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The Sub-National Politics of Setting Health Development Agenda: An Insight Into Yobe Health Development Plan

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Abstract
Democratic regimes have always been confronted with political, social and economic factors in making decisions in their health development policies. Despite its importance, the health development plans made at sub-national levels are often neglected in most political discourse. In Yobe state, North Eastern region of Nigeria where health indices are poor and financial resource inadequate, the relevance of the health policy agenda setting remains an important starting point. This study influenced by Kingdon's stream theory provides the health development agenda (HDA) of Governor Gaidam regime from 2009-2015 through the perceptions of health stakeholders in Yobe state. The qualitative study involved 28 interviews with informants and review of policy documents that underscores what, why and how the regime's HDA was developed. The study highlighted the power play through the regime's responsibilities, mandates, strategic objectives and priority agenda setting in achieving health development in the state. Furthermore, through the political lenses of agenda setting in the state, the emphasis was laid on the process, content and context of the regime's HDA. Although the HDA were home-driven, the motivations comes from local health problems related to health goals advocated by international development partners aimed to reduce IMR, UMR, MMR and other diseases all by 2015. Although the SSHDP provided 8 priority areas of key interventions in documents, in practice only 5 priority areas were prominent. Finally, the targets identified will serve as the justification to assess the regime's accountability since its intentions and goals could be judged from the extent of its performance.

Keywords: Health, Politics, Policy, Agenda Setting, Yobe State, Nigeria

1. Introduction

There has been a growing consensus among scholars that public health policymaking nationally and internationally should be more inclusive (Yang and Qian, 2016). This approach ensures proactive participation of all stakeholders and equitable access to health care for the target population considered to be evidence-based. While it may be achieved, one challenge that affects its success is the provision of a public good that requires large resource inputs that are most challenging for governments in low and middle-income countries (LMICs)

(Yang and Qian, 2016). The key contention is that in developing nations, available resources are scarce and that health situations are poor, hence the urgency for agenda setting. This revelation is not surprising as there are variations in health situations between developed and developing nations. For instance, across the globe, every year, almost 3 million newborn and 265000 mothers lost their lives due to childbirth complications with Sub Saharan Africa (SSA) accounting for more than half of such deaths (WHO, 2014). This means that although there has been progressing in addressing these health challenges across the globe, WHO (2014) and Liu et al. (2015) revealed that a large proportion of the current deaths of women and children occur in developing nations, especially in SSA region. This explains the reasons Under 5 children and pregnant women in developing nations are more likely to die when compared to those in the developed nations.

It was as a result of this increasing health challenge evident in many countries that in 2000, the United Nation (UN) member states initiated the 8 Millennium Development Goals (MDGs). In fact, the 3 health's related MDGs 4, 5 & 6 emphasised the need for improved health access, quality and coverage to reduce child mortality, improve maternal health and combat HV/AIDS, malaria and other diseases respectively (UN, 2001). In Nigeria, beyond this political declaration at the global level, the Federal Government of Nigeria (FGN) had equally adopted MDGs at the national level. In fact, Nigeria's National Strategic Health Development Plan (NSHDP) adopted from the Global Health Initiative (GHI) like the health-related MDGs have emphasised reduction of child mortality, improvement in maternal health and efforts to combat communicable and non-communicable diseases by 2015 (Oyibocha et al., 2014). Similarly, Nigeria's National Economic Empowerment and Development Strategy (NEEDS) had equally captured health development as one core pillar. Although previous and current national efforts to combat public health concerns in Nigeria through health policy developments have not yielded the desired outcomes in some parts of the country (Kayode et al., 2012; Oyibocha et al., 2014; Ataguba et al., 2016; Umar & Bawa, 2016), certain plans are much to be desired.

