively adequate provision and distribution of teaching and learning aids. The past government (i.e. 2011/15 administration of Ibrahim shehu Shema) has provided adequate provision of books, charts, graphs, typeset for teaching and learning. Although Books and charts on English, mathematics and science as well as laboratory tools are still needed (BE5).
>
> There are adequate teaching aids in some areas. However, there are inadequate in others. Facilities such as chalks, curriculum for 9 years, maps and computer are relatively adequate. However, over head projector, radio set, video set, television set, News papers/magazine and laboratory facilities are not available at all.

BE6, on this issue FGD 8 and FGD 9 reveal that;

> There is adequate provision in terms of capital projects. The matching grant is contributing immensely. The state spends over three Billion naira annually. This

usually comes from federal government, NGOs and state government. However, the problems at a stake are running cost. The state provides the salary and the running cost for the SUBEB officials at headquarter only. The local governments are responsible for the staff salary of the LGEAs, the figure is very huge (i.e. over 19 Billion Naira).

However, FGD 10 and FGD 11 responded that;

The situation is terrible, particularly on the issue of salary in the sense that some teachers spent two month and some time three month without salary. Although, this delay start in August, 2016, and has now been addressed. There is no implementation of promotion since 2013. This explains the lack of welfare of the past administration in the sector which is also related to the issue of funding. There is also delay in the release of money from UBEC and the state government is not helping matters in terms of releasing fund to the SUBEB (BE6).

BE7, on this issue FGD 8 and FGD 9 reveal that;

There is need for more teachers, provision of qualitative furniture, construction of more classes, provision of health and water facilities in the schools, concern for teachers' welfare and withdrawal of political interest in educational sector. There is need for creation of awareness for people to send children to school and allow them to complete the circle.

In same vein, FGD 10 and FGD 11 say that;

The schools, teachers, furniture and welfare are inadequate. There is also politicization of the system which paved the way for indiscipline. Some teachers are not punctual and cannot be penalized by the appropriate body because; they are son of the soil.

Table 5.6 Themes on Research Question (Portable Drinking Water)

From the table below, it can be seen that portable drinking water is a theme with a subtheme represented by codes ranging from PDW 1 to PDW 5.

1	PDW 1	Adequacy of sources of water
2	PDW 2	Functioning of the sources of water
3	PDW 3	Maintainance and Treatment
4	PDW4	Adequate Funding
5	PDW5	Challenges of provision of portable drinking water

Source: field survey, 2017.

Water resource is very essential for human life. The importance of portable drinking water can never be over emphasized. The three levels of government are all committed to the provision of portable drinking water. On this note FGD 12, and FGD 13 say that;

There is adequate provision of portable drinking water in the state. The administration is committed to such provision. The treatment water and non treatment water had both

> improved. There is also intervention from the donor in terms of provisions of portable drinking water. Although in the rural areas, sometimes there is the problem of drinking water. This can be attributed to the poor maintenance culture of the polity (PDW1).

However, FGD 14, state that; (PDW1)

> There is a shortage of portable drinking water, the sources are inadequate. Some communities have to travel for 3 kilometers before they get the water. The sources of water are not really portable. We used water from the stream uncovered well, water from the tabs and other sources. Even those ones are inadequate.

In terms of functioning of the sources, FGD 12 and 13 reveals that;

> We are really trying in terms of making sure that all sources are functional. However, this is beyond what government alone can do. There is need for the community too, to be organized and ensure effective functioning of such sources. We have been repairing these sources almost every day. Therefore, government is trying its best (PDW2).

However, FGD 14 has this to say;

> There are more – none functional sources, than the functional ones, there are some places that have not been repaired for over one year. The communities and politicians are the ones that usually repair them. Some sources do not need anything other than covering them (e.g. uncovered well) (PDW2)

There is critical issue about accessibility of portable drinking water in the community. On this note, FGD 12, and 13 says that;

> There are adequate sources of portable water and this made the sources accessible to the people. There are some communities have no portable drinking water, but we are trying to reach them. There are no communities without access to water. But maybe it is not really portable (PDW3).

However, FGD 14 reveals that;

> There are many communities without access to water. There is a critical challenge in terms of accessibility of the water for domestic use. Even the places that have boreholes, wells and electrified summer, they use to have inadequacy of portable drinking water especially between Februarys to June (PDW3).

With regards to funding for maintenance and treatment (PDW4), FGD 12, 13 and 14 revealed that;

> Government is really trying, but it is solely community and politicians that are doing it. The communities are really trying. Maintenance is beyond government alone. There is also need for other stakeholders to put hand together (PDW5).

There is assumed effort by both government at three levels and communities. However, there are some challenges in terms of portable drinking water. On this note, FGD 12, 13 and 14 has this to say;

> Poor attitudes toward the sources of water by the community, inadequate funding and political consideration in terms of localization of borehole and electrified summer are the major challenge of provision of portable drinking water. There is also low level of private sector participation in the provision of portable drinking water.

5.3.2 Quantitative Analysis and Test of Hypotheses.

Table 5.7: Respondents opinion on Democratic governance provide adequate facilities

Variables	Frequency	Percent	Valid percent	Cumulative percent
Strong Agree	57	24.4	24.4	24.4
Agree	105	44.9	44.9	69.2
Undecided	12	5.1	5.1	74.4
Disagreed	48	20.5	20.5	94.9
Strongly Agreed	12	5.1	5.1	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

From the above table 5.7 it can be seen that 57 respondents representing 24.4% of the total respondents strongly agreed that democratic government provides adequate health facilities in katsina local government. 105 respondents representing 44.9% of the total respondents also agreed that democratic government provide adequate health facilities in the local government. 12 respondents representing 5.1% of the total respondents are not very clear about the above assertion. 48 respondents representing 20.5% of the entire respondents disagree with the above assertion. 12 respondents representing 5.1% strongly disagreed with the assertion that democratic government provides adequate health facilities in the local government.

From the above discussion it is vividly clear that 162 respondents representing 69.2% of the entire respondents agreed that democratic governance provides adequate health facilities in katsina local government. This can also be proved from the interview responses conducted in KSPHCDA, KTLG PHCD, and some patients or beneficiaries who solely commends the effort of democratic governance in terms of provision of adequate health facilities.

Table 5.8: Number of Health facilities required and number available in katsina local government

Variables	Health Post	PHC Clinics	PHC centers	MCHC	Total
Number required	12	12	1	12	37
Number available	13	1	1	14	29

Sources: KSPHCDA, 2016

From the above table 5.8 it can be seen that there are 29 health facilities under Katsina local Government and the requirement is to have 37 facilities. However, there is also one federal medical centre, 3 General/specialist hospitals and 2 health facilities belong to Nigerian police and Nigerian army. Therefore if we put all together (29+6) there are 35 public health facilities in katsina local government. This number can be relatively sufficient for the population of Katsina local government i.e. 338, 000/35 = 9657 people per health facility. In addition to that there is high level of commitment in terms of maintaining the health facilities. This can be deduced from the experience gained during observation.

According to the views of executive chairman and officials of KSPHCDA, there is no more issue of quantity of health facilities in Katsina state. They required more of functionality of the facilities. The State is using a model of one functional facility per political ward (i.e. 1 CHC, 1 PHC and 1 Health post). Therefore going by such model, it

can be deduced that democratic governance provides adequate health facilities in Katsina local government. It is pertinent to know that the state government is responsible for the provision of health facilities in the local government.

Table 5.9: Response on Sufficient Medical/ Health Staff in the Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	11	4.7	4.7	4.7
Agree	40	17.1	17.1	21.8
Undecided	15	6.4	6.4	28.2
Disagree	94	40.2	40.2	68.4
Strongly disagree	74	31.6	31.6	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.9 shows that 11 respondents representing 4.7% of the total respondents strongly agreed that there are sufficient medical/Health staffs in the health facilities. 40 respondents representing 17.1% of the entire respondents agreed that, there are sufficient medical/Health staffs in the facilities. 15 respondents representing 6.4% of the entire respondents have not decided about the assertion. 94 respondents representing 40.2% of the entire respondents disagreed with the above assertion. 74 respondents representing 31.6% of the entire respondents strongly disagreed with the assertion that there are sufficient medical/Health workers in the health facilities.

From the above discussion it can be seen that 168 respondents representing 71.8% of the entire respondents believed that, there are no adequate medical/health staffs in the health facilities. This can be proved from the result of interview held with the management of KTSPHCDA, KTLGPHCD and some community leaders who revealed that, there is shortage of technical manpower in the primary health care sector in katsina state. Moreover, a carefull study of the staff inventory/list of Katsina local government

PHCD shows that the last recruitment in the primary Health Care sector of the local government was in June 2006 (i.e. 11 years without recruitment). This goes to shows the lack of commitment to procure human resources that would handle the health facilities. More so, data from the local government service commission showed that, about 21 technical staffs were retired in PHC department of Katsina local government (from 2006 to 2016) without replacement. Also 6 health facilities were built and 8 were expanded but nobody was employed to handle the facilities within such period.

Table 5.10: Number and Category of Staffs Required and Number Available In PHCD, Katsina Local Government

Category	Number expected	Number available	Critical requirement
Doctor	1	0	1
Nurse	4	4	0
Midwife	66	5	51
CHO	13	9	4
CHEW	188	7	161
JCHEW	184	72	172
EHA	38	17	21
Pharm Tech	13	3	10
Pharm Asst.	13	2	11
Lab Tech	13	4	11
Lab Asst.	13	3	10
DSA	1	4	3
Med Record	25	4	21
Health atten.	218	51	176
Others	134	23	134
Total	934	208	726

Source: KSPHCDA 2016

From the above table 5.10 it can be seen that the number of technical staff required in PHCD of KTLG is 934 while the number available is 208. There is a gap of 726 technical staffs for effective primary health care service delivery. Although there are other casual staffs (i.e. 30 technical) and midwifes/CHEW (i.e. 28 from the SURE- P and MSS (now under KSPHCDA) but yet they are inadequate. The number available i.e. 208

constitute only 22.3% of what is required (i.e. shortage of 762 or 77.7%). This also proves the inadequacy of technical staff in PHCD of KTLG. Therefore the number of maternal mortality rate, infant mortality ratio and under 5 mortality ratio increasing in the state and local government as shown in chapter four, can be attributed to such inadequacy of technical manpower. Observation also shows that some health facilities are managed only by casual staffs while some have only 3 permanent staffs under KTLG. Therefore they operate only between 8:00 am to 4:00 pm due to inadequate staffs. It is important to note that, local government should not be blame for under staffing in the PHC sector. The state government through MFLG, SPHCDA and LGSC is responsible for the procurement, training, discipline and welfare of employees at the local government level.

Table 5.11: Response on the Competency of Medical and Health Workers in KTLG

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	26	11.1	11.1	11.1
Agree	90	38.5	38.5	49.6
Undecided	46	19.7	19.7	69.2
Disagree	51	21.8	21.8	91.0
Strongly disagree	21	9.0	9.0	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.11 shows that 26 respondents representing 11.1% of the total respondents strongly believed that there is technical/competency of manpower in the PHCD of KTLG. 90 respondents representing 38.5% of the total respondents also agreed on the above assertion. 46 respondents representing 19.7% of the respondents are unable to decide on the above assertion. 51 respondents representing 21.8% of the entire respondents disagreed on the assertion. While 21 respondents representing 9.0% of the respondents strongly disagreed about the competency of the medical/Health workers in

KTLG. This goes to shows that 116 respondents representing 49.6% of the entire respondents agreed that there is competent manpower in PHCD of KTLG.

With regards to the above, responses from the interview with some patients in the clinics shows that, the staffs are relatively competent interms of discharging their duties. This can also be proved from the staffs' inventory which shows that almost all the staffs have more than 12 years working experience. Therefore as they have the minimum requirement to handle their duties, they also have minimum of 12 years experience in the service. Also secondary data from KTLG showed that about 28 staffs (Medical/Health) have undergone in service training from 2011 to 2016. Likewise data from KSPHCDA showed that there are at least 7 training programmes annually for medical/Health workers in the 34 local governments. Some training is organized by agency (i.e. KSPHCDA) While others are organized by the NGOs. In the same vein, staff inventory also revealed that, there are many workers (Medical/Health) that have either BS.c or Msc in public health and other related fields. This means that they can also train others on how to deliver effective and efficient services.

Table 5.12: Response on Essential Drugs in the Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	4	1.7	1.7	1.7
Agree	48	20.5	20.5	22.2
Undecided	28	12.0	12.0	34.2
Disagree	112	47.9	47.9	82.1
Strongly disagree	42	17.9	17.9	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.12 showed that 4 respondents representing 1.7% of the respondents strongly agreed that, there are essential drugs in the health facilities. 48

respondents representing 20.5% of the respondents agreed that democratic governance provides essentials drugs in the health facilities. 28 respondents representing 12.0% of the respondents are unable to decide on the above assertion. 112 respondents representing 47.9% of the respondents disagreed with the above assertion. 42 respondent representing 17.9% of the respondents also show their strong disagreement with the assertion that democratic governance provides essentials drugs in the health facilities. From the above, it can be deduced that, majority of the respondents i.e. 154 representing 65.8% disagreed on the assertion that there is essential drugs in the facilities.

However, responses from the interview with the officials of the SPHCDA and KTLGPHCD showed that there is frequent provision of essential drugs for primary health care purpose. Although, some had stopped from 2015 some were reduced by 50% of the supply. There is also a response of interview with some patients in the clinics who reveals that sometimes they get drugs for ANC (i.e. polic acid. Iron tabs, etc). Although they shows that sometimes there are other drugs but they are almost at the same price with the one from outside. Likewise observation showed that there are no free drugs in the facilities at all, but there are some facilities with the drugs at cheaper price. It was also learned that WDC, DHC and others stakeholders provides drugs. Also interview result showed that, the category of drugs that meant to be free are usually supplied by the NGOs, such as $MCHC_{2,}$ save the children, frings CHAI, USAID etc. They are mostly for tuberculosis, HIV, sickle cells and malnutrition. Moreover, observation in medical store of KTLG showed that there are some drugs/injections such as Ampiclox, Ampiciline, penicillin, cotrimoxozole etc. donated by MCHC2 based on pushed method whereby the facilities will only received the supply without in-depth study to establish the essential

drugs required by the community. There are also some drugs/injections that are not in any way needed in the PHC facilities; e.g, Ampiclox injection. It was said by the informant that the injection is to be given 6 hourly while the facilities (some) due to under staffing are only operating 12 hours. Also observation showed that some drugs/injections are to expire by March 2017, but they are still abundant in the store.

However, to be sincere, there is list of 141 essential drugs received by the medical store of KTLG supplied by ministry for local government under sustainable drugs supply scheme (SDSS) and consumables. Those drugs are supplied quarterly and distributed to the 34 local governments of the state.

Table 5.13: Cost of SDSS Drugs and Consumable Received and Supplied In Katsina Local Government PHCD.

Supplier	**2011**	**2012**	2013	2014	2015	2016	Total
KTLG	651,201	695,500	600,000	600,000	600,000		
MFLG	---	2,234,200	2,234,200	2,800,000	1,200,000	---	
SPHCDA	1,650,000	1,019,900	1,019,900	600,000	200,900	---	
NGOs	N.A	N.A	N.A	N.A	N.A	N.A	
Total	2,301,201	3,949,600	3,854,100	4,000,000	2,00,900		

Source: KSPHCDA, 2016 and KTLG medical store 2016.

From the above 5.13 table it can be seen that there are four stakeholders that supplied essentials drugs to KTLG. The table showed that in 2011, 2,301,201 Naira was spent for the supplied of essential drugs. Also in 2012, 3,949,600 Naira was spent on the same drugs. In 2013 3,854,100 were spent on the supplied of such drugs. In 2014, 400,000 were also spent on supplied of such drugs. While in 2015, 2,000,000 were spent for such supply. There is no data on what MCHC2, CHAI, USAID, GLOBAL, UNICEF, Saved the children spent on the procurement of such drugs and consumables to Katsina local government.

Table 5.14: Cost of Drugs and Consumable Supplied By/To SPHCDA

Summary of Drugs and Consumables Supplied to LGAs through the State Primary Health Cre Development Agency							
Year	Free Medicare Scheme	Epid Control and Management	Child Health Week	Family Planning Commodities	Subsidy for DRF	Mobile Ambulance Services	Almajiri FMS
2010.	60,000,000.00	3,000,000.00	6,400,000.00	NA		18,000,000.00	4,200,000.00
2011.	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2012.	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2013.	60,000,000.00	8,200,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2014.	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2015.	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2016.	30,000,000.00	3,000,000.00	6,400,000.00			NIL	NIL
TOTAL	**390,000,000.00**	**26,200,000.00**	**44,800,000.00**			**108,000,000.00**	**25,200,000.00**
GRAND TOTAL							**594,200,000.00**

Source: KSPHCDA 2017.