With regards to the disparity in health situations in Nigeria's six geopolitical zones, the North East showed the worst health indices over the years (MDG, 2015; NPC and ICF Macro, 2008; UNDP, 2015). More worrisome is that in the 6 states in North East region, the situation in Yobe state poses a more serious concern with the state having far worse than the national average for maternal and child health indicators (MDG, 2015; NPC and ICF Macro, 2008; UNDP, 2015). In the year 2007 alone, National Immunisation Coverage Survey (NICS) showed that the proportion of under1 children immunised against measles was only 22.9% in Yobe state which was below the national average of 85% (NPI, 2007). Only about 12% and 4% of women and men (15-49 years) respectively had a comprehensive knowledge of HIV-AIDS (NPC and ICF Macro, 2008). Also, only about 12% and 32% of women and men (15-49 years) respectively were literates (NPC and ICF Macro, 2008) with an overall 80% of its population living under the poverty line (NBS, 2010). By any standard, these socio-economic indicators in Yobe state are much higher than the national or regional average and thus considered unacceptable that must be addressed by any serious democratic regime.

In 2009, when Governor Gaidam was sworn in, he promised to initiate and implement priority health development goals towards addressing those health deficiencies in Yobe state. Addressing these health challenges, Ataguba et al. (2016:1213) argued that these issues are major challenges to health system strengthening that continue to retard socio-economic development. Importantly, since the return of democracy in 1999, health development remains on the concurrent legislative list of Nigeria's constitution. Hence, the search for solutions for a health problem in Nigeria calls for specific concern due to the diversity of the nation that must be investigated (Kayode et al., 2012). Again, despite having national policies, there is "an ongoing social catastrophe of poor performance in maternal health coupled with an unacceptably high number of maternal deaths in Nigeria" (Rai et al., 2012:407). This means that previous policies might have failed to produce the desired result due to prescriptive, generalised, and not area specific and evidence-based that took into consideration the local context of sub-nationalities. This point captured why NPC and ICF Macro (2008) showed that among the challenge to achieving the desired reduction in infant and maternal mortality is associated with population, declining resources and geographic variations in the political and health agenda at sub-national levels.

Of recent, Walter et al. (2008) made a case that there is less attention given to how do policy analysis, research design, theories or methods best inform what policy analysis. This advancement is particularly important as health policy analysis remains a multidisciplinary approach that aims to uncover interactions between institutions, interests and ideas in the policy process. Based on this Walter et al. (2008) advanced that it is useful both retrospectively and prospectively to understand past policy failures and successes to plan for future policy implementation which this study aims to achieve. In this study, we defined public policy as "the principles, guidelines or orientations adopted by a government body in guiding the affairs of people in a given polity" (Dlakwa, 2008:2). Public health policy in will therefore, remain an attempt by the government to address public health issues of concern through the adoption and implementation of desired goals and objectives which could include actions or inactions of a regime that affects relationships of institutions, organisations, service delivery, funding arrangements and the overall health system in a given society.

It is interesting to note that while policy frameworks are categorised in to four phases: agenda setting, formulation, implementation, and evaluation (Dlakwa, 2008; Sapru, 2008; Walter et al., 2008), policy agenda setting remains an important starting point where a number of societal problems are identified and given attention by policy makers. However, as policy makers and politicians are faced with numerous public health issues among other socio-economic challenges in Low and Middle-Income Countries (LMICs), how such decisions are made are often limited and challenging (Yang and Qian, 2016).To advance this key argument, we pose the question: what persuades policy makers to select certain public health priorities from competing for policy issues particularly in LMICs like Nigeria and Yobe state in particular? This is important as although there are various regional and national studies on HDA, the current literature simply ignored the roles of sub-national governments where in most cases such responsibilities lie with them (Seshadri et al.; Umar and Bawa, 2016). Similarly, McCollum et al. (2016) have argued that the while the global and national goals remain similar, the performance at sub-national national may depict different scenario with discrepancies that may bring about the potential for prioritisation in terms of goals in achieving health development in a particular place.

In addition, previous quantitative research does not provide better insights on what, why, when and how Yobe state is lagging behind in health development which might be attributed to the fact that health decision making is complex associated heterogeneous values and cultures of policy makers (Font et al., 2016). Hence, what remains largely unknown are the perceptions and experiences of end users, health care providers and health policy makers on the reasons behind the abysmal performance despite huge investments by the government. Also related, is that since health development is unevenly characterised by different patterns, magnitudes, and factors that influence the choice democratic regime make in achieving health development, it requires additional insights to explain such nature of performance. Overall, since the politics of setting HDA at sub-national levels are not much understood or analysed, this qualitative study thus provides the perception and experience of health informants and stakeholders in identified thematic areas.

2. Methodology

2.1 Study setting: the study was conducted in Yobe described as one of the states with the worst health indices in Nigeria (NPC and ICF Macro, 2008). The Governor Gaidam's regime from 2009-2015 served as the case in point. Located in North Eastern region of Nigeria, Yobe state was created on 27th August 1991. According to the 2006 national population census, the state has a population of 2,321,339 people made up of 52% male and 48% female (NBS, 2010). Projection indicates that Yobe's current population is about 3.5 million with children under 5 constituting about 20% (YBSG, 2010). Yobe state has 70% rural population with 12% and 32% literacy rate between female and male respectively. The state has 17 Local Government Areas (LGAs) with 178 political wards (YBSG, 2010). Islam is the predominant religion of the people. Kanuri, Fulani, Hausa, Bade, Ngizim, Kare-Kare, Bolewa and Ngamo are the major ethnic groups in Yobe state. Farming and commerce are the main occupations of the populace.

2.2 Yobe health situation: like in most states in Nigeria, Yobe operates a pluralistic health care delivery system with orthodox and traditional systems served by 528 health facilities (508 public and 20 private) fairly

distributed across the state (YBSG, 2010). As reported in the proceeding of Yobe economic summit, the major health problems afflicting the population of Yobe state were malaria, diarrhoea, respiratory tract infections such as tuberculosis and anaemia, malnutrition, hypertension and HIV/AIDS (Ngama et al., 2009). This poor health situation was further aggravated by the high number of infant, Under 5 and maternal mortality rates mostly associated with poor health service delivery (YBSG, 2010). Table 1 below provides key health indicators in Yobe state as at 2008.

Table 1: Key health indicators in Yobe State, Nigeria

S/N	INDICATOR	National Average	N. East	Yobe st.
1	Total fertility rate (TFR)	5.7%	7.2%	7.5%
2	Use of family planning modern methods by married women (15-49)	23.7%	3.5%	2%
3	Ante Natal Care (ANC) provided by a skilled health worker	58%	43%	36%
4	Skilled health attendant at birth	39%	15.5%	9%
5	Pregnant women delivery in a health facility	35%	12.8%	6%

Source: National Population Commission (2008) and ICF Macro, NDHS 2008 report

These key health challenges were aggravated by an inadequate supply of essential drugs and medical supplies, decaying infrastructure, an inadequate and inequitable mix of professional health workers leading to low morale, weak referral systems and poor coverage across the state (YBSG, 2010). In order to reverse this scenario, the state government organised its first ever State Economic Summit in 2008 which revealed that underlying this negative situation was the general lack of or poor management and weak institutional arrangement that led to the duplication of public health functions, service delivery, poor coordination and inadequate funding (Ngama et al., 2009). With these key public health concerns, Yobe state over the years is therefore not considered to be on the right track in achieving MDGs 4, 5, and 6 which continue to undermine its health development that must be addressed through policy matters.

2.3 Study design: the study utilised qualitative research approaches because agenda setting for health policy is influenced by social, economic and cultural factors (Font et al., 2016). Hence, the qualitative approach offered an in-depth view of informant and stakeholders in their real-life context (Yin, 2011). The qualitative approach is considered appropriate to assess the insights of stakeholders on the various aspects covered in the regime's response to health care development in Yobe state.

2.4 Selection of informants: members of relevant institutions and health stakeholders in Yobe state were included in the study. Purposive sampling was employed to choose 28 key informants from 6 categories of informants. The first categories were politicians (commissioners, legislators and gubernatorial candidates). Second category comprised of top government bureaucrats, executive secretaries and Directors. The third categories were health workers (medical doctors, nurses, midwives and health assistants). Fourth, the civil society involved representatives of health labour unions and observers. They included Nigeria Medical Association (NMA), National Association of Nigeria Nurses and Midwives (NANNM), Joint Health Sector Union (JHSU), and the National Union of Journalists (NUJ). Fifth, the representative of development partners included Maternal, Newborn, and Child Health (MNCH), United Nations Children's Education Fund (UNICEF) and Women 4 Health (W4H). Similarly, community leaders (traditional, religious and gender) were also involved. These stakeholders who have participated in health policy development in the state particularly under Gaidam's regime from 2009-2015 were therefore involved in the study as summarised in Table 2 below.