From the above table 5.14 it can be seen that the state is really committing a huge amount of money for the procurement of essentials drugs. The table showed an increased in the supply for epid control and management in 2013. This is due to the disaster of measles and cholera that was experienced in the year 2013. The table also shows a reduction in the year 2016. This can be attributed to the economic recession and the change of political leadership (from Barr. Ibrahim shehu Shema administration of PDP, to the present administration of Rt. Aminu Bello Masari of APC). Data for the cost of subsidy on DRF is not available in the MOH and Budget and planning department. Likewise the amount spent on reproductive health is not available. The above discussion showed that there is frequent supply of drugs and consumables in the state but sometimes they are not based on the problems of the community. Sometimes drugs supplies are kept

in the store without distribution. This is part of the reasons that majority of the respondents disagree that there is essential drugs in the health facilities.

Table 5.15: There Are Functional Laboratories in the Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	7	3.0	3.0	3.0
Agree	64	27.4	27.4.1	30.3
Undecided	19	8.1	8.1	38.5
Disagree	110	47.0	47.0	85.5
Strongly disagree	34	14.5	14.5	100.0
Total	234	100.00	100.0	

Source: SPSS output from field survey, 2017.

From the above table 5.15 it can be seen that 7 respondents representing 3% of the respondents strongly agreed that there are functional laboratories in the facilities. 64 respondents representing 27.4% of the respondents agreed with the assertion that there are functional laboratories in the facilities. 19 respondent representing 8.1% of the respondents are undecided about the assertion. 110 respondents representing 47% of the respondents agreed on the above assertion. 34 respondents representing 14.5% of the respondent strongly disagreed with the assertion.

From the foregoing it is vividly clear that 144 respondents representing 61.5% of the respondents unanimously agreed that there are no functional laboratories in the facilities. This can also be proved from the responses of interview with the officials of PHC sector (i.e. PHCD and SPHCDA) whereby their responses stated that there are only laboratories in the CHC and some PHC. None of the other facilities (MCHC, HP, dispensaries) have laboratories. In the same vein, interview with the in charge of the facilities and some patients shows that there are only essential services (i.e. PT, MP/Widal, HIV screening, PCV and grouping) in the laboratories. Observation also

shows that services like RBS, Genotype, Smear Sputum, MCS, Viral Load, CD4 etc, are not available at all. Also observation shows that due to under staffing in the laboratories, there is always congestion. It was also learned that, laboratories are not adequate in terms of the facilities required and there is the problems of missing and mixing the results. Some patients complained that they received a result which does not belong to them. Sometimes even the staffs are disagreeing with the laboratory results due to the ineffectiveness of the services. It was also learned that some tests are conducted by the laboratory attendants. However, data from KSPHCDA showed that, there is a provision for laboratory consumables to the CHC only.

Table 5.16: Cost of Laboratory Consumable Received By PHCD from KTLG and KSPHCDA

Year	KTLG	KSPHCDA	Total
2011	652,201	245,900	897,101
2012	695,500	231,400	926,900
2013	600,000	395,000	995,000
2014	600,000	401,000	1,001,000
2015	600,000	485,000	1,085,000
2016	---	---	---
Total	3,146,701	1,758,300	4,905.001

Source: KTLG 2016 and KSPHCDA 2016

From the above table 5.16 it can be seen that there is a provision for laboratory consumables worth 897,101 in 2011, 926,900 in 2012, 995,000 in 2013, 1,001,000 in 2014 and 1,085,000 in 2015. Data for 2016 is not available. This goes to shows that both KTLG and KSPHCDA had supplied the laboratory consumables to PHCD in KTLG. From the foregoing, it can be deduced that there are laboratories in PHCs and CHC of KTLG but they are not fully functional and the services are not effective.

Table 5.17: Functional Maternities in the Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	19	8.1	8.1	8.1
Agree	115	49.1	49.1	57.3
Undecided	13	5.6	5.6	62.8
Disagree	59	25.2	25.2	88.0
Strongly disagree	28	12.0	12.0	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017

The above table 5.17 shows that 19 respondents representing 8.1% of the respondents strongly agreed that there are functional maternities in the facilities. 115 respondents representing 49.1% of the respondents agreed on the above assertion. 13 respondents representing 5.6% of the total respondents have not decided on the assertion. 59 respondents representing 25.2% of the respondents disagree with the assertion. While 28 respondents representing 12.0% of the total respondents strongly disagreed with the assertion. From the foregoing it can be seen that 134 respondents representing 57.3% of the entire respondents unanimously agreed that there are functional maternities in the facilities. This is in line with the interview responses conducted at the CHC and PHC Katsina which shows that, there are maternities in the facilities. Some women responded that they are enjoying maternal care services and its operating 24 hours. However, maternities are only available in MCHCs, CHC and 3 PHCs. The remaining facilities do not offer maternal care services. Also data from KSPHCDA shows that there are 6 midwifes in KTLG apart from 5 that belong to the KTLG. This goes to shows that there are midwives that provides maternal care services with the assistance of CHEWs.

Table 5.18: Number Of Midwifes Received By KTLG under MSS/SURE-P

Category	2011	2012	2013	2014	2015	2016	2017	Total
Midwives	2	4	2	4	3	2	4	21
CHEW	2	5	2	4	2	2	-	17
Totals	4	9	4	8	5	4	4	38

Source: KTLG, 2016 and KSPHCDA 2017

From the above table 5.18 it can be seen that KTLG had received 38 staff under MSS/SURE-P. This comprises 21 midwives and 17 CHEW. A part from that the local government had also received some CHEWs from SPHCDA under N-Power scheme. It is pertinent to note that the number of midwifes/CHEWs have been reduced to 11 only. This is because many have gotten job in other places thereby withdrawn from the programmes. Moreover, observation shows that there are maternities in the facilities but they are not adequate for the people. There are only 2 beds in some maternities and sometimes there are more than ten (10) women coming for the same purpose. Also it was noted that, the maternal care services (ANC and PNC) are effective as the turned out in the register shows the increase in the attendance. Therefore it can be said that maternities are functional but inadequate. More, so there are no doctors that could assist the midwives in the case of complication during delivery. This can also be a factor responsible for the increase in less than 5 years mortality rate, infant mortality ratio and maternal mortality rate in katsina local government.

Table 5.19: Adequate Funding of Primary Health Care

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	37	15.8	15.8	15.8
Agree	131	56.0	56.0	71.8
Undecided	18	7.7	7.7	79.5
Disagree	32	13.7	13.7	93.2
Strongly disagree	16	6.8	6.8	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

From the foregoing it can be seen that 37 respondents representing 15.8% of the respondents strongly agreed that democratic government provides adequate funding for primary health care. 131 respondents representing 56.0% of the respondents agreed with the assertion. 18 respondents representing 7.7% have not decided. 32 respondents

representing 13.7% of the respondents disagreed with the assertion. Very insignificant number of the respondents i.e. 16 representing 6.8% of the entire respondents strongly disagreed with the above assertion.

Therefore, it can be understood that 168 respondents representing 71.8% of the respondents unanimously agreed that, democratic government provides adequate funds for primary health care. Although data for annual estimates on primary healthcare in the state is not available for the researcher, but there is a data on the cost of drugs and laboratory consumables supplied by the KSPHHCDA (see Chapter four). There are also annual estimates of KTLG on PHC for the period under study (see Chapter four). It can be said that there is relatively adequate funding of PHC by the democratic governance. Although, the benchmark for funding of primary health care is 26% of annual estimates, but considering the personnel cost and over head cost as well as the capital expenditure on PHC for the period under study it can be agreed that there is a fair funding of primary health care in the local government and the state at large.

This can also be proved from the report of interview where by the officials of the KSPHCDA and KTLG revealed that there are no many problems in terms of funding of primary health care. What is needed now is adequate manpower and creation of awareness. Likewise observation shows that health facilities are mostly in a good condition and the staff salary is relatively good. A careful study of the staff payroll shows that health workers receive highest salary (CONHESS) more than any other workers in Katsina local government and katsina state at large. Therefore it can be deduced that the funding of primary health care is relatively fair.

Table 5.20: Democratic Governance Provides Adequate Primary Schools

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	44	18.8	18.8	18.8
Agree	127	54,3	54.3	73.1
Undecided	15	6.4	6.4	79.5
Disagree	41	17.5	17.5	97.0
Strongly disagree	7	3.0	3.0	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

From the above table 5.20 it can be seen that 44 respondents representing 18.8% of the entire respondents strongly agreed with the above assertion. 127 respondents representing 54.3% of the respondents agreed with the assertion. 15 respondents representing 6.4% of the respondents are undecided on the above assertion. 41 respondents representing 17.5% of the respondents disagreed with the assertion. 7 respondents representing 3.0% of the entire respondents strongly disagreed with the above assertion. From the foregoing it can be agreed that 171 respondents representing 73.1% of the entire respondents unanimously agreed that democratic governance provides adequate primary schools. This can also be proved from the result of interview conducted with the officials of SUBEB and LGEA Katsina which shows that there are relatively adequate schools in the state and local governments. Likewise interview with the community leaders such as PTA, SBMC, NUT, CDA etc. shows that the number of schools is relatively sufficient. It was also learned that establishment of 3 new schools were also approved and the work will soon commence. The number of schools constructed/renovated within the period under study has already been presented in chapter four. Likewise the number of pupils and numbers of schools in LGEA katsina has been presented in chapter four.

Table 5.21: There Are Adequate Teachers in the Schools

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	24	10.3	10.3	10.3
Agree	68	29.1	29.1	39.3
Undecided	16	6.8	6.8	46.2
Disagree	89	38.0	38.0	84.2
Strongly disagree	37	15.8	15.8	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

From the above table 5.21 it can be seen that 24 respondents representing 10.3% of the respondents strongly agreed with the above assertion. 68 respondents representing 29.1% of the respondents agreed with the above assertion. 16 respondent representing 6.8% of the respondents are undecided about the adequacy of teachers. 89 respondents representing 38.0% of the respondents disagreed with the assertion. 37 respondents representing 15.8% of the respondents strongly disagreed with the assertion that there are sufficient teachers in the schools. From the foregoing it is vividly clear that 126 respondents representing 53.8% of the entire respondents unanimously disagreed that there are sufficient teachers in the schools. This goes in line with the responses on the interview conducted with the SUBEB and LGEA officials which shows that there is total inadequate shortage of teaching staff in primary education sector. Observation also shows that there are some schools with over 700 pupils but with staff strength of 7 teachers. There are also some schools that are having 4 staffs with the 405 pupils. In the same vein result of the secondary data showed that there are 89,507 pupils with the staff strength of 1212. The pupils teacher ratio is 89,507/1212=74:1. This is against the UBE Act 2004 requirement of 40:1. In addition to that there are some schools like Rafin dadi with the pupils/teachers ratio of 95:1. Observation and interview with some teachers shows that there is a school with 653 pupils and 8 teachers, but only 4 are available, 2 are on

maternity leave, 1 sick leave and 1 study leave. Therefore the remaining 4 teachers are to manage over 653 pupils.

Table 5.22: Number of Teachers Available In LGEA Katsina

LGEA Teachers	Casual	Fed Teachers Scheme	N-Power	Voluntary	Total
1212	48	12	146	16	1434

Source: SUBEB 2016 and KTLGEA 2017

The above table 5.22 shows the total number of teachers in LGEA katsina i.e. 1434. From the foregoing it can be deduced that there are no adequate teachers in LGEA katsina.

Table 5.23: Responses on the Competency Of Teachers

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	9	3.8	3.8	3.8
Agree	77	32.9	32.9	36.8
Undecided	23	9.8	9.8	46.6
Disagree	90	38.5	38.5	85.0
Strongly disagree	35	15.0	15.0	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.23 shows that 9 respondents representing 3.8% of the respondents strongly agreed that the teachers are competent. 7 respondents representing 32.9% of the respondents agreed that there are competent teachers in the schools. 23 respondents representing 9.8% have not decided about the issue of competent teachers. 90 respondent representing 38.5% of the respondents disagreed with the assertion. 35 respondents representing 15% of the respondents strongly disagreed on the above assertion. This goes to show that 125 respondents representing 53.5% of the respondents unanimously disagreed that there are competent teachers in the schools.

Table 5.24: Distribution of Teachers And Their Qualification In LGEA Katsina

Qual.	OND	HND	NCE	Bsc/BA	Bsc. ed/BA.ed	Others	Total Avail.
Numb. Avail	201	10	905	16	72	8	1212
Numb.qual.	---	--	905	---	72	---	977

Source: KTLGEA, PRS 2017

From the above 5.24 table it can be seen that out of 1212 teachers available, there are 977 qualified/professional teachers (i.e. 80.6%). The remaining 235 or 19.4% of the teachers are not qualified/professional teachers. However, secondary data from SUBEB and LGEA shows that there is continuous in house and in service training for teachers which means a source for capacity development.

Table 5.25: Number of Staff Benefitted From Both in – Service and In House Training

Year	In–service programmes	In house training by SUBEB	NGOs	Total
2011	5	42	11	58
2012	5	42	9	56
2013	5	42	6	53
2014	5	42	13	60
2015	5	42	--	47
2016	5	42	--	47
Total	30	252	39	321

Source: SUBEB 2016 and LGEA 2017.

The above table 5.25 shows that 321 teachers received various training between 2011 to 2016. This means that there is continuous training organized by SUBEB and there is provision for in service training (i.e. 5 teachers) annually. In addition to that UNESCO and other NGOs also organized training for the teachers as a means of capacity building. However, focus group interview with PTA chairman and other chairmen of CDAs revealed that there are problems in terms of teachers' competency. This involves the problems of female teachers that dominated the LGEA katsina who hardly take morning period (i.e. English and Mathematics) which is very essential for the basic

education. Also, responses shows that some are incapacitated, some indiscipline (coming late and closing early) and some are not even attending to the pupils.

The above discussion has also been proved from the experience in the observation, when the researcher visited Rafin dadi, Shinkafi and K/Marusa primary schools around 8:30 to 9:30 am and learned that some female teachers are not around, some are around but not in the class. Likewise the researcher went to Sabuwar Kofa, K/Durbi and Filin Samji primary schools and learned that about 3 female teachers are sleeping around 11:00 to 12:00 am. It was also learned that there is a tradition of selling some commodities by the teachers in the school. This was also noted when the researcher saw some staffs gathering towards one office where 2 female teachers are selling wrappers, rice, sugar to their collogues on credit.

Closely related to the competency of the teachers is the willingness to attend to class and teach the pupils accordingly. Therefore the issue of willingness is also lacking. To be sincere to the teachers, there is no welfare in the basic education sector in the state. This range from lack of promotion, running cost, prompt paymentof salary etc. A careful looked at staff inventory shows that, the last promotion in basic education sector of the state was in 2012 (i.e. 4 years without promotion) some teachers have not been receiving salaries for 7 months (i.e. June to December). Therefore this tends to reduce the morale of teachers in terms of delivering their best. Although the present administration is trying in terms of promotion of teachers as almost all (those due for promotion) have now been promoted and it was said by the officials in (KTLGEA) that it will be implemented in February 2017 while arrears for such promotion will be paid by March.

Table 5.26: Responses on Adequacy and Conduciveness of the Classrooms

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	7	3.0	3.0	3.0
Agree	56	23.9	23.9	26.9
Undecided	21	9.0	9.0	35.9
Disagree	113	48.3	48.3	84.2
Strongly disagree	37	15.8	15.8	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.26 shows that 7 respondents representing 3.0% strongly agreed on the above assertion. 56 respondents representing 23.9% of the respondents agreed that there are adequate and conducive classrooms for learning in KTLGEA. 21 respondents representing 9% of the respondents are undecided about the assertion. 113 respondents representing 48.8% of the respondents disagreed with theassertion. 37 respondents representing 15.8% of the respondents strongly disagreed that there are adequate and conducive classes for learning. This goes to shows that 150 respondents representing 64.1% of the respondents unanimously disagreed with the above assertion. Data on the number of classes constructed/renovated from 2011 to 2016 shows that, 2 new primary schools were built and 33 schools with 159 classes were renovated. This means that there are relatively good classes in the KTLGEA (see chapter four). There are 790 classes for about 90,000 pupils (i.e. 114:1). Data from SUBEB shows that the pupils' classrooms ratio in KTLGEA stood at 121:1. Interview responses also show that there are relatively good classes in the LGEA katsina. However, the classes are not adequate for the pupils. According to focus group interview with the community leaders, some classes have over 100 pupils. Observation shows that, there are some schools with over 128 pupils per class (128:1). However, observation proved that almost (i.e. 90%) of the classes are in good condition. This can be attributed to the fact that schools in KTLGEA are mostly located

in the Katsina Township. Therefore, the urbanization policy of the government also speaks volumes in terms of schools structure. Likewise the inadequacy of the classes can be attributed to the fact that KTLGEA is a metropolitan/urban local government which means many people know the important of education and are sending their children to schools. This can be part of the factors responsible for over congestion in the classes.