Table 2: Categories of Key Stakeholders

Category	Number of informants	Description of informants
Politicians	5	Ruling party & opposition members
Health administrators	6	Appointed & career
Health workers	6	Professionals & non-professionals
Health civil society	5	Professionals & non-professionals

Health development partners	3	Internationals
Community leaders	3	Traditional, Religious & Gender
Total	**28**	**Key Stakeholders**

2.5 Sources/methods of data collection: in-depth interview and review of health documents served as the main source of data for the study. The interviews were carried out in English (which is the official language of the state and the country) by the first author in Yobe state over a period of six months between May and September 2016. The interviews which lasted between 25-80 minutes were mostly conducted at the informant's offices or their convenient places. The semi-structured interview guides were used to understand what, how and why the regime's health priority agenda and targets were developed from 2009-2015 in the state. Specifically, the aspects covered in the interview were what were the regime's health development objectives? what prompted the initiation of the development objectives? were these development objectives in line with the citizen's needs and demands? and how relevant were the development objectives in the democratic process? In essence, areas related to how health agenda sets were prepared, the relationships between and among stakeholders and interest groups, how health problems were identified, formulated and agenda set, how the substance of such problems exerts influence on the agenda-setting were covered.

The interview sessions were audio-taped with a digital recorder and notes were also taken as back up and to record non-verbal expressions. The audio recording during the interview was to ensure the correct statements (verbatim) and the accuracy of the data generated (Merriam, 2014). The follow-up interviews were later followed by several emails and phone conversations for member checks. The information from the in-depth interview was triangulated with those obtained from document reviews. The documents reviewed include national and state health guidelines to give a broad view of the health system and agenda setting in Nigeria and Yobe state in particular as obtained in Table 3 below:

Table 3: Key Documents Reviewed

Author	**Year Available**	**Title of Document**
Federal Ministry of Health	2010	National Strategic Health Development Plan (NSHDP)
Yobe State Government	2010	State Strategic Health Development Plan (SSHDP)
Yobe State Government	2008	Yobe Socio-Economic Reform Agenda 2008-2011 (YOSERA II)
Yobe State Government	2011	Yobe Socio-Economic Reform Agenda 2011-2015 (YOSERA III)
Yobe State Government	2011	Policy Document for the Implementation of Programmes and Projects (2011-2015)
Governor Ibrahim Gaidam	2009-2015	Speeches of Governor Gaidam related to Health Sector 2009-2015

2.6 Data analysis: the thematic analysis approach to qualitative research was deployed. Hence, after careful and critical analysis of the raw data from the interviews, meanings were attributed to each statement, comment and description of informants. This is achieved by categorising the textual data into clusters of similar entities or conceptual categories. The categories in the transcript of the informants were collated either through the chronology of events, themes and or its interconnectivity. In addition, sub-themes that emerged within each category were analysed. Through this gradual process, the researcher had through such practical orientations of qualitative research learnt the rigours of inductive reasoning where data were manually sorted, categorised and clustered into abstracts and specific themes. While there are various computer-assisted qualitative data analysis software (CAQDAS) programmes such as ATLAS/ti, Nvivo, etc for qualitative studies, the analysis of data for this study was done and achieved manually. The advantage of the manual coding enabled the researcher being the research instrument to be immersed in the data.

To achieve a systematic credence, the study utilised the Kingdon's stream theory to frame the findings in a theoretical context. The theory advances that health policy is made through the convergence of three streams which includes problem, politics and policy. The Kingdon's framework as is mostly suitable for agenda setting

(Walter et al., 2008), that is a highly complex process which according to Fischer and Strandberg-Larsen (2016:357) requires "substantive evidence, support, timing and political will in order for an issue tobe recognised as 'important enough' to be on the agenda."

2.7 Ethical considerations: the study protocol was approved by the Ethics Committee of Universiti Putra Malaysia on 25th May 2016 with reference number UPM/TNCPI/RMC/1.4.18.2 (JKEUPM). Permission was also sought and granted from Yobe state government which provided access to top government officials and the release of important documents for the research. Prior to conducting the interview, the consent form was first presented to informants indicating the purpose of this study, assurance of their privacy and confidentiality, right to voluntary participation and or withdrawal.

3. Results and Discussions

Responsibilities, rights and mandates in health policy making in Yobe state

Informants interviewed revealed that the health system in Yobe state involves all groups and institutions responsible for health care services through regulation and financing health programmes right from national to household level. Their opinion was influenced by their knowledge on the objective of the nation's health policy to attain universal health access by 2015 (Oyibocha et al., 2014). It is on this view that informants advanced that the state government, therefore, functions through its mandated authorities. In essence, the State Ministry of Health (SMoH) through key engagements with the State House of Assembly (SHoA) and other stakeholders is responsible for the formulation and implementation of health policy in the state. It should, however, be noted that while the state government through various bodies remains the major player, various organisations have supported the state government on situational analysis, setting targets and milestone, choice of delivery strategies, and monitoring and evaluation of health policies and programs.

In discharging this responsibility, most informants, argued the constitutional duties and responsibilities of the state government with regards to the rights of citizens in the provision of health care services are considered paramount. This opinion was also captured in the state health care objective founded on the principles of justice, equality and freedom as captured in chapter 2 section 17d of the 1999 constitution of Nigeria. It requires that state government shall provide "adequate medical and health facilities for all persons." In addition, the constitution broadly provides that state shall:

> promote social welfare and security towards the citizens as one of its primary purposes; provide adequate social facilities, goods and services that will improve the general well-being of all citizens; provide adequate shelter, food, water, sanitation and health facilities to all citizens, including those with special needs.

This constitutional provision is not surprising as health is now considered and promoted at the centre stage of national and international development as a fundamental human right (Pieterse, 2016: UN, 2001). It is expected of any democratic regime to deliver. This, for instance, relates to the activities and advocacies by the WHO through the UN due to agreements and conventions that led to the introduction of the health-related Millennium Development Goals (MDGs) which were recently replaced by the Sustainable Development Goals (SDGs). These declarations include the Universal Declaration on human rights; international convention on rights of children; international covenant on civil and political rights; international covenant on economic, social and cultural rights; and convention rights of people living with disabilities, etc.

With these declarations similarly adopted at national and sub-national levels including in Yobe state, the informants argued it shows that international policy makers and stakeholders exert an important influence on how health care programme is designed, adopted and implemented just as advanced by Mukanu et al. (2017). These scholars further buttressed that this was the reason for the emergence of MDGs (Mukanu et al., 2017) which tasked the UN signatory nations to adopt and implement similar policies and programmes in their respective countries (McCollum et al., 2016; Mukanu et al, 2017).

Relating to this international framework, it means that the goals and declarations are expected to be domesticated as national and sub-national health policies. Relating to this context in Yobe state, a politician with work experience in the health sector explains.

> It is not surprising to find out that the health policies in Yobe state as in the case of most Nigerian states are lifted from the international health policies earlier provided by WHO and UN through the MDGs. They were the same policies and goals imported to Nigeria's national socio-economic development agenda such as NEEDS and NSHDP. In Yobe state, they are largely adopted although with slight changes to conform to our local and peculiar challenges in the health care service delivery.

Within the broader perspective, this indicates that since Nigeria is a UN member state, the influence of international health development goals like the GHI which prescribed how health funding, functioning and functionaries were to be achieved at the lower levels of government (Seshadri et al, 2016) is similarly felt in the country and in Yobe state. In fact, Nigeria's NSHDP adopted from the GHI like the health-related MDGs have emphasised reduction of child mortality, improvement in maternal health and efforts to combat communicable and non-communicable diseases by 2015 (Oyibocha et al., 2014). Overall, the goal for Nigeria's NSHDP emphasised efforts towards the attainment of universal health care access by 2015 through the involvement of all stakeholders in assuring high-quality health care service delivery that is considered accessible, affordable, sustainable, properly managed and controlled" (Oyibocha et al., 2014:29).