Table 5.27: Adequacy of Furniture/Instructional Materials

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	16	6.8	6.8	6.8
Agree	60	25.6	25.6	32.5
Undecided	10	4.3	4.3	36.8
Disagree	113	48.3	48.3	85.0
Strongly disagree	35	15.0	15.0	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017

From the above 5.27 table it can be seen that, 16 respondents representing 6.8% of the respondents strongly agreed that there are adequate furniture and instructional materials in the schools. 60 respondents representing 25.6% of the respondents agreed with the above assertion. 10 respondents representing 4.3% of the respondents have not decided. 113 respondents representing 48.3% of the respondents disagreed with the assertion. 35 respondents representing 15% of the respondents strongly disagreed with the assertion that, there is adequate furniture and instructional materials in the schools. This goes to shows that 148 respondents representing 63.3% of the entire respondents unanimously disagreed with the assertion.

Response from the interview with teachers and some community leaders reveals that there is inadequacy of furniture and instructional materials in the schools. Also observation shows that, there are some classes that do not have furniture at all and some

pupils are receiving lessons on the floor. There are only 24 schools with good and complete furniture. The remaining is either not in good condition, or there is none at all. Moreover, it was noted that most of the schools are operating 2 arms per day. Therefore the furniture is over stressed. Likewise it was noted that the PTA/SBMC and CDAs are trying in terms of maintenance of furniture. With regards to instructional materials, it was learned that there are some instructional materials (see chapter four). While other instructional materials like video tape, television, maps, laboratories are not available.

Table 5.28: Democratic Governance Provides Adequate Funds on Basic Education

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	35	15.0	15.0	15.0
Agree	126	53.8	53.8	68.8
Undecided	13	5.6	5.6	74.4
Disagree	41	17.5	17.5	91.9
Strongly disagree	19	8.1	8.1	100.0
Total	234	100.0	100.0	

Source: SPSS output from field survey, 2017

From the above 5.28 table, it can be seen that 35 respondents representing 15% of the respondents strongly agreed that democratic government provides adequate funds for basic education. 126 respondents representing 53.8% of the entire respondents agreed on the above assertion. 13 respondents representing 5.6% of the total respondents have not decided with the above assertion. 41 respondents representing 17.5% of the entire respondents disagreed with the above assertion. 19 respondents representing 8.1% of the entire respondents strongly disagreed with the above assertion.From the foregoing it can be deduced that 161 respondents representing 68.8% of the entire respondents unanimously agreed that, there is adequate funding of basic education in KTLGEA and katsina state respectively.

Responses of the interview conducted with the officials of SUBEB and KTLGEA reveals that there is adequate funding of basic education in the state. However, both the SUBEB officials and LGEA staffs (Teachers) reveal their dissatisfaction with the issue of staff salaries and running cost. Likewise, secondary data shows that there is adequate provision in terms of capital expenditure. With regards to the issue of funding on personnel cost, it was learned that the state only pays for the salaries of SUBEB officials at the Headquarter. However, 100% of the personnel cost of the LGEAs are paid by the ministry for local government. The state is not complying with the UBEC Act 2004 that requires the state and local government to jointly finance the personnel cost of teachers.

It was also learned that there are huge amount of money received by the SUBEB from the NGOs such as USAID, JAID, UNESCO etc. which are also meant for boosting basic education in the state. In addition to that, there is also World Bank assisted funds (sometimes through SBMC) purposely for aiding the community self help projects. It is pertinent to note that the main source of funds for running basic education is either through matching grants (Account with the CBN in which the state is to pay 50% and the federal through UBEC to pay the remaining 50%).

Table 5.29: Summary of Annual Estimates of SUBEB Katsina State

2012				
Expenditure	FG	SG	LG	TOTAL
Capital	832,432,430	2,531,243,494	----	3,363,675,924
Recurrent	----------	153,127,872	17,837,516,167	17,990,644,039
Total	832,432,430	2,684,371,366	17,837,516,167	21,354,319,963
2013				
Expenditure	FG	SG	LG	TOTAL
Capital	832,432,430	2,378,295,509	---	3,228,295,509
Recurrent	----------	158,107,567	16,047,102,2851	16,205,210,418
Total	850,000,000	2,536,403,076	16,047,102,851	19,433,505,927
2014				
Expenditure	FG	SG	LG	TOTAL
Capital	1,030,000,000	2,711,125,061	---	3,741,125,061
Recurrent	----------	160,191,994	17,651,813,137	17,812,005,131
Total	1,030,000,000	2,871,317,055	17,651,813,137	21,553,130,192

2015				
Expenditure	FG	SG	LG	TOTAL
Capital	500,000,000	2,261,534,245	---	2,761534,245
Recurrent	----------	152,754,916	18,454,168,779	18,606,923,195
Total	500,000,000	2,414,289,161	18,454,168,279	21,368,457,440
2016				
Expenditure	FG	SG	LG	TOTAL
Capital	876,756,756	2,726,367713	---	3,603,124,465
Recurrent	----------	153,941,533	19,376,876,693	19,530,818,226
Total	876,756,756	2,880,309,246	19,376,876,693	23,133,942,691

Source: SUBEB Annual estimates (2012 to 2016).

From the above table 5.29 it can be seen that the state's annual estimates has been relatively increasing from 2012 to 2016 with the exception of 2013 when the figure dropped to 19.5 Billion Naira. However, three things shall be learned from the above table (Annual estimates)

Firstly, local government has been the sole financer of personnel cost for LGEA staff (i.e. teaching and non teaching staff). This is against the UBE Act 2004 requirement which states that both state and local government shall participate in such personnel cost. The second thing to learn is the effort by the present administration that increased the capital expenditure to 3.6 Billion Naira in 2016, in spite of the economic recession experienced by both the federal and state governments due to dropped in oil price from the international market. This means that the previous administration should have budgeted more than that amount (i.e. 3.6 Billion) when the economy/oil prices is around $140 per barrel. This goes to shows the concern of the present administration on basic education, and likely utilization of resources. Thirdly, careful looked at the staff inventory shows that there were no promotion since 2012 and there is no recruitment/replacement in Basic education sector since March 2015. However, the personnel cost rose from 18.6 Billion Naira in 2015 to 19.6 Billion in 2016. There is no convincing justification for such increased in personnel cost during interview. Fourthly,

in spite of the abundant resources in the Basic education sector yet, the state was unable to procure manpower which could help to reduce the inadequacy of staff in the Basic education sector. Instead the state opts to keep renovation/rehabilitation of schools which is not much required in the sector. Here one would also ask why some schools were renovated more than 2 times in 6 years and they are still under renovation. These and many other questions are unanswered during the research.

However, an informant said that government preferred to use capital project in education sector so that, it can be used during political campaign. Also the officials benefitted from the 10% of the total contract awarded and they are to share it by themselves. Likewise structures can be seen visible and can help to create more popularity of the political leader. Besides, contracts are also awarded as means of settling political stalwarts. From the foregoing it can be deduced that there is relatively fair funding of basic education sector in the state, but the utilization of funds in a more desired areas is the major problems.

Table 5:30 Responses on democratic government provides portable drinking water

Variable	Frequency	Percentage	Valid percent	Cumulative percent
Strongly Agreed	16	4.7	4.7	4.7
Agreed	158	67.5	67.5	72.8
Undecided	8	3.4	12.4	76.3
Disagreed	29	12.4	12.0	88.0
Strongly disagreed	28	12.0	100.0	100.0
Total	234	100.0		

Source: field survey, 2017

From the above table it can be seen that 11 respondents representing 4.7% of the respondents strongly agreed that democratic government provides adequate source of portable drinking water in katsina local government. 158 respondents representing 67.5% of the respondents representing 67.5% of the respondents also agreed with the above

assertion. 8 respondents representing 3.4% of the respondents have not decided on the above assertion. 28 respondents representing 12% of the respondents strongly disagreed with the assertion. From the foregoing it is vividly clear that 174 respondents representing 72.8% of the entire respondents unanimously agreed that democratic government provides adequate source of portable drinking water in katsina local government. This can also be proved from the experienced gained during observation. It was noted that most of the houses have no problems with the source of water. It was also learned that there are many private sources of water in katsina and it help to address the problems of shortage of portable drinking water. Likewise, it was noted during observation that, of the 18 centers visited, there are no queue and no any challenge in term of getting the water. In the same vein, result of the secondary data showed that, there are 429 public sources of water. There are also 265 private sources. These together make 649 sources of portable drinking water.

Table 5:31 The sources of portable drinking water are functional

Variable	Frequency	Percentage	Valid percent	Cumulative percent
Strongly Agreed	01	0.4	0.4	0.4
Agreed	150	64.1	64.1	64.5
Undecided	20	8.5	8.5	73.1
Disagreed	29	12.4	12.0	85.5
Strongly disagreed	34	14.5	14.5	100.0
Total	234	100.0	100.0	

Source field survey, 2017

The above table show that 1 respondent representing 0.4% strongly agreed that the sources of portable drinking water have functional. 150 respondents representing 64.1% agreed that the sources are functional, 20 respondents representing 8.5% have not decided on the issue. 29 respondents representing 12.4% disagreed with the ascertion. 34 respondents representing 14.5% strongly disagreed with the ascertion. From the

foregoing, it can be established that 151 respondents representing 64.5% of the entire respondents unanimously agreed that the source of portable drinking water are functional. This can also be proved from the responses of interview with the stakeholders which shows that about 90% of the sources of water are functional; they revealed that there is high level of commitment by the present administration in terms of maintenance of the source of water. It was also revealed that, the communities are also trying in terms of such functioning by providing some support for the maintenance.

Observation also showed that, of the 18 centres visited by the researcher, 16 are functional and 1 is under repairs. There is only 1 source at filin bugu that has not been functioning for over two years. Likewise secondary data showed that, "between 2011 to 2016, the local government has repaired 268 borehole, 23 water solar system and 2 non treatment sources. It was also learned that, some motorized solar system have been repaired four times in a year. From the foregoing it can be deduced that the source of water supply are functional in katsina local government.

Table 5:32 Respondents Opinion on Access to Sources of Water

Variables	Frequency	Percentage	Valid Percent	Cumulative percent
Agreed	180	76.9	76.9	76.9
Undecided	11	4.7	4.7	81.6
Disagreed	41	17.5	17.5	99.1
Strongly disagreed	2	0.9	0.9	100.0
Total	234	100.0	100.0	

Source: Field Survey, 2017

From the above table it can be seen that 180 respondents representing 76.9% of the respondents agreed that people have access to the sources of water. 11 respondents representing 4.7% have not decided on the issue. 41 respondents representing 17.5% of the respondents disagreed with the ascertion. 2 respondents representing 0.9% of the

respondents strongly disagreed with the ascertion. From the forgoing, it can be decided that 180 respondents representing 76.9% of the entire respondents unanimously agreed that people have access to the sources of water in katsina local government. This is line with experience gained during observation where it was noted that people are just coming to petch water without harm or any kind of discrimination. Although in some centers people pay ₦5 per 25 liter. This money is for the maintenance sake only. They also enjoy the services inspite of the money attached. The above experience is significantly different from the situation in Bindawa local government. This is because there is long que in Bindawa local government where by people have to wait/stay for three hours before they get their turn. Some peoples do not have access to sources of water and politics plays role on who shall be given more water than other. Some people have no option than to use the water from the stream for domestic uses.

Table 5:33 Responses on adequate funds for treatment/maintenance

Variables	Frequency	Percent	Valid Percent	Cumulative percent
Agreed	168	71.8	71.8	71.8
Undecided	39	16.7	16.7	88.5
Disagreed	12	5.1	5.1	93.6
Strongly Disagreed	15	6.4	6.4	100.0
Total	234	100.0	100.0	

Source: Field Survey, 2017

From the above table it can be seen that 168 respondents representing 71.8% of the entire respondents agreed that there is adequate funds for treatments and maintenance of sources of portable drinking water. 39 respondents representing 16.7% of the respondents have not decided on the ascertion. 12 respondents representing 5.1% of the entire respondents not agreed with the ascertion. From the foregoing it can be deduced that 168 respondents representing 71.8% unanimously agreed that there is adequate funds

for treatment/maintenance of sources of portable drinking water. This is in line with the response of interview which shows that government is committed to the maintenance of such sources. However, people also have to take part in terms of maintenance. Result of the secondary data also shows that there is frequent provision for the maintenance from the local government, RUWASA and NGOs. It was also noted N325, 000,000 was spent for the maintenance of sources of water between 2011 to 2016. In comparison with Bindawa local government, it was noted from interview, observation and secondary data that there is low level of commitment in terms of mentainance culture and therefore, some borehole/motorized solar system have stay for over one year before government repair it and the community are not organised enough to do it, except the WCA that emerged just in 2012 and is not really functional.

Test of Hypotheses for Katsina Local Government

Decision Rule

The hypotheses will be tested and the results will be decided upon on the basis of 95% level of confidence which is 0.05 significance level. Therefore, if our p-values are less than 0.05, we fail to reject the null hypotheses and accept the alternate. Otherwise, the alternate will be accepted.

Hypothesis One

H_{01}. There is no significant relationship between democratic governance and provision of primary health care in Katsina Local government area.

Table 5.34:Analysis of variance (ANOVA[a])

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	63.262	1	63.262	1002.505	.000[b]
	Residual	14.640	232	.063		
	Total	77.902	233			

a. Dependent Variable: Primary Health Care

b. Predictors: (Constant), Democratic Governance

Table 5.34, above shows the F statistics which stood at 1002.505 having a p-values of 0.000 which is less than 0.05, indicating that its significance at 95% confidence level. This implies that the model is fit and the variables are not wrongly selected. Hence, we can proceed with the regression analysis.

Table5.35: Model summary of Regression Result

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.701[a]	.612	.601	.25120	1.079

a. Predictors: (Constant), Democratic Governance

b. Dependent Variable: Primary Health Care

Table 5.35 above shows the coefficient of correlation (r), the coefficient of determination (r^2) and the adjusted r^2. The correlation coefficient (r) being 0.701 indicates that there is a strong and positive correlation between democratic government and primary health care. The coefficient of determination (r^2) stood at 0.612 indicating that 61.2% of the variations in primary health care can be explained by democratic governance. The adjusted r^2 stood at 0.601 indicating that democratic governance would still explain 60.1% of the variations in primary health care even if other variables are added to the model.

Table 5.36: Regression Standard coefficients

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.109	.036		57.947	.000
	Democratic Government	.433	.014	.701	31.662	.103

a. Dependent Variable: Primary Health Care

Table 5.36 above shows the coefficients of the variables in model. Thus the model is presented:

PH = 2.109 + 0.433 DG +c

Where PH = Primary Health Care

DG = Democratic Governance

From the above model, the coefficient of democratic governance stood at 0.433 which is positive. This implies that more efforts towards democratic government would lead to better primary health care. However, the significance of this can be judged from the t statistics and its significance. The t statistics of democratic governance stood at 32.662 with a p-value of 0.103. Indicating that the relationship depicted in the model is statistically insignificant at 95% confidence level. This implies that we do not have enough statistical evidence to reject the null hypothesis.

Based on the above analyses, we fail to reject the null hypothesis H_{01} which states that there is no significant relationship between democratic governance and provision of primary health care in Katsina Local government area.

Hypothesis Two

H_{02}. There is no significant relationship between democratic governance and provision of primary education in Katsina Local government area.

Table 5.37 Analysis of Variance (ANOVA)

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	68.952	1	68.952	767.448	.000[b]
	Residual	20.844	232	.090		
	Total	89.796	233			

a. Dependent Variable: Primary Education

b. Predictors: (Constant), Democratic Governance

Table 5.37 above shows the F statistics which stood at 767.448 having a p-value of 0.000 which is less than 0.05 indicating that its significance at 95% confidence level.

This implies that the model is fit and the variables are not wrongly selected. Hence, we can proceed with the regression analysis.

Table 5.38 Model Summary of Regression Result

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.676[a]	.568	.564	.29974	1.114

a. Predictors: (Constant), Democratic Governance
b. Dependent Variable: Primary Education

Table 5.38 above shows the coefficient of correlation (r), the coefficient of determination (r^2) and the adjusted r^2. The correlation coefficient (r) being 0.676 indicates that there is a moderate and positive correlation between democratic governance and primary education. The coefficient of determination (r^2) stood at 0.568 indicating that 56.8% of the variations in primary education in Katsina Local government area can be explained by democratic government. The adjusted r^2 stood at 0.564 indicating that democratic governance would still explain 56.4% of the variations in primary education even if other variables are added to the model.

Table 5.39 Regression Standard coefficients Results

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.987	.047		42.168	.000
	Democratic Government	.512	.018	.676	27.703	.061
a. Dependent Variable: Primary Education						

Table 5.39 above shows the coefficients of the variables in model. Thus the model is presented:

PE = 1.987 + 0.512 DG + c
Where PE = Primary Education
DG = Democratic Governance

From the above model the coefficient of democratic government stood at 0.512 which is positive. This implies that more efforts towards democratic governance would lead to better primary health care. In spite of the above, the significance of this can be judged from the t statistics and its significance. The t statistics of democratic governance stood at 27.703 with a p-value of 0.061 indicating that the relationship depicted in the model is statistically insignificant at 95% confidence level implying that we do not have enough statistical evidence to reject the null hypothesis.

Based on the above analyses, we fail to reject the null hypothesis H_{01} which states that there is no significant relationship between democratic governance and provision of primary education in Katsina Local government area.

Hypothesis three

H_{03}. There is no significant relationship between democratic governance and provision of portable drinking water in Katsina Local government area.

Table 5:40 Analysis of Variance (ANOVA)

Model		Sum of Squares	Df	Mean square	F	Sig.
1	Regression	3.086	1	3.086	5.733	.017[b]
	Residual	124.885	232	.538		
	Total	127.971	233			

a. Dependent Variables: Portable Drinking Water
b. Predictors: (Constant), Democratic Governance

Table 5:40 above shows the F statistics which stood at 5.733 having a p-value of 0.017 which is less than 0.01 indicating that its significance at 99% confidence level.

This implies that the model is fit and the variables are not wrongly selected. Hence, we can proceed with the regression analysis.

Table 5: 41 Model Summary of Regression Result

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.655[a]	.524	.511	.73369

a. Predictors: (Constant), Democratic Governance

Table 5:41 above shows the coefficient of correlation (r), the coefficient of determination (r^2) and the adjusted r^2. The correlation coefficient (r) being 0.655 indicates that there is a moderate and positive correlation between democratic governance and portable drinking water. The coefficient of determination (r^2) stood at 0.524 indicating that 52.4% of the variations in portable drinking water can be explained by democratic governance. The adjusted r^2 stood at 0.511 indicating that democratic governance would still explain 51.1% of the variations in portable drinking water even if other variables are added to the model.

Table 5.42 Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.016	.184		10.942	.000
	Democratic Governanve	.659	.066	.655	2.394	.017

a. dependent variables: Portable drinking water

Table 5.42 above shows the coefficients of the variables in model. Thus the model is presented:

PDW =2.016 + 0.659 DG + c

Where PDW = portable drinking water

DG = Democratic Governance

From the above model the coefficient of democratic governance stood at 0.659 which is positive. This implies that more efforts towards democratic governance would lead to better portable drinking water. The significance of this can be judged form the t statistics and its significance. The t statistics of democratic governance stood at 12.394 with a p-value of 0.017. Indicating that the relation depicted in the model is significant at 95% confidence level. This implies that we have enough statistical evidence to reject the null hypothesis.

Based on the above analyses, we reject the null hypothesis H_{03} which states that there is no significant relationship between democratic governance and provision of portable drinking water in Katsina Local government area. As such we accept its alternate H_3 which states that there is significant relationship between democratic governance and provision of portable drinking water in Katsina Local government area.

Data Presentation, Analysis and Test of Hypotheses for Bindawa Local Government

Table 5.43: Responses on Democratic Governance Provides Adequate Health Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	21	21.9	21.9	21.9
Agree	41	42.7	42.7	64.6
Undecided	18	18.8	18.8	82.3
Disagree	12	12.5	12.5	95.8
Strongly disagree	4	4.2	4.2	100.0
Total	96	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.43 shows that 21 respondents representing 21.9% of the entire respondents strongly agreed that democratic governance provides adequate health facilities. 41 respondents representing 42.7% agreed with the assertion. 18 respondents representing 18.8% have not decided on the accretion. 12 respondents representing 12.5%

disagreed with the assertion. 4 respondents representing 4.2% of the respondents strongly agreed with the assertion that democratic governance provides adequate health facilities. From the above discussion it can be seen that 62 respondents representing 64.6% of the entire respondents unanimously agreed that democratic governance provides adequate health facilities.This is in line with the responses of the interview conducted with the officials of KSPHCDA, BDW LG and some community leaders who say that there are more than sufficient health facilities in the local government. Moreover, data from SPHCDA and BDLG shows that there are 68 health facilities in the local government.

Table 5.44: Number/Category of Health Facilities Required Available

Number	HP	HC	PHC	CHC	Mobile Ambulance	Total
Number required	12	12	12	1	_	37
Number available	12	45	6	1	1	68
Critical gap/excess	0	33	6	0	1	31

Source: KSPHCDA 2016 and BDLG 2017

From the above table 5.44 it can be seen that there are balance in the number of health post available and the number required. There is also excess of 38 health facilities/MCHC. However there is gap in terms of PHCs in the sense that 12 are required but only 6 are available. The requirement of CHC is one facility and there is also such number in the local government. In addition to that, there is also mobile ambulance operating in a day hours only.

It is interesting to know that while Katsina local government has less than 30 health facilities (i.e. below the requirement of 37); Bindawa local government has 68 which are above the requirement (i.e. 34 excess). The issue here is that katsina local government is urban/metropolitan local government where people are staying in one place. Even the 12 political wards of the local government, 11 of them are within Katsina

Township. Therefore one is not expected to see many facilities in such settlement. There are also other facilities in the town ship that are not under local government. These are General Hospitals, FMC, Army Clinics, Police Clinics, Orthopedic and Turai Yar Aduwa Specialist Hospital. However Bindawa local government has 68 facilities due to the nature of various settlements. Therefore 11 political wards in the local government are all scattered and therefore, each must have some facilities and for the purpose of political/equality, the state and local government must ensure balance in the distribution of such facilities. In addition to that, the other reason for excess of health facilities in Bindawa local government was because of the fact that the former North–west coordinator of NPHCDA came from Doro ward, of Bindawa local government. Therefore during his reign he ensured that five (5) health facilities were allocated to Bindawa local government. In addition to that the vice chairman of PDP in the state (i.e. 2011 – 2015) also came from that local government and he ensured that 4 health facilities were constructed in the local government.

However, the availability of health facilities is one thing but their function is another thing. Here observation shows that the facilities are looking good in terms of their structure, but they are lacking other component for effective functioning. These are maternities, laboratories, pharmacy etc. It was also learned that there are some political wards like Baure, Doro and Tama with 7 facilities each. Moreover, looking at the population of Bindawa local government (i.e. 152356) it can be said that there are sufficient health facilities in the local government 152356/68 = 2240:1 this goes to show that there is 2240 people for 1 health facility. However, considering the current W.H.O health facility model of 1 functional PHC, 1 functional HC and 1 functional PHC clinic

per ward, it can be said that, there are sufficient health facilities in the local government. Moreover, a careful look at the patient register shows that, some facilities received not more than 6 patients per week.

Table 5.45: There are sufficient Medical/Health staffs in the health facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	2	2.1	2.1	2.1
Agree	21	21.9	21.9	24.0
Undecided	11	11.5	11.5	35.4
Disagree	41	42.7	42.7	78.1
Strongly disagree	21	21.9	21.9	100.0
Total	96	100.0	100.0	

Source: SPSS Output from field survey, 2017.

From the above table 5.45 it can be seen that 2 respondents representing 2.1% strongly agreed that, there are adequate technical manpower in the facilities. 21 respondents representing 21.9% of the respondents agreed that, there are sufficient staffs in the facilities. 11 respondents representing 11.5% have not decided about the assertion. 41 respondents representing 42.7% of the respondents disagreed with the assertion. 21 respondents representing 21.9% strongly disagreed with the above assertion. This goes to show that 62 respondents unanimously agreed that there is no adequate technical manpower in the health facilities. This is in line with the response of the interview conducted with the officials of SPHCDA and BDLG when they revealed that in adequate man power is the critical challenge of PHC at both the local and state government. Interview with the patients and WDC, DHC, CDA chairmen also shows that, there is critical shortage of technical manpower in the health facilities. Data from SPHCDA and BDLG also shows that there is gap in terms of technical manpower as follows:

Table 5.46: Number Of Staffs Required And Number Expected.

Category	Number expected	Number available	Critical gab
Doctor	1	1	1
Nurse	4	2	2
Midwife	61	0	61
CHO	12	9	3
CHEW	173	17	156
JCHEW	178	7	171
EHA	35	7	28
Pharm Tech	12	0	12
Pharm Asst.	12	0	12
Lab Tech	12	0	12
Lab Asst.	12	2	10
DSA	16	5	11
Medical Record	23	0	23
Health Attendant	202	89	113
Others	124	40	89
Total	862	168	694

Source: KSPHCDA 2015 and BDLG 2017.

From the above table 5.46 it can be seen that according to the WHO manpower standard of 68 staff per CHC, 5 per dispensary, 8 staffs per HC or MCHC, 46 staffs per PHC, there is shortage of manpower in the PHC sector of the local government. The number expected is 862, the number available 168 and there is a gap of 694. This goes to shows the extent of inadequacy of manpower in BDLG PHC. Observation also shows that there are some PHCs with only 3 technical staffs and they work only between 8:00 am to 6:00 pm due to lack of manpower. Also it was observed that there are no midwifes in the local government except those received under MSS/SURE-P. This can be part of the factor responsible for increases in infant mortality rate, child mortality ratio and maternal mortality ratio as shown in chapter four.

Table 5.47: Distribution of PHC staffs (other than LGPHCD Staffs).

Prog	Midwifes	CHEW	EHA	JCHEW	Lab tech	Med rec	Total
Casual	0	9	3	19	3	2	36
SURE-P	0	3	--	1	---	---	4
MSS	7	6	---	2	---	---	15
N-Power	---	6	1	1	---	----	8
Total	7	24	4	23	3	2	63

Source: KSPHCDA 2017, BDLG 2017

The above table 5.47 shows that there are 7 midwife, 24 CHEW, 4 EHA, 23 JCHEW, 3 Lab Tech and 2 medical record staffs in BDLG under different programme. This number is almost 45% of the staff under BDLG PHCD. Although it was said that some CHEW and midwifes have now been rescheduled to be posted to their local government of origin. This is due to the fact that the ₦20,000 given to them by KSPHCDA is not adequate to leave their community and work in another community 24 hours. At this juncture, it is interesting to ask why there are adequate facilities but there is no adequate manpower in both Katsina and Bindawa local government. The answer is that the political leadership is more concern with the project of infrastructure that can be seen visible and can be used for political campaign. Likewise some facilities are built by neither the local nor the state government, but by the NPHCDA and NGOs. Though there are some by local government, state government and some under the conditional grant scheme of MDGs. However, it is evidently that the state is not performing anything in terms of provision of manpower. A careful study of the staff inventory shows that the last recruitment was done in 2006 (i.e. 12 years without recruitment). And the number of health facilities has been multiplied between 2006 to 2016 (i.e. from 38 in 2004 to 68 2016). The local governments are not allowed to recruit from 2006 to date. From the foregoing, it can be deduced that there is critical shortage of technical manpower in the health facilities of Bindawa local government.

Table 5.48 Competency of the Medical/Health staffs

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	5	5.2	5.2	5.2
Agree	16	16.7	16.7	21.9
Undecided	14	14.6	14.6	36.5
Disagree	39	40.6	40.6	77.1
Strongly disagree	22	22.9	22.9	100.0
Total	96	100.0	100.0	

Source: SPSS from field survey, 2017.

The above table 5.48 it shows that 5 respondents representing 5.2% agree strongly that there are competent medical/health staffs in the local government. 16 respondents representing 16.7% of the entire respondent agreed that there are competent staffs. 14 respondents representing 14.6% have decided on the above assertion. 39 respondents representing 40.6% of the entire respondents disagree with the above assertion. 22 respondents representing 22.9% of the respondents also strongly disagree with the assertion that there are competent Medical/Health staffs in the health facilities.From the above table it can be seen that 61 respondents representing 63.5% of the entire respondents unanimously agreed that there are no competent medical/health staff in the health facilities.

However, interview with the community leaders and BDLG officials reveals that there is competent manpower in the PHC sector of the local government. Also, there is interview with the patients which shows that they are relatively satisfied with the competency of the health workers. Data from the secondary sources also shows that none of the staff has less than 12 years working experience which means that they are experienced staff who even train others when they came for practical attachment from schools of health technologies. However, it is pertinent to note that there is still in competency in terms of staff in the laboratories that are usually on casual bases. Likewise, there are some in charge of health facilities that have E.H.O certificate which does not require them to serve in such capacity. In the same vein the staffs of environmental department are now posted to PHC department to handle the facilities and provide the same services with the CHEW and Midwifes and they are not really

competent in such responsibilities. There is also the problem of JCHEW female staffs that are engaged in casual bases and are posted to be the in charge of maternities. There are also the problems in terms of competency of laboratory staff as they are on casual bases and fresh/raw graduate of schools of health technology who are not experience with the practical or application of such work. In the same vein some staffs are serving in such facilities for over 8 years therefore they are deskilled and they are not practicing the work. Now they are posted to PHC and CHC, and their incompetency is exposed.

From the above discussion it can be deduced that there are competent medical/health staff in the facilities of Bindawa local government. It is pertinent to know that there is more competent manpower in katsina local government than that of Bindawa local government. This can be justified from the responses of interview and questionnaire whereby 68% agreed on the capacity of manpower in PHC katsina while only 21.9% agrees with the competency of manpower in Bindawa local government. Likewise the secondary data of staff inventory shows that there are many staffs with B.Sc public Health, CHO, Lab Tech and Pharm Tech in katsina local government than that of Bindawa local government.

The factor responsible for such competent manpower in katsina local government involves urban area local government where there are more training institutions and complicated health problems than in the rural areas. There is also the issue of literacy whereby there is more literate people in the urban than in the rural. There is also issue of challenges whereby the staff of Katsina LGPHCD, faces from their colleagues in FMC, GH etc. which energized them for further studies. However, such challenges are not common in the rural areas like Bindawa local government.

Table 5.49: Adequacy of Essential Drugs in the Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	6	6.3	6.3	6.3
Agree	23	24.0	24.0	30.2
Undecided	8	8.3	8.3	38.2
Disagree	31	32.3	32.3	70.8
Strongly disagree	28	29.2	29.2	100.0
Total	96	100.0	100.0	

Source: SPSS Output from field survey, 2017

The above table 5.49 shows that 6 respondents representing 6.3% strongly agrees that there are essential drugs and they are given to the people. 23 respondents representing 24% of the respondents agreed that there are essential drugs in the facilities. 8 respondents representing 8.3% decided on the issue. 31 respondents representing 32.3% disagreed with the assertion. 28 respondents representing 29.2% of the respondents strongly disagreed with the assertion that there are drugs in the facilities and they are given to the peoples. This goes to shows that 59 respondents representing 61.5% of the entire respondents disagreed with the assertion that there are essential drugs in the facilities. However, interview responses shows that, there are provision for the drugs but it is not sufficient for the people. Data from the secondary sources shows that there is subsidy for DRF, reproductive health consumables, drugs for child health weak, free Medicare drugs, almajiri drugs and epids control and management drugs. This goes to shows that there are provision but not adequate in a specific areas (i.e. disaster management, Reproductive Health and Child Health programme).

Table 5.50: Cost of Drugs and Consumable Supplied By BDLG and Some Ngos

Year	Cost by L.G	Cost by NGOs	Total
2011	450,000	1,049,000	1,499,000
2012	480,000	295,000	775,000
2013	250,000	389,000	639,000
2014	300,000	400,000	700,000
2015	---	---	---
2016	---	495,000	495,000
Total	1,480,000	2,628,000	4,108,000

Source: KTSG 2015, BDLG 2016, medical store 2015

From the above table 5.50 it can be seen that the local government had supplied drugs and consumables worth 1,480,000 between 2011 to 2014 the NGOs like MCHC2, Frings, save the children had also supplied drugs worth 2,626,000 for the local government this goes to shows that the NGOs spent almost twice of the local government spent for the supply of drugs.