However, while at the national level, the federal governments have developed broad visions, missions, programmes, strategies and interventions towards reducing public health challenges (Oyibocha et al., 2014; Mukanu et al., 2017) the literature largely ignored the sub-national levels such as Yobe state. This means that the previous methodology applied in most cases neglected how, where and why certain health policies are developed (Mukanu et al., 2017) in specific communities. Based on the decentralisation argument, the provision of health care by the state government is generally seen as an element that underscores sub-national government effort towards achieving universal health coverage (Awosusiet al., 2015) through social justice and fairness which advocates affirmative action especially for the most vulnerable groups in the society.

In Yobe state, opinions indicated that the state government has made wide consultations with various stakeholders at community and district levels in order to enhance ownership, commitment and oversight functions. This approach took into consideration local contextual cultural, economic or political issues that are known to influence population health outcomes of health policies and programs in the state. Such an approach thus addresses what Bezruchka (2012) described as the disparity of the felt need and optimal demand for specific health services due to socio-cultural, economic, and health policy environment. This ultimately affects the health outcome among different population settings. Thus, to address the issues of coverage and equity to health care services to all citizens including in Yobe state, policy makers and implementers must therefore provide a policy framework that ensures equal access health promotion, specific protective measures, early diagnosis, treatment and rehabilitative services to all citizens (American College of Physicians, 2008).

While emphasising decentralisation in health development agenda McCollum et al. (2016) had earlier argued that although the overall global and national health agenda mostly remain similar, the sub-national national may depict different scenario with potential for prioritisation in terms of goals and targets. Importantly, in the current federal system in Nigeria, democratic regimes at the state government level are expected to improve their health systems by initiating its respective HDA in conformity with the nation's health development agenda based on their social, political and economic and cultural environments (Constitution of Nigeria, 1999). While mirroring sub-national context in Nigeria to indicate decentralisation efforts of HDA, the remark of Governor Gaidam is worth sharing in full:

> ... As we are all aware, infant and maternal mortality rates are extremely high in the Northeast sub-region. This issue has been a thing of serious concern to all well-meaning Nigerians and that everything humanly possible should be done to arrest the situation. It is in the realization of this that Yobe state government, perturbed by the situation, introduced various measures aimed at curtailing the situation through free medical care for pregnant mothers and children under the age of five. This is in conformity with MDG (Millennium Development Goals) set a target of reducing mortality rates among children under the age of five by two-third through the year 2015 and maternal mortality by three-quarter through 2015. **(**Address by H.E, Executive Governor of Yobe state, Alhaji Ibrahim Gaidam on the Occasion of the Summit of Yobe state Council on Health on 27th January 2010).

Although there have been efforts by previous democratic regimes in Yobe state to address health challenges over the years, this remark seems to show that since the inception of this regime in 2009, the health sector in Yobe state needed urgent attention. For most informants, since Yobe state government is the second tier of government, it is therefore constitutionally and politically mandated to plan and develop its overall health systems for the benefit of its citizens. Hence, this standpoint reflects the regime's political commitment and determination in Yobe's interest in gradually developing its health care system through mutual collaborations and partnership with other national levels and all stakeholders. This demonstrates that health care is contextually and culturally contingent activity that must be clearly understood beyond current international and national levels in order to address their unique and peculiar challenges.

Strategic health objectives and priority agenda setting

Although previous effort has been done to address health challenges in Yobe state, over the years, its health service delivery was not considered to be on the right track in achieving its MDGs 4, 5, and 6 thereby impeding its development and socio-economic growth. Hence, when this regime came into power, it was perturbed by the poor health situation in the state. To address the gap, the regime came up with its first ever health strategic development plan with the following vision and missions respectively:

> To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of the people of Yobe state (YBSG, 2010:9).