However, observation shows that there are drugs and consumables only in CHC Bindawa. The remaining 67 facilities have no drugs or any other consumables received from government. There are two PHCs that have some drugs but it is the DHC that provides the drugs to sell at affordable prices. Observation also in the 23 facilities visited by the researcher shows that there are some drugs and consumables in 17 health facilities. The drugs are bought by the staffs so that they can sell to the patients at a higher price than the market value. This means that some staffs have turned the facilities into a private/commercials pharmaceuticals chemist and they are even exploiting the patients. From the foregoing, it can be deduced that there are no essentials drugs in the facilities in Bindawa local government. This is entirely different from the situation in katsina local government whereby there are relatively essentials drugs in the facilities and the staffs are not turning the facilities into a business premises. The factors responsible for lack of drugs in Bindawa local government involves lack of political will by the local government to supply drugs adequately, lack of politicians to donate drugs, low literacy rate/awareness which makes people to patronize whatever they see in the facilities without really asking for the justifications.

Table 5.51: Responses on the Functional Laboratories in the Facilities

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	20	20.8	20.8	20.8
Agree	22	22.9	22.9	43.8
Undecided	7	7.3	7.3	51.0
Disagree	29	30.2	30.2	81.3
Strongly disagree	18	18.8	18.8	100.0
Total	96	100.0	100.0	

Source: SPSS output from field survey, 2017

The above table 5.51 shows that 20 respondents representing 20.8% of the respondents strongly agreed with the above assertion. 22 respondents representing 22.9% also agreed with the assertion that there are functional laboratories. 7 respondents representing 7.3% have not decided. 29 respondents representing 30.2% of the respondents disagreed with the assertion. 18 respondents representing 18.8% strongly disagree with the assertion.From the above, it can be seen that 47 respondents representing 49% of the respondents strongly disagreed that there are functional laboratories in the facilities of Bindawa local government. This can be proved from the responses of interview with the officials of BDLG that says there are only four laboratories in the 4 PHCs and 1 in CHC. They are relatively functional in the sense that they provide essential services like PT, MPS, PCV, and Grouping. Apart from that other services are not available in the laboratories at all and other 63 facilities do not have the laboratories at all. Likewise interview with the patients shows that there are very limited laboratory services in the facilities. In addition to that, interview with WDC and other community leaders shows that communities through WDC/DHC are the one that provides the laboratory consumables at affordable prices.

Data available shows that the SPHCDA provide the laboratory consumables to CHC only. However there are some NGOs like Global funds, CHAI, Frings that help to

provides determines for HIV screening and other tools for tuberculosis test.Data for what local government supply in terms of such consumables is not available. Observation shows that laboratories are inadequate in terms of the services they provide; there are also the problems of laboratory personnel. It was learned that in some PHC the test are conducted by the laboratory attendant and some casual Lab Assistants. It was also noted during the observation that there is no proffer organization in the laboratories as the specimen collection, testing, results collection and waiting rooms is in the same place. It was also learned that from the interview with the patients and observations, some people (patients) were given the result that they were not tested for. In the same vein, there is a problem of congestion in the laboratories in the sense that sometimes patients stays for more than 2 hours waiting for the result of MPs, PCV or grouping. In the same direction it was observed that the laboratories are only operating between 9:00 to 4:00 pm except on request. It was also learned that the officials are engaged in exploiting the patients especially during blood transfusion where by patients have to pay over ₦6000 for 1 bag of blood. Even the price of empty bags is ₦800 in the market but they are selling it at ₦1800 and above in the laboratories. From the foregoing it can be deduced that there are no functional laboratory services in Bindawa local government. The above discussion shows a different situation in katsina and Bindawa local government. There are relatively functional and adequate laboratory services in katsina local government, while inadequate and in effective laboratory services in Bindawa local government.

Table 5.52: Responses on Functional Maternal Services in Bindawa Local Government.

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	11	11.5	11.5	11.5
Agree	25	26.0	26.0	37.5
Undecided	13	13.5	13.5	51.0
Disagree	26	17.1	27.1	78.1

Strongly disagree	21	21.9	21.9	100.0
Total	96	100.0	100.0	

Source: SPSS output from field survey, 2017

The above table 5.52 it shows that 11 respondents representing 11.5% of the respondents strongly agreed that there are functional maternal services. 25 respondents representing 26% agreed that there is a functional maternal service. 13 respondents representing 13.5% have not decided on the assertion. 26 respondents representing 27.1% disagreed that there is functional maternal services in the facilities. 21 respondents representing 49% of the respondents unanimously agreed that there are no functional maternal services in the local government.

Interview conducted with patients shows that there are relative maternal care services in the facilities. They reveal that the staffs are trying and they are enjoying their services particularly during ANC and PNC. However, the staffs are inadequate and cannot attend to all the patients most of the times. Likewise there is no doctor except in CHC Bindawa and PHC Doro to refer to in case of complication during delivery. Likewise interview with staffs including in charge of maternity, shows that there are relatively adequate services for maternal care in some facilities. However, they complained that most of the women hardly come for ANC and undergo baseline laboratory investigations. Therefore, they are finding it difficult to conduct delivery for such kind of women. They have no information about first, second and third trimester and there were no Ultra Sound Scan (USS) to provide their E.D.D and other necessary information. They also complained that most of the women do not want to come for the PNC to weigh the babies, monitor their growth and immunize them.

Observation shows that, there are only 6 health facilities that are really functioning in terms of maternal care services. The remaining 62 facilities do not offer maternal services at all. Likewise it was observed that the staffs conducting the services are mostly CHEW and are casual, mss, sure-p or volunteers. Therefore they lack the real technical competency to provide effective maternal services. Likewise, it was learned that there are no ANC drugs except in CHC Bindawa PHC Tama and PHC Doro. The remaining facilities have no ANC drugs at all. Therefore, the women have to buy it outside.In the same vein there are only two beds in the labor room and maximum of 6 beds in the maternity ward. It is interesting to note that while there is relatively adequate and effective maternal care services in katsina local government, the situation is entirely different in Bindawa local government (i.e. in effective maternal care services). Also in katsina local government, there are higher level of awareness in terms of women coming for ANC and compliance with the medical advices given to them. However, the level of such awareness in Bindawa local government is very low. The justification for such two issues (i.e. effective services and level of awareness) can be attributed to the factors like urban literacy level and low level of literacy in the rural areas. Likewise there were midwives and experience CHEWS in Katsina local government than in Bindawa local government. Some staff in katsina local government has been exposed to such maternal care services for very long time ago. While the issue of maternal care services for Bindawa local government people is still premature.

Table 5.53: Responses On Democratic Government Provides Adequate Funds To Primary Health Care.

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	1	1.0	1.0	1.0
Agree	40	41,7	41.7	42.7
Undecided	6	6.3	6.3	49.0

Disagree	20	20.8	20.8	69.8
Strongly disagree	29	30.2	30.2	100.0
Total	96	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.53 shows that, 1 respondent representing 1.0% of the respondentstrongly agreed that democratic government provides adequate funds for primary health care. 40 respondents representing 41.7% agreed with the assertion. 6 respondents have not decided on the assertion. 20 respondents representing 20.8% of the respondents disagreed with the assertion. 29 respondents representing 30.2% of the respondents strongly disagreed with the assertion.From the above discussion, it can be seen that 49 respondents representing 51% of the entire respondents unanimously agreed that democratic government did not provides adequate funds for primary health care.

Interview conducted with the officials of KSPHCDA and BDLG shows that there is fair funding of primary health care in terms of infrastructures and personal cost. Even the salary of medical staff that was suspended in June, has now been reversed. There is also adequate funding of training of the medical/health staffs. Although it was said during interview that the running cost has been suspended and there were no supply for drugs and laboratory consumables.

Observation also shows that, of the 23 health facilities visited, there were 20 facilities in a good condition. It was also learned that WDCs/DHC and other CDA are really trying in terms of managing health facilities. However, it was noted that the funds are not used for maternal care, laboratory, and pharmacy and community awareness; rather they are used for reconstruction, fencing, mobile ambulance, training and maintenance of the manpower. There were no attempts in terms of provision of adequate

manpower to the facilities. From the foregoing it can be deduced that democratic governance provides fair funding of primary healthcare in Bindawa local government.

Table 5.54: Response on Democratic Governance Provide Adequate Schools in BDLG

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Agree	16	16.7	16.7	16.7
Undecided	17	17.7	17.7	34.4
Disagree	47	49.0	49.0	83.3
Strongly disagreed	16	16.7	16.7	100.0
TOTAL	96	100.0	100.0	

Source: SPSS output from field survey, 2017.

The above table 5.54 shows that 16 respondents representing 16.7% agreed that democratic government provides adequate primary schools. 17 respondents representing 17.7% are undecided about the assertion. 47 respondents representing 49.0% of the respondents disagreed with the above assertion. 16 respondents representing 16.7% strongly disagreed with the assertion. From the foregoing it is vividly clear that 63respondents representing 65.7% of the entire respondents unanimously agreed that democratic government does not provide adequate primary schools.

However, interview with LGEA officials shows that there are relatively adequate schools in the local government. Although there are 5 schools that are annex and not taken over by government. The schools are managed by the communities. The officials' response shows that there is need for at least 20 more schools in the local government. This is because, the communities are scattered in various settlements therefore some have a distance of about 4.5 kilometers before they assess primary schools. Secondary data shows that there are 69 primary schools in the local government. These schools are distributed across education areas. They are relatively sufficient for the population/enrolment of 43514. Observation shows that there are some schools that do

not have up to 200 pupils. The schools are only insufficient in some places like Tama, Doro and Bindawa. In other places there are schools that are not even occupied by the effected number of pupils. Schools like Bakar doga, Santar bila does not have up to 100 pupils. Likewise it was learned that truancy is the common behavior in the local government. Observation also shows that, some settlements have to travel for 4.5 kilometers before they got to schools. This goes to shows that there is relative fair number of schools in the local government. The above situation shows how rural local government; Bindawa is, in terms of schools. This is because there are schools but they are not being used in some places. This is entirely different in Katsina local government in the sense that the schools in the local government are congested and they are even using morning and evening session. This shows the parents commitment to send children to schools. While the situation in Bindawa shows less concern towards basic education.

Table: 5.55: Responses On Adequacy Of Teachers In The Schools

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	5	5.2	5.2	5.2
Agree	28	29.2	29.2	34.4
Undecided	21	21.9	21.9	56.3
Disagree	30	31.3	31.3	87.5
Strongly disagree	12	12.5	12.5	100.0
Total	96	100.0	100.0	

Source: SPSS output from field survey, 2017.

This table 5.55 above shows that 5 respondents representing 5.2% strongly agreed that there are adequate teachers in the schools. 28 respondents representing 29.2% agreed that there are adequate teachers in the schools. 21 respondents representing 21.9% of the respondents have not decided on the above assertion. 30 respondents representing 31.3 of the respondents disagreed that there are adequate teachers in the schools. 12 respondent representing 12.5% of the respondent strongly disagreed with the assertion. This goes to

shows that 42 respondents representing 43.8% of the entire respondents unanimously agreed that there are no adequate teachers in the schools.

This goes in line with the response of interview conducted with the officials of LGEA, SUBEB and some community leaders which show that in adequate manpower is critical challenge in basic education sector of Bindawa local government. The pupils/teachers ratio in Bindawa local government is shown in chapter four. Observation also shows that there are some schools like Tama, Bindawa, Doro and Shibdawa model with relative fair manpower i.e. 62:1. However it was learned that, there are some schools with the pupil's ratio of 97:1. There are also some schools with only 3 teachers (i.e. Headmaster, moral teacher, one other teacher). It was also learned that some teachers are absconded from duty for more than 6 month on the ground that they are on study leave but there were no release letter showing the approval of SUBEB for their study. This situation is almost the same with the situation in Katsina local government in the sense that there is inadequate manpower in both the two local governments.

Table 5.56: Responses on the Competency of Teachers in BDLGEA

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	2	2.1	2.1	2.1
Agree	36	37.5	37.5	39.6
Undecided	32	33.3	33.3	72.9
Disagree	24	25.0	25.0	97.9
Strongly disagree	2	2.1	2.1	100.0
Total	96	100.0	100.0	

Source: SPSS Output from field survey, 2017

The above table 5.56 shows that 2 respondents representing 2.1% strongly agreed that the teachers are competent in discharging their duties. 36 respondents representing 37.5% of the entire respondents agreed with the above assertion. 32respondents

representing 33.3% have not decided on the above assertion. 24 respondents representing 25% of the entire respondents disagreed with the assertion. 2 respondents representing 2.1% strongly disagreed on the assertion. From the above discussion it can be seen that 38 respondents representing 39.6 of the entire respondents unanimously agreed that the teachers are competent in discharging their duties. This is in line with the result of interview which shows that there are competent teachers in LGEA Bindawa. Likewise secondary data shows that over 80% of the teachers have the minimum qualification for teaching as prescribed by the UBE Act 2004. The data also shows that there is a continuous training programme organized by SUBEB, LGEA, and NGOs etc.

Table 5.57: Distribution Of Teachers And Their Qualification In BDLG

Qual.	Grade II	OND	NCE	HND	BSC/BA ed	others	Total
Number	19	64	370	2	31	17	503

Source: BDLG, 2017.

The above table 5.57 shows that there are 401 professional teachers in Bindawa local government. This means that over 80% (i.e. 401/503x100) are qualified teachers.

Table 5.58: Responses on Adequacy and Conduciveness of the Classes

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	16	16.7	16.7	16.7
Agree	36	37.5	37.5	54.2
Undecided	17	17.7	17.7	71.9
Disagree	25	26.0	26.0	97.9
Strongly disagree	2	2.1	2.1	100.0
Total	96	100.0	100.0	

Source: SPSS Output from field survey, 2017

The above table 5.58 shows that 16 respondents representing 16.7% strongly agreed that there are adequate and conducive classes in BDLG. 36 respondents representing 37.5% agreed on the above assertion. 17 respondents representing 17.7%

have not decided on the above assertion. 25 respondents representing 26% of the respondents disagreed with the assertion. This goes to shows that 52 respondents representing 54.2% of the entire unanimously agreed that there are adequate classroom and they are conducive for learning in Bindawa local government.

However, interview with the officials of SUBEB, LGEA and BDLG shows that, the classes are relatively adequate and they are in good condition. This means that there are more than 80% of the classes in good condition. This can be proved from the secondary data from SUBEB and LGEA Bindawa which shows that about 325 classes were renovated between 2011 to 2016. However, observation in some schools shows that there are some classes without even black boards. There are some classes that do not have windows and some does not have ceiling. There are also some schools in Yangora, Giremawa, Doro, Shibdawa, and Kamri with dilapidated classes. The situation is even worst in Dan Doro, Kaura, Dadin kowa and Bangaraje primary schools where some pupils are receiving lessons under shade of the tree. There were also some schools that are not even functioning due to poor condition of the classes. In terms of adequacy there are relatively adequate of classes in sense that some classes are even empty due to their availability. This is entire different with the situation in katsina local government where by the classes are inadequate and are over used (morning and afternoon session), but they are in good condition.

Table 5.59: Adequacy of Furniture and Instructional Materials

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	5	5.2	5.2	5.2
Agree	41	42.7	42.7	47.9
Undecided	6	6.3	6.3	54.2
Disagree	38	39.6	39.6	93.8

Strongly disagree	6	6.3	6.3	100.0
Total	96	100.0	100.0	

Source: SPSS Output from field survey, 2017.

The above table 5.59 shows that 5 respondents representing 5.2% strongly agreed that there are adequate furniture and instructional materials in the local government. 41 respondents representing 42.7% agreed with the assertion. 6 respondents representing 6.3% have not decided on the above assertion. 38 respondents representing 39.6% disagreed with the assertion. 6 respondents representing 6.3% of the respondents strongly disagreed with the assertion. This goes to shows that 46 respondents representing 47.9% of the entire respondents unanimously agreed that there are sufficient furniture and instructional materials in the schools.

Interview with the officials of Bindawa LGEA shows that there are over 7000 pupils three sitter furniture in the local government, but only 4502 are in good condition. The officials also revealed that the furniture is the second critical challenges of Basic education in the local government. However, it was noted that the present administration is trying in the provision of schools furniture. It was also reveals that there are continuous supplies of furniture under the present administration.