> To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the Yobe State Health System (YBSHS) to be able to deliver effectively, quality and affordable health (YBSG, 2010:9).

Beyond the policy document, most informants argued that the regime's overall aim was to provide affordable health care for all citizens with specific emphasis on welfare, prevention, improved access, and quality. To put it clearly, the regime's emphasis was to provide health care within the context of social welfare as 80% of citizens in the state are poor (NBS, 2010). Additionally, with 98% and 97% of women and men respectively without health insurance coverage in Nigeria including Yobe state (NPC & ICF Macro, 2008), most citizens as advanced by the informants in Yobe state cannot be able to afford health care without the government's intervention. Their opinion seems to portray the motivation that regimes in a democracy set up like Nigeria can only be maintained if it is responsive to the welfare of its citizens where health remains an important element of socio-economic development (Ojakorotu and Allen, 2009).

Furthermore, it has been reported that there is a mutual benefit between welfare to citizens and regime performance as it improves the sustenance of democracy in developing countries like Nigeria (Ojakorotu and Allen, 2009). In fact, in Yobe state, where there is a high level of poverty, unemployment and illiteracy (NPC & ICF Micro, 2008) coupled with growing number of widows and orphans due to Boko Haram terrorist activities,

such social welfare approach to health is considered paramount and important. The expectation of most informants is that the regime's welfare policy will salvage vulnerable children and women from losing health care for their current and future wellbeing. Although such social welfare programme may be costly for the regime to run as advanced by some few informants, it may, however, distinguishes it from previous democratic and non-democratic regimes in the state and or even in the nation at large.

With regards to health priority agenda setting, although the SSHDP (2010-2015) like Nigeria's NSHDP provides 8 priority areas, in practice only five agenda were considered reoccurring among informants. Firstly, in line with the regime's social welfare approach to health care, on 26th May 2009, it introduced its first-ever free maternal, newborn and child health (MNCH) and the victims of accidents. Since its introduction in 2009, the free MNCH policy has remained a health priority intervention of this regime with focus on achieving MDG goals numbers 4 and 5 expected to show greater pathway towards reducing maternal and neonatal deaths (Lunze et al., 2015; Ntambue et al., 2016: Yeji et al., 2015). Through this special intervention targeting 2015, the goals were to reduce infant mortality rates by 90%, child mortality rates by 90%, maternal mortality rates by 60%, under-nutrition among children by 30% and prevalence of communicable diseases (polio, malaria, Tuberculosis, etc) by 75% (YBSG, 2010:24-43; YOSERA III:69).

Secondly, the regime's intention was to improve financial allocation to the health sector towards meeting the "Abuja declaration." The declaration envisaged 15% budgetary allocation in the state's allocation to the health sector. Informants shared that since Yobe state has continued to be with poor health indices the regime's resolve to allocate more financial resources towards meeting the Abuja declaration was not only imminent but strategic. This seems plausible as achieving the funding requirement, improved allocation, and enhanced releases in the health sector will improve health outcome. Although improved public health expenditure is significant for overall health development in most developing societies including Nigeria, Arthur (2016) specifically cautioned that most budgets in developing societies are merely considered as paperwork designed and presented to satisfy status quo. In Yobe state like in other states in Nigeria, this challenge is added by the lack of a reliable source of revenue other than from the monthly federal allocations. Its general implication is that any drop in revenue base or poor allocation of financial resources to the health sector may, therefore, affect the financial performance of the state government in its health development agenda.

Thirdly, enhancing leadership and governance were identified as another priority health policy development agenda of the regime. Evidence has shown that poor health system occasioned by lack of defined roles; responsibilities and clear strategic direction have made healthcare functions and systems inefficient and ineffective over the years in Yobe state (YBSG, 2010). To address this challenge, the state Strategic Health Development Plan (SHDP) was for the first time initiated and approved in the state in 2010. Also, to reposition the involvement of key actors and institutions in making decisions at the local levels, the establishment of Primary Health Care Management Board (PHCMB) in 2010 was achieved aimed at providing clear mandate