Observation also shows that there are some schools like Bindawa, Doro and Shibdawa model that have relative adequacy of furniture. Santar Gawo also has complete furniture supplied by the present administration. It was also noted that most of the schools visited (i.e. 21 out of 23) have no complete furniture. Details for the cost and number of furnitures supplied between 2011 to 2016 have been presented in chapter four. There are also instructional materials in the local government. Observation shows that

most of them are not even used by the teachers. This situation is almost similar with katsina local government. Also furniture is more adequate in Bindawa local government than in katsina local government. Likewise there is more usage of instructional materials in katsina local government than in Bindawa local government.

Table 5.60: Democratic Governance Provides Adequate Funds in Basic Education

Variables	Frequency	Percentage	Valid percent	Cumulative percent
Strongly agree	13	13,5	13.5	13.5
Agree	51	53.1	53.1	66.7
Undecided	16	16.7	16.7	83.3
Disagree	15	15.6	15.6	99.0
Strongly disagree	1	1.0	1.0	100.0
Total	96	100.0	100.0	

Source: SPSS Output from field survey, 2017.

The above table 5.60 shows that, 13 respondents representing 13.5% strongly agreed that democratic government provides adequate funds in Basic education. 51 respondents representing 53.1% agreed with the assertion. 16 respondents representing 16.7% have not decided on the assertion. 15 respondents representing 15.6% disagreed with the above assertion. 1 respondent representing 1% of the respondent strongly disagreed about the assertion. This goes to shows that 64 respondents representing 66.7% of the entire respondents agreed with the assertion, that democratic government provides adequate funding in Basic education.

Interview responses show that, democratic government provides adequate funding in terms of infrastructures provisions. It also shows that the past administration has tried in terms of provisions of manpower, particularly, between 2002, to 2012. There is also little to shows in terms of government spending on procurement, capacity development and welfare from 2013 to 2016. Interview with some teachers also shows that democratic government has less concern in the expenditure/spending of teachers rather it pays more

attention on infrastructures. Data available shows that (see Chapter four) government capital expenditure on personnel cost was around 18.5 billion (with the exception of personnel cost in 2016 which rose to 19.5 billion). No explanation for such increased in the personnel cost. However, there was no recruitment, promotion or annual increment throughout 2016. There are also some teachers that leave the service for many reasons such as age ground, years of services etc. From the foregoing it can be deduced that democratic government provides adequate funding on structures than manpower in the local government.

Table 5:61 Response on democratic government provides adequate sources of portable drinking water.

Variable	Frequency	Percentage	Valid percent	Cumulative percent
Strongly Agreed	1	1.0	1.0	1.0
Agreed	66	68.8	68.8	69.8
Undecided	7	7.3	7.3	77.1
Disagreed	9	9.4	9.4	86.5
Strongly disagreed	13	13.5	13.5	100.0
Total	96	100.0	100.0	

Source field survey, 2017

The above table shows that 1 respondent representing 1% of the respondents strongly agreed that democratic government provides adequate source of portable drinking water. 66 respondents representing 68.8% of the respondents agreed that democratic provides adequate sources of portable drinking water. 7 respondents representing 73% of the entire respondents have not decided on the above ascertion. 9 respondents representing 9.4% of the respondents disagreed with the ascertion. 13 respondents representing 13.5 % of the respondents strongly disagreed with the ascertion. From the foregoing, it is vividly clear that 67 respondents representing 69.8% of the entire respondents unanimously agreed that democratic government provides adequate

sources of portable drinking water in Bindawa local government. There are 298 sources of portable drinking water and there are also 29 private sources of water.

However, observation shows that the sources are unevenly distributed. There are some communities with 24 sources provided by the democratic government between 2011 to 2016. However, there are some communities with the only one sources of water and is not even functioning. This was also proved by the secondary data, which shows that some political wards like Doro, Bindawa and Tama have not less than 39 boreholes each. However, Yangora, Baure and Daye ward have less than 15 boreholes each.

Table 5:62 Respondents Opinion on the Function of the Sources of Water

Variable	Frequency	Percentage	Valid percent	Cumulative percent
Agreed	40	41.7	41.7	41.7
Disagreed	50	52.1	52.1	93.8
Strongly disagreed	6	6.3	6.3	100.0
Total	96	100.0	100.	

Source field survey, 2017

From the above table it can be seen that, 40 respondents representing 41.7% of the respondents unanimously agreed that the source of portable drinking water are functional. 50 respondents representing 52.1% of the respondents disagreed with the ascertion. 6 respondents representing 6.3% of the respondents strongly disagreed with the ascertion. This is in line with the interview result conducted with the stakeholders which shows that, of the over 300 sources of portable drinking water. Only 129 are really functional. There is no prompt action for repair from local government and community perspective. There is also lack of good maintenance culture in the sense that people (water consumer) consider the boreholes as no one's property. Therefore, they have poor attitudes towards the maintenance of such facilities.

Observations also show that, of the 14 centers visited 7 are functional. There are some that has not been functioning for over two years. There is also problems in the sources of water in the sense that some children are send to fetched water and they cannot use the borehole properly. However, information from the secondary data shows that the local government is committed to maintenance of such facilities. Between Januarys to December 2016, ministry for local government spent N15, 000,000 for the maintenance of the sources only. Likewise, the WCA also spent N3,500,000 for the maintenance between 2011 to 2015. In the same vein 3 NGOs have also spent N4, 600,000 for the repair of boreholes, tabs and motorised solar system. In the same vein, 13 philantrophers have also spent 4,210,000 for such repairs.

Table 5: 63 Respondents Opinion On The Access To Source Of Portable Drinking Water.

Variable	Frequency	Percentage	Valid percent	Cumulative percent
Agreed	38	39.6	39.6	39.6
Disagreed	50	52.1	52.1	91.7
Strongly disagreed	8	8.3	8.3	100.0
Total	96	100.0	100.	

Source: field survey, 2017

The above table shows that, 38 respondents representing 39.6% of the entire respondents agreed that people have access to source of water. 50 respondents representing 52.1% of the respondents disagreed with the ascertion. 8 respondents representing 8.3% of the respondents strongly disagreed with the ascertion. This to show that 58 respondents representing 60.4% of the entire respondents unanimously agreed that there is no access to sources of portable drinking water in Bindawa local government. This is in line with the experience gained during observation where by the reasercher learned that, there are some communities that do not have a single source of portable drinking water. They have to travel for atleast 4.5 kilometers before they accessed the

water. Also they have to join the que atleast for 3 hour before they get their turn. Sometimes they used the water from the stream for domestic uses. This is also a factor responsible for the increase in diseases and poor retention of pupils in the schools.

Table 5:64 Respondents opinion on adequate funds for the maintenance/treatment of water

Variable	Frequency	Percentage	Valid percent	Cumulative percent
Agreed	32	33.3	33.3	33.3
Undecided	6	6.3	6.3	39.6
Strongly disagreed	58	60.4	60.4	100.0
Total	96	100.0	100.	

Source: field survey, 2017

The above table shows that 32 respondents representing 33.3% of the respondents agreed that there are adequate funds for maintenance of source of portable drinking water. 6 respondents representing 6.3% of the respondents representing have not decided on the ascertion. 58 respondents representing 60.4% of the respondents unanimously disagreed that there are adequate funds for the maintenance of sources of portable drinking water. This is in line with the secondary data obtained from the local government which shows that, the local government spent less than one million naira annually for the maintenance of such sources. Likewise observation shows that, the people have to be contributing money for the maintenance of sources of water. In addition to that every water consumer has to pay N10 per 25 litre of water as means to save for rainy day. This is also another factor responsible for none functioning of over 50% of the sources of portable drinking water. In comparison with katsina, Bindawa has poor maintenance culture and inadequate funds for such maintenance. Therefore, it can be deduced that there is no adequate funds for maintenance in Bindawa local government.

Test of Hypotheses for Bindawa local government

Hypothesis One

H_{01}. There is no significant relationship between democratic governance and provision of primary health care in Bindawa Local government area.

Table 5.65: Analysis of Variance (ANOVA)

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	11.820	1	11.820	413.480	.000[b]
	Residual	2.687	94	.029		
	Total	14.507	95			

a. Dependent Variable: Primary Health Care

b. Predictors: (Constant), Democratic Governance

Table 5.65: above shows the F statistics which stood at 413.48 having a p-value of 0.000 which is less than 0.05 indicating that its significance at 95% confidence level. This implies that the model is fit and the variables are not wrongly selected. Hence, we can proceed with the regression analysis.

Table 5.66: Model Summary of Regression Results

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.703[a]	.615	.610	.16907

a. Predictors: (Constant), Democratic Governance

Table 5.66 above shows the coefficient of correlation (r), the coefficient of determination (r^2) and the adjusted r^2. The correlation coefficient (r) being 0.703 indicates that there is a strong and positive correlation between democratic governance and primary health care. The coefficient of determination (r^2) stood at 0.615 indicating that 61.5% of the variations in primary health care in Bindawa Local Government can be explained by democratic governance. The adjusted r^2 stood at 0.61 indicating that democratic governance would still explain 61% of the variations in primary health care even if other variables are added to the model.

Table 5.67: Regression Standard Coefficient Results

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.632	.041		63.747	.000
	Democratic Government	.325	.016	.703	20.334	.074

a. Dependent Variable: Primary Health Care

Table 5.63 above shows the coefficients of the variables in model. Thus the model is presented:

PH = 2.632 + 0.325 DG + c

Where PH = Primary Health Care

DG = Democratic Governance

From the above model the coefficient of democratic governance stood at 0.325 which is positive. This implies that more efforts towards democratic governance would lead to better primary health care. The significance of this can be judged from the t statistics and its significance. The t statistics of democratic governance stood at 20.334 with a p-value of 0.074 indicating that the relationship depicted in the model is statistically insignificant at 95% confidence level. This implies that we do not have enough statistical evidence to reject the null hypothesis.

Based on the above analyses, we fail to reject the null hypothesis H_{01} which states that there is no significant relationship between democratic governance and provision of primary health care in Bindawa Local government area.

Hypothesis Two

H_{02}. There is no significant relationship between democratic governance and provision of primary education in Bindawa Local government area.

Table 5.68: Analysis of Variance ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	16.858		16.858	386.322	.000[b]

	Residual	4.102	94	.044		
	Total	20.960	95			

a. Dependent Variable: Primary Education

b. Predictors: (Constant), Democratic Governance

Table 5.68 above shows the F statistics which stood at 386.322 having a p-value of 0.000 which is less than 0.05 indicating that its significance at 95% confidence level. This implies that the model is fit and the variables are not wrongly selected. Hence, we can proceed with the regression analysis.

Table 5.69: Model Summary of Regression Results

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.697[a]	.604	.592	.20890

a. Predictors: (Constant), Democratic Governance

Table 5.69 above shows the coefficient of correlation (r), the coefficient of determination (r^2) and the adjusted r^2. The correlation coefficient (r) being 0.697 indicates that there is a strong and positive correlation between democratic governance and primary education. The coefficient of determination (r^2) stood at 0.604 indicating that 60.4% of the variations in primary education in Bindawa Local government area can be explained by democratic government. The adjusted r^2stood at 0.592 indicating that democratic governance would still explain 59.2% of the variations in primary education even if other variables are added to the model.

Table 5.70: Regression Standard Coefficients Results

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.178	.085		13.820	.000
	Democratic Government	.444	.023	.697	19.655	.101

a. Dependent Variable: Primary Education

Table 5.70 above shows the coefficients of the variables in model. Thus the model is presented:

PE = 1.178 + 0.444 DG + c

Where PH = Primary Education

DG = Democratic Governance

From the above model the coefficient of democratic governance stood at 0.444 which is positive. This implies that more efforts towards democratic governance would lead to better primary education. However, the significance of this can be judged from the t statistics and its significance. The t statistics of democratic governance stood at 19.655 with a p-value of 0.101 indicating that the relationship depicted in the model is statistically insignificant at 95% confidence level. This implies that we do not have enough statistical evidence to reject the null hypothesis.

Based on the above analyses, we fail to reject the null hypothesis H_{01} which states that there is no significant relationship between democratic governance and provision of primary education in Bindawa Local government area.

Hypothesis Three

H_{01}. There is no significant relationship between democratic governance and portable drinking water in Bindawa Local Government Area.

Table 5.71 Analysis of Variance(ANOVA[a])

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	9.719	1	9.719	30.265	.012[b]
	Residual	30.187	94	.321		
	Total	39.906	95			

a. Dependent Variable: Portable drinking water
b. Predictors: (Constant), Democratic Governance

Table 5.71 above shows the F statistics which stood at 30.265 having a p-value of 0.012 which is less than 0.05 indicating that its significance at 95% confidence level. This implies that the model is fit and the variables are not wrongly selected. Hence, we can proceed with the regression analysis

Table 5.72 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.594[a]	.344	.336	.56669

a. Predictors: (Constant), Democratic Governance

Table 5.72 above shows the coefficient of correlation (r), the coefficient of determination (r^2) and the adjusted r^2. The correlation coefficient (r) being 0.594 indicates that there is a moderate and positive correlation between democratic governance and Portable drinking water. The coefficient of determination (r^2) stood at 0.344 indicating that 34.4% of the variations in Portable drinking water in Bindawa Local Government can be explained by democratic governance. The adjusted r^2 stood at 0.336 indicating that democratic government would still explain 33.6% of the variations in Portable drinking water even if other variables are added to the model

Table 5.73 Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.261	.194		11.647	.009
	Democratic Government	.447	.063	.594	5.501	.052

a. Dependent Variable: portable drinking water

Table 5.73 above shows the coefficients of the variables in model. Thus the model is presented:

PDW = 2.261 + 0.447 DG + c

Where PDW = Portable drinking water

DG = Democratic Governance

From the above model the coefficient of democratic governance stood at 0.447 which is positive. This implies that more efforts towards democratic governance would lead to better portable drinking water. The significance of this can be judged form the t statistics and its significance. The t statistics of democratic governance stood at 5.501 with a p-value of 0.052. Indicating that the relation depicted in the model is insignificant

at 95% confidence level. This implies that we do not have enough statistical evidence to reject the null hypothesis. Based on the above analyses, we fail to reject the null hypothesis H_{03} which states that, there is no significant relationship between democratic governance and provision of Portable drinking water in Bindawa Local government area.

5.4 Comparison between Urban (Katsina Local Government) and Rural (Bindawa Local Government)

From the data presented and analysed it was observed that people in katsina local government have more awareness in terms of using the health facilities and primary schools. There are more women attending ANC and PNC in katsina state (i.e 45%) than Bindawa local government (i.e 23%). Also the literacy rate in katsina local government stood at 65% while in Bindawa local government it stood at 46% respectively. The maternal mortality rate, child mortality rate and infant mortality rate is far better in katsina local government than in Bindawa local government (see chapter four). In terms of number of health facilities, Bindawa local government has more health facilities (i.e. 68) than katsina local government (i.e. 29). However, the facilities in katsina local government are more functional than that of Bindawa local government. People in katsina use the facilities than in Bindawa local government. This cannot be disputed from the fact that, Bindawa is a rural local government where people are living in a various settlement. Therefore they need more facilities than in Katsina Urban where people are living in a closer settlement. Likewise there is another factor of political leadership. Bindawa local government has only 41 health facilities prior to 2009. However, between 2010 to 2014, there were 26 new health facilities. This also cannot be separated from the fact that the North – Western coordinator of NPHCDA, the state vice chairman of PDP, the then commissioner of health, the chairman house committee on health and budget of

the state assembly all came from Bindawa local government. Therefore, they insisted for the construction of health facilities in their local government.

Also, with regards to manpower, both local governments have inadequate manpower. However, due to political reason, Bindawa local government received highest number of MSS and SURE-P. It was also learned that both the two local governments have competent manpower, but that of katsina is far better than in Bindawa. There are more experience and qualitative manpower in katsina than in Bindawa. Katsina local government has many staff with B.Sc public Health, CHO and others. This cannot be separated from the fact that katsina local government has more challenging health issues than Bindawa local government.

In terms of essential drugs, there is SDSS, DRF and NGOs intervention in both the local governments. However, Bindawa received more from NGOs than katsina local government. This is due to the fact that NGOs are more rural/community based than the government. It was also learned that reproductive health facilities are more available in katsina than Bindawa local government. It was also observed that there are limited laboratory services (only 5 facilities) in Bindawa than in Katsina. Almost all the facilities in katsina have laboratories services. The maternal care service is another area of disparity between Bindawa and katsina local governments. Bindawa local government has only 6 facilities with maternal care services and is provided by either CHEW or midwifes under MSS/SURE-P. This is entirely different in katsina local government; there are about 28 facilities that provides maternal care services and with relatively competent manpower. With regards to funding it was learned that, katsina local government provides more financial commitment than Bindawa local government.

With regards to Basic education it was learned that katsina local government has inadequate schools and manpower. There are only 31 primary schools for about 90,000 pupils in katsina. While Bindawa have 69 schools for 43500 pupils. In terms of classrooms it was learned that there are no adequate classroom in katsina local government than in Bindawa local government. However, 89% of the classrooms in katsina are in good condition while less than 80% are in good condition in Bindawa local government. It was also learned that there are more competent manpower in katsina, than in Bindawa local government. The pupils'/teacher ratio in katsina and Bindawa are relatively, the same which means both local governments has inadequate teaching staff. With reagards to furnitures there are more furniture in Bindawa than in Katsina local government. This is due to the fact that, there are no 2 arms/session in schools in Bindawa. Observation and interview also shows that teachers use instructional materials in katsina than in Bindawa. Katsina complained for instructional materials while Bindawa have no issue about that. In terms of funding, the annual estimate for both LGEAs is not available, but there is indication from the action plan and other projects documents that SUBEB allocated more projects to Bindawa than katsina local government although katsina local government has more storey building projects than Bindawa local government. With regards to enrolments, retention and completion, it was learned that katsina is far better by enrolling more than what is obtainable in Bindawa local government. Katsina was also found to be better in terms of retention, transition and completion. As we have seen 89,507 pupils in school with the completion of 12,230. This means that if these trends continue increasing (as noted in chapter four) there is tendency for improvement in Basic education. However, Bindawa local government with the

enrolment of 43,500, but transition of 3809 and completion of 3168 is a signal to poor enrolment and retention which if this continue decreasing there is tendency for the reduction of literacy rate in the local government.

In terms of water supply, there were more functional sources of portable drinking water in Katsina than in Bindawa local government. It was learned that while portable drinking water is a critical challenge in Bindawa local government, it is not an issue in Katsina local government. It was also learned that, people used to travel for 3 kilometers before they access water for domestic use in some places of bindawa local government. However, the highest to travel before access to water is 0.5 kilometers. There is also both treatment and non treatment water in Katsina local government. However, there are only sources of non treatment water in Bindawa local government. Interms of mentenance, it was learned that government is more active in Katsina than in Bindawa local government.

5.6 Summary of Major Findings

The presentation and analysis of data as well as test of hypotheses have revealed some significant and fundamental findings on the impact of democratic governance on service delivery in katsina state; specifically as it related to primary health care, water supply and basic education thus, the following findings were revealed.

1. It was found that democratic governance provides adequate health facilities, competent manpower and supply of essential drugs under various shemes. There is also inadequate manpower in the PHC sector of the state. However, such drugs are inadequate and are not based on the needs of the people. It was also found that reproductive health consumables are inadequate in Katsina local government and not available at all in the Bindawa local

government. Functional laboratories were only located at CHC in the urban area than in the rural. These undermined the provision of PHC service delivery in the study area.

2. It was also found that, there was low level of awareness in terms of using the facilities in Bindawa local government. There are only 20.1% of women receiving ANC in Bindawa local government and 43.5% for katsina local government. This is below the WHO standard of 90% of women to received ANC. This led to the incrased maternal mortality rates, child mortality ratio, infant mortality ratio, malarias and other related deseases.
3. It was found that schools and teaching staff are inadequate in both katsina and Bindawa local governments. The pupil/teacher ratio in Bindawa local government stood at 87:1 and 74:1 for katsina local government. This is below 40:1 standard of the UBE Act 2004. However, there are no adequate furnitures in both local governments. There is increased in the enrolment retention, transition and completion in Katsina local government. However, the enrolment and completion rate in Bindawa local government is poor. This undermined the provision of primary education in the study areas.
4. It was found that, there are no adequate sources of portable drinking water in Bindawa local government. Some pupils can not go to school because; they have to fetch water for the parents for domestic use. Although, WCA was found very functional in terms of mentenance; yet, there are many boreholes that are not functional for over a year.

SECTION SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

This work is an examination of the impact of democratic governance in service delivery in katsina state; a study of katsina and Binadawa local government from 2011 to 2016. The central problems which the research addressed was examining whether the projects of democratic governance has improved the provision of primary health care and basic education in katsina state. The variables investigated by the study were provisions of adequate and competency of manpower in basic education and primary health care sector, essential drugs, laboratories and maternal care services, furniture and instructional materials, classrooms and adequate funding of basic education, water supply and primary health care. Research questions, objectives and hypotheses were tailored in line with these variables.

The significance of the study is justified to the fact that it has bridged the gap in existing knowledge on the impact of democratic government on service delivery in katsina state, in relation to primary health care, water supply and basic education. The finding of the study also would assist the leaders in katsina state, federal government and other state in appreciating the democratic government in katsina state. The findings will also serve as a point of reference to officials of primary health care and basic education, researchers and members of the public in understanding the impact of democratic government in service delivery particularly in katsina state.

Literature on the concept of democratic governance, service delivery, socio – economic development, human development primary healthcare, water resources and

basic education were reviewed. Overview of primary health care and basic education requirement was also extensively discussed. Related empirical studies carried out by other scholars in the field were also critically examined and criticized; theories was also discussed and applied to the study as a framework for the study.

Survey research design was adopted and data were generated from both primary and secondary source with questionnaires, interview and observations as instrument for generating the primary data. The populations of the study were the people of katsina and Bindawa local governments (i.e. 490,356), the sample size adopted was 382. For questionnaire, 362 people were given questionnaires in katsina and Bindawa local government, political awards and community development association like VHC, DHC, SBMC, PTA, and CDA were used in administering questionnaire. Focus group interview was conducted with the officials of SPHCDA, RUWASA, WATSAN, SUBEB, KTLG, BDLG, LGEAs, chairmen of CDA, NUT, MHW, SBMC, DHC, WCA and some patient in facilities and some teachers in the school. Multi – stage sampling were adopted in sampling the respondents.

Data were presented and analysed using frequency and percentage. Hypotheses were tested using regression analysis through SPSS computer statistical percentage version 20.0 which tested the effects of the independent or predictor variables on the dependents or criteria variables at a $P<0.05$ level of significance. The entire three null hypotheses formulated for the study were accepted in Bindawa local government while two hypotheses were accepted and one where rejected in Katsina local government. The study revealed that, democratic governance has impacted in provision of primary health care, water supply and basic education services.

It was also found that, there is availability and access to primary health care and basic education in katsina state. It was also found that there is low level of awareness in terms of women attending ANC and the parent to send their children to school. It was noted that, there is no adequate sources of portable drinking water in Bindawa local government compared to Katsina local government. It was also found that there is continuous construction and renovation of schools in katsina state but there is no provision for procurement of manpower. It was also found that maternal mortality ratio, child mortality ratio and less than 5 mortality ratio has been increasing in the state. Other findings were also inadequate provision for essential drugs, laboratories services and lack of furnitures as well as conducive classrooms for learning, lack of portable drinking water and poor mentenance culture in Bindawa Local Government.

6.2 Conclusions

In view of the data presented and analysed as well as the hypotheses tested in chapter five, it was found that democratic governance in Katsina state pays more attention to provision of health and education infrastructures neglecting the provision of manpower, basic healthcare tools, furnitures and instructional materials. This undermined the impact of such provision and leads to poor enrolment, retention and completion in the basic education sector. Many schools and health centers cannot operate accordingly as there were no adequate workers to provide the services. It also affects maternal care services as it shows the increased maternal mortality, child mortality, prevalence of malaria, malnutrition and other related deseases. This finding is in line with the theoretical framework which states that manpower provison and proffessinalisation is a critical determinant of service delivery. Essential drugs supply base on push methods is

also against the theory of localism as it states that for effective service delivery, provision of goods and services should be based on the needs of the polity The low level of awareness also is a serious factor that undermined the attainment of healthcare policy objectives. In adequate sources of portable drinking water hinders the health living and educational objectives in the study area. The study therefore concluded that, the impact of democratic government in primary health care, water supply and basic education will remain on attainable if the issues of sources of portable drinking water and their mentenance, adequate and competent manpower, laboratories and essential drugs, furnitures and instructional materials, conducive classrooms, creation of awareness and equal distribution of such resources are not carefully addressed.

6.3 Recommendation

From the analysis of the survey result, discussion and inference drawn, the following recommendations are made:

1. Government should also increase the provision of such drugs and laboratory consumables. Rural facilities should be considered in terms of provision of essential drugs. Laboratories and their services shall be extended not only in the CHC but also at all the PHCs, MCHCs and HCs so that test can be conducted at that facilities without going to CHCs and GHs. The laboratory officials should be carefully supervised and strong internal control system should be employed to stop the officials from exploiting.
2. Local government should be empowered to recruit technical manpower particularly CHOs CHEW, Lab Tech, Midwives Pharm Tech, Nurses and medical records that could boost she provision of primary health care services. This will help to make the facilities to be operating 24 hours and each unit (e.g. maternity, laboratory and pharmacy) to be

handle by the specialist in that area. There should be consistent awareness creation through sensitization programmes by the PHC department of the local government through traditional rulers, VHC, DHC, CDA and other medias for the rural people to accept the medical services/advices and women to come for ANC.

3. There should be provision of adequate and competent manpower in the basic education sector. The LGEAs should be capacitated to recruit more teachers to help in the basic education sector. The current situation of 75:1 pupils' teacher ratio can only be addressed by providing more competent teachers. Also, there should be more classes in Bindawa local government and more schools should be constructed in katsina local government. This will reduce over stressing the schools in katsina and provides more convenient atmosphere for learning in Bindawa local government. There should also be provision of adequate and qualitative furniture in all the schools in two local governments.
4. More sources of portable drinking water should be provided in Bindawa local government, maintenance culture should also be improved and more funds shall be provided for rural water supply. Government should also improve in the support given to Katsina local government in terms of provision of portable drinking water

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APPENDIX1

QUESTIONNAIRE FOR THE BENEFICIARIES OF PRIMARY HEALTH CARE, WATER RESOURCES AND BASIC EDUCATION IN KATSINA AND BINDAWA LOCAL GOVERNMENTS

Department of Public Administration
Faculty of Administration
Ahmadu Bello University,
Zaria

Dear Respondent,

I am M.Sc Student in the Department of public Administration, Ahmadu Bello University, Zaria, undertaking a research on the topic.

Impact of Democratic Governance on Service Delivery in Katsina state: A study of some selected local governments.

I will be grateful if you can fill the attached questionnaire. Your personal and objective views will be highly appreciated and valued. Please be rest assured that all information provided by you would be used purely for academic purpose and shall be treated with absolute confidentiality.

Thanks for anticipated cooperation.

Thanks

Shehu Sani
Researcher

SECTION A: PERSONAL INFORMATION

1. **Gender a. Male [ ] b. Female [ ]**
2. **Level of Education a. SSCE [ ] b. NCE/ND [ ] c. HND/BSC [ ] e. Others [ ]**
3. **Local Government a. Katsina [ ] b. Bindawa [ ]**
4. **Age a. 18 – 29 [ ] b. 30 – 39 [ ] c. 40 – 49 [ ] d. 50 and above.**

SECTION B: INSTRUCTIONS

Please answer all the questions by ticking ( ) only one number or letter that best represents your opinion based on the following scales:

1. Strongly Agree
2. Agree
3. Undecided
4. Disagree
5. Strongly Disagree

There is no Significant Relationship between Democratic Governance and Provision of Primary Health Care.

S/N	Variables	Strongly Agreed	Agree	Undecided	Disagree	Strongly Disagreed
1.	Democratic government provides adequate health facilities.					
2.	There are sufficient medical/Health staffs in the health facilities.					
3.	The medical staff are competent					
4.	There are essential drugs in the health facilities.					
5.	There are functional laboratories in the health facilities.					
6.	There are functional maternities in the facilities.					
7.	Democratic government provides adequate funds for primary health care.					

8. Please, give suggestion on how to enhance better primary health care services

_____

_____

There is no significant relationship between Democratic Governance and promotion of basic education

S/N	Variables	Strongly Agreed	Agree	Undecided	Disagree	Strongly Disagreed
1.	Democratic government provides adequate primary schools.					
2.	There are adequate teachers in primary schools.					
3.	The teachers are competent					
4.	The class rooms are adequate and conducive for learning.					
5.	Furniture and instructional materials are adequate.					
6.	Democratic government provides adequate funds for basic education.					

There is no significant relationship between democratic governance and portable water supply in Katsina and Bindawa Local Governments.

S/N	Variables	Strongly Agreed	Agree	Undecided	Disagree	Strongly Disagreed
1.	Democratic government provides adequate sources of portable water.					
2.	The sources of water are functioning well.					
3.	People have access to portable water					
4.	Adequate funding to treatment plant					

APPENDIX ii

CHECK LIST OF INTERVIEW WITH THE OFFICIALS OF PHC, DHC, MHW AND CDAs

1. adequacy of health facility in the local governments
2. adequacy and the quality of staff in the health facility
3. adequacy and impact of essential drugs and laboratory in primary health care
4. maternal care services in the local government
5. funding of primary health care under democratic administration
6. performance of democratic government in promoting primary health care?
7. common problems of primary health care under democratic administration?
8. suggestion on how to improve the quality of primary health care

CHECK LIST OF INTERVIEW WITH THE EDUCATION SECRETARIES, PTA, SBMC, TEACHERS AND CDAs.

1. adequacy of schools in the local governments?
2. adequacy and quality of staff in the primary schools?
3. adequacy of classrooms
4. adequacy of teaching and learning aids in the schools?
5. funding of primary education under democratic administration?
6. performance of democratic government in promoting primary education?
7. common problems of primary education under democratic administration?
8. measures of improving primary education

CHECKLIST OF INTERVIEW WITH THE EXECUTIVE CHAIRMAN AND DIRECTORS OF KATSINA STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY (KSPHCDA)

1. funding structure/pattern and requirement of primary health care in katsina state?
2. most essential equipments needed for better primary health care?
3. The agency is to provide structure for comprehensive health care (CHC) while the ministry of local government and local government service commission are to provide man power. How suitable is this arrangement for better health care service delivery.
4. staff strength in the primary health care facilities in the state (CHC, PHC and Health post)?
5. provision for essential drugs in the state?
6. maternal care services in the state?
7. major problems of primary health care in katsina state?
8. suggestions on how to improve primary health care in the state

CHECKLIST OF INTERVIEW WITH THE MANAGEMENT OF KATSINA AND BINDAWA LOCAL GOVERNMENT

1. over concentration in provision and renovation of health facilities.
2. factor responsible for inadequate manpower in PHC sector
3. inadequate provisions of laboratories services/consumables and essential drugs

4. low level of awareness and low turnout in terms of using the health facilities.
5. supervision of health facilities/services
6. the funding of PHC
7. challenges of primary health care in your local government
8. suggestion for these challenges, please.

CHECKLIST OF INTERVIEW WITH OFFICIALS OF KATSINA STATE UNIVERSAL BASIC EDUCATION BOARD (SUBEB)

1. adequacy of primary schools in katsina state?
2. effectiveness of the funding patterns/requirement of Basic education in the state.
3. frequent renovation of schools in katsina state.
4. essential requirements of basic education in katsina state?
5. availability and performance of the above requirement in katsina state.
6. challenges of basic education in katsina state

7. suggestions on how to improve basic education in the state.

APPENDIX III

FOCUS GROUP INTERVIEW: LOCAL EDUCATION AUTHORITY KATSINA

S/N	NAME	POSITION
1.	Sule Hussain	class Teacher
	Hassan Umar	class Teacher
	Murja Abdu	class Teacher
	Abubakar Lawal	class Teacher
	Abubakar abba	class Teacher

S/N	NAME	POSITION
2.	Balarabe Nayaya	SBMC chairman, LGEA katsina
	Mukhtar Isah	NUT Chairman
	Abubakar A Alkasim(Sarkin Alhazan Katsina)	P.T.A Chairman
	Binta Hassan	CDA
	Sanusi Nayaya	Traditional ruler

S/N	NAME	POSTION
3.	Mannir Yahaya	Education Secretary
	Isah Katsina	PRS
	Abdullahi Saulawa	Quality assurance
	Abubakar abba	Academic Services
	Hassan B. Umar	Exams and Records

FOCUS GROUP INTERVIEW: **BINDAWA LOCAL EDUCATION AUTHORITY**

S/N	NAME	POSITION
4.	Nura Yusuf	Education Secretary
	Ahmad Ahmad D	Unit head Q.AQualification
	Babangida Muhd	Q.A officer
	Abdurrahman Salisu	M & E
	Shuaibu Haladu	Q.A officer
	Suleiman Sabo Ango	Head Master

S/N	NAME	POSITION
5.	Sada Umar	N.U.T chairman
	Lawal Saidu	PTA chairman
	Yusuf Ibrahim	C.D Ass chairman
	Muntari Lawal	P.T.A chairman
	Bala Hassan	SBMC chairman

	Aminu Liman	WDC chairman

S/N	NAME	POSITION
6.	Aminu Hassan	Class Teacher
	Haruna Usman	Class Teacher
	Mudassir Ahmad	class Teacher
	Muhd Sani S	Class teacher
	Karima A. Tukur	Class Teacher
	S. Zailani	Class Teacher

FOCUS GROUP INTERVIEW: KATSINA PRIMARY HEALTH CARE DEPARTMENT

S/N	NAME	POSITION
7.	Mohd H. Mohd	Surveillance officer
	Hassan Aliyu	M & E
	Bala Sani	Diseases cont unit head
	Aminu Kado	ILO
	A/mumini Tukur	U/H Health education
	Bala Sule	PHC coordinator
	Muhd a/aziz	Accountant

S/N	NAME	POSITION
8.	Cmrd Muntari Garba	chairman MHWUN
	Aminu Hassan	Chairman CDA
	Aminu A/mumin	Chairman DHC
	A. Bala Y sule	Traditiona Ruler
	Badamasi Lawal	Chairman Concern citizen group
	Abdu Iliyasu	W/Kudu – T

S/N	NAME	POSITION
9.	Sani Iliyasu	I/C PHC
	Sani Abdu	I/C PHC
	Aminu Kabir	I/C PHC
	Bilki Sani	I/C maternity
	Hannatu Isah	I/C maternity
	Hadiza Aliyu	I/C Laboratory
	Kabr Sule	I/C pharmacy
	Rabi Hassan	Valunter

S/N	NAME	POSITION
10.	Halima Sabo	Patient
	Amina Garba`	Patient

	Sani Kabiru	Patient
	Hajara Adamu	Patient
	Bilki Nasiru	Patient
	Haladu Gawo	Patient

S/N	NAME	POSITION
11.	Binta Ibrahim	Patient
	Sani Kabir	Patient
	Marya Hashimu	Patient
	Asiya Liman	Patient
	Hassan Garba	Patient
	Aisha Lawal	Patient
	Zainab Kabir	Patient
	Halima Sabo	Patient

FOCUS GROUP INTERVIEW: PHC DEPT BINDAWA LOCAL GOVT

S/N	NAME	POSITION
12.	Alh Abdurrahaman Namariya	PHC Coodinator
	Dikko Mamman	DCNO
	Bala Garba	Health Edu U/H
	Sani Dutsi	U/H M & E
	Haj Bilkisu M	U/H I.L.O
	Nana R. Mamman	U/H Disease Contrl

S/N	NAME	POSITION
13.	Yunusa Balarabe	I/C CHC BDW
	Sufiyanu Abubakar	I/C PHC Baure
	Dahiru Abubakar	I/C Dispensary
	Muhd Lawal	Pharmacist
	Murtala Almu	I/C PHC Doro
	Fatima Shehu	I/C Maternity
	Fatima Ibrahim	I/C Lab
	A/ganiyu Aliyu	Lab Tech

S/N	NAME	POSITION
14.	A/ganiyu Aliyu	Lab Tech
	Murtala Almu	Chairman MHWUN BDW
	Lawal I Sani	Chairman WDC
	Bishir Garba	Chairman CDA
	A. Tukur Master	Chairman DHC
	Abdu Liman	Chairman WASH
	Rabi Usman	PRO FOMWAN

S/N	NAME	POSITION
15	Hasiya Bello	Patient
	Sani Haladu	Patient
	Hauwa'u Ibrahim	Patient
	Baraatu Sule	Patient
	Barau Halle	Patient
	Ado Garba	Patient

S/N	NAME	POSITION
16.	Kabir Isah	Patient
	Nana Lawal	Patient (ANC)
	Hasula Rabe	Patient (ANC
	Saudatu Ali	Patient
	Binta Lado	Patient
	Hauwa Rabe	Patient
S/N	NAME	POSITION
17.	Sanusi Bishir	Director WATSAN
	Hamza Sani	U/H
	Binta Ibrahim	U/H
	Badamasi Mustapha	U/H
	Abbati U. Sanusi	Store Officer

KATSINA STATE PRIMARY HEALTHCARE DEVELOPMENT AGENCY

S/N	NAME	POSITION
18.	Dr Mu'awuya Aminu	Exec. Chairman
	Dr U.G Usman	Director Epist
	Dr Shamsu Yahaya	Director PHC
	Yau Kayawa	Z.T.O NPHCDA Katsina Branch
	Pharm. Bala Katsina	Director Pharmacy

FOCUS GROUP INTERVIEW: SUBEB OFFICIALS

S/N	NAME	POSITION
19.	Badaru Ado	A.D Quality assurance
	Aminu Mohd	A.D PRS
	Mansur Aliyu	Finance officer
	Bara'u Sule	A.D Academic Services
	Sanusi Nalado	Project Manager

FOCUS GROUP INTERVIEW: RUWASA OFFICIALS

S/N	NAME	POSITION
20.	Sani G. Usman	M and E
	Hamisu Sani	Admin Unit.
	Hamza Sulaiman	Finance officer

	Sagir Hassan	Field Operation
	Kabir Abdullahi	Planning

FOCUS GROUP INTERVIEW:MANAGEMENT OF KATSINA LOCAL GOVERNMENT

S/N	NAME	POSITION
21.	Sada Ammani	HLGA
	Mansur Dankano	Treasurer
	Sani Abubakar	Director ESSD
	Uba Hassan	Director WATSAN
	Lawal Isah	Director Pers.

FOCUS GROUP INTERVIEW: MANAGEMENT OF BINDAWA LOCAL GOVERNMENT

S/N	NAME	POSITION
22.	Yahaya Sani	HLGA
	Bilya Musa	DPM
	Zailani Isiyaku	Director ESSD
	Mohd D. Sulaiman	Treasurer
	Basiru Zango	Staff Officer

FOCUS GROUP INTERVIEW: WATER CONSUMERS ASSOCIATION BINDAWA

S/N	NAME	POSITION
23.	Lawal Hamza	Chairman
	Bishir Sama'ila	Secretary
	Saminu Musa	Treasurer
	Ibrahim Sale	Member
	Umar Mai unguwa	Member

FOCUS GROUP INTERVIEW: WATSAN DEPARTMENT BINDAWA

S/N	NAME	POSITION
24.	Khailani Mani	Director WATSAN
	Shafiu Kabir	Unit head
	Balarabe Musa	Unit head
	Shamsu Salmanu	Unit head
	Masa'udu Ilu	Store Officer

APPENDIX IV

YEAR	Rehabilitation and construction of classes, toilets storey buildings, office, store and electrification.	Furniture for pupils, teachers and visitors.	Games facilities ECCDE.	Generator bore holes and others.	Total
2010	1,132,179,891	51,125,000			1,183,304,891
2011	1,560,318,685	175,530,000			1,735,848,685
2012	1,601,179,216	144,409,000	9,762,940		1,735,848,685
2013	1,733,497,734	230,987,637	20,339,460		1,984,824,831
2014	1,544,192,915	230,507,456		145,781,583	1,920,481,954
2015	1,495,993,668	221,837,110		35,070,246	1,752,901,024
TOTAL	9067362109	1054396203	30,102,400	180,851,829	10,332,712,541

Cost of projects under SUBEB From 2010 to 2015

Source: SUBEB, 2016

APPENDIX V

Summary of projects cost and description from 2010 to 2015

Year	Description	Amount
2012	Construction of a block of 2 classrooms, office and toilet in 12 schools (ECCDE components).	71,492,731
	construction/extension of storey building on existing structures with electrification and external works in 4 schools	614,580,171
	Construction of blocks 2 classrooms office, store, toilet and rehabilitation of 73 schools.	473,297,731
	Construction of blocks of 3 classrooms in 59 schools and additional 33 schools	383,359,222
	Construction of block of 6 cubic toilets in 16 schools.	25,718,000
	Furniture for four school (2,436 pupils) and 189 for teachers.	16,825,041
	Furniture also for pupils and teachers in 14 schools (ECCDE).	45,570,000
	Provisions and installations of ECCDE games facilities in 12 schools.	4,038,000
	Construction of a block of 2 classrooms, office store and toilets in 9 schools.	9,762,940.68
	Construction of a block of 2 classrooms, office store and toilets in 9 schools.	41,624,320
2013	Storey building with electrification and external works in 5 schools.	600,916,322
	Furnitures for the schools.	60,972,000
	Blocks of 2 classrooms office and toilets in 29 schools (ECCDE).	155,343,189
	2 classrooms office and store in 77 schools and rehabilitations.	476,188,678.70
	3 classrooms in 84 schools	501,049,544
	Furnitures for 67 schools	52, 172,000
	Furniture for 76 jss	86,412,000

	ECCDE special furnitures for 25 schools	31,431,637
	ECCDE Games Village facilities and installation in 25 schools.	20,339,460
2014	Exrention of storey building with electrification in 3 schools.	342,900,923.64
	Furnitures for the 3 schools for pupils and teachers.	33,782,000
	2 classrooms office, store and 4 cubicle toilets in 32 schools.	177,600,000
	2 classrooms office, store and 4 cubicle toilets in 52 schools.	278,160,172
	Examination hall office, toilets, Generator, printer, and other accessories in 17 JSS.	92,713,727
	General rehabilitation 92 schools.	745,531,820
	Procurement of 4x4 full option shell specs and 4x2 full option frame single carbin in 8 schools.	38,067,856
	1 bore hole with an overhead tank(2500 litres) and tapping points in 10 primary schools.	5,000,000
	Teachers and pupils furniture and visitor chairs in 83 schools.	196,725,456
2015	Storey building with electrification and external works in 2 schools.	230,246,000
	Furniture for 2 schools.	23, 246,000
	2 classrooms office and VIP toilets with store in 28 primary schools.	164,000,000
	4 cubicle VIP toilets and some classes in 63 primary schools.	314,144,711.26
	1 block of three classrooms with electrification in 12 JSS.	74,800,000
	Furnitures in 90 schools (Teachers and pupils).	61,523,110
	Procurement of 4x4 full option shells specs for monitoring (SUBEB H.Q).	35,070,246
	General rehabilitation of schools structures in 104 primary schools.	712,238,239.9
	Furnitures for teachers and pupils in 101 primary schools.	137,068,000

APPENDIX VI

Table 5.25: Summary of Annual estimates of SUBEB Katsina state

2012				
Expenditure	FG	SG	LG	TOTAL
Capital	832,432,430	2,531,243,494	----	3,363,675,924
Recurrent	---	153,127,872	17,837,516,167	17,990,644,039
Total	832,432,430	2,684,371,366	17,837,516,167	21,354,319,963
2013				
Expenditure	FG	SG	LG	TOTAL
Capital	832,432,430	2,378,295,509	---	3,228,295,509
Recurrent	----	158,107,567	16,047,102,2851	16,205,210,418
Total	850,000,000	2,536,403,076	16,047,102,851	19,433,505,927
2014				
Expenditure	FG	SG	LG	TOTAL
Capital	1,030,000,000	2,711,125,061	---	3,741,125,061
Recurrent	---	160,191,994	17,651,813,137	17,812,005,131
Total	1,030,000,000	2,871,317,055	17,651,813,137	21,553,130,192
2015				
Expenditure	FG	SG	LG	TOTAL
Capital	500,000,000	2,261,534,245	---	2,761534,245
Recurrent	---	152,754,916	18,454,168,779	18,606,923,195
Total	500,000,000	2,414,289,161	18,454,168,279	21,368,457,440
2016				
Expenditure	FG	SG	LG	TOTAL
Capital	876,756,756	2,726,367713	---	3,603,124,465
Recurrent	---	153,941,533	19,376,876,693	19,530,818,226
Total	876,756,756	2,880,309,246	19,376,876,693	23,133,942,691

Source: SUBEB Annual estimates (2012 to 2016).

APPENDIX VII

Summary of Drugs and Consumables Supplied to LGAs through the State Primary Health Cre Development Agency							
Year	Free Medicare Scheme	Epid Control and Management	Child Health Week	Family Planning Commodities	Subsidy for DRF	Mobile Ambulance Services	Almajiri FMS
2,010.00	60,000,000.00	3,000,000.00	6,400,000.00	NA		18,000,000.00	4,200,000.00
2,011.00	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2,012.00	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2,013.00	60,000,000.00	8,200,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2,014.00	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2,015.00	60,000,000.00	3,000,000.00	6,400,000.00			18,000,000.00	4,200,000.00
2,016.00	30,000,000.00	3,000,000.00	6,400,000.00			NIL	NIL
TOTAL	**390,000,000.00**	**26,200,000.00**	**44,800,000.00**			**108,000,000.00**	**25,200,000.00**
GRAND TOTAL							**594,200,000.00**

APPENDIX VIII

1. Key indicators in Public Primary School

Table 1.Profile of Katsina LGAs based on Key School Indicators in Public Primary School for 2015/2016 ASC

LGA	Pop. Of 6-11 years	Enrolment in Primary Schools	Enrolment in Preprimary Schools	Number of Primary Schools	Number of Teachers in Primary Schools	Nb of Usable Classrooms Prepri & Prim	Pupils/Classrooms Ratio in Pre-Primary and Primary schools	% of Public Preprimary & Primary Schools with no Source of water	Pupil Toilet Ratio in Pre-Primary and Primary	% of Public Preprimary & Primary Schools with no Health facilities	% of Classrooms in Public Prepri & Prim Schools without good blackboard
BAKORI		71,403	5,184	86	843	508	151	29%	161	19%	36%
BATAGARAWA		41,358	1,389	66	603	422	101	62%	169	53%	16%
BATSARI		31,305	1,624	88	341	396	83	84%	132	51%	23%
BAURE		44,706	1,466	86	640	349	132	85%	321	71%	56%
BINDAWA		43,514	4,056	69	503	393	121	58%	177	20%	32%
CHARANCHI		22,851	1,746	57	441	324	76	60%	83	44%	23%
DAN MUSA		57,465	4,021	71	499	404	152	62%	206	61%	44%
DANDUME		23,384	1,205	56	340	312	79	73%	104	46%	39%
DANJA		33,011	2,057	59	372	354	99	59%	173	12%	39%
DAURA		73,396	4,857	48	548	426	184	50%	326	29%	35%
DUTSI		32,148	818	34	323	235	140	71%	178	38%	27%
DUTSIN-MA		44,284	1,392	75	831	561	81	67%	113	39%	18%
FASKARI		49,572	2,349	81	616	398	130	68%	190	35%	58%
FUNTUA		54,264	2,617	63	797	474	120	52%	261	16%	45%
INGAWA		42,296	1,993	72	511	415	107	67%	129	24%	38%
JIBIA		49,965	2,625	73	605	402	131	71%	212	37%	30%
KAFUR		53,471	1,600	81	1,229	458	120	73%	278	6%	63%
KAITA		26,945	1,195	60	506	348	81	65%	74	22%	28%
KANKARA		51,051	2,772	92	771	517	104	52%	123	4%	45%
KANKIA		45,319	1,266	66	566	420	111	71%	117	17%	30%
KATSINA		89,507	5,711	48	1,212	790	121	25%	228	10%	11%
KURFI		27,274	1,435	73	492	411	70	58%	71	42%	30%
KUSADA		42,353	1,892	37	275	291	152	54%	172	27%	23%
MAI'ADUA		48,439	1,032	66	561	325	152	59%	150	50%	27%
MALUMFASHI		57,727	3,911	78	605	432	143	76%	268	1%	45%
MANI		55,259	1,669	69	702	468	122	49%	208	30%	31%
MASHI		24,328	776	61	543	325	77	57%	106	43%	39%
MATAZU		32,939	1,430	59	424	324	106	68%	151	41%	45%
MUSAWA		44,051	1,091	71	534	434	104	80%	189	52%	58%
RIMI		32,664	2,034	60	513	373	93	90%	135	3%	29%
SABUWA		24,413	-	56	236	301	81	66%	103	-	68%
SAFANA		53,985	2,123	72	518	328	171	82%	268	40%	36%
SANDAMU		24,868	1,152	52	354	335	78	44%	82	58%	24%
ZANGO		27,740	1,414	46	581	369	79	70%	119	9%	56%
TOTAL		1,477,255	71,902	2,231	19,435	13,622	114	64%	161	31%	36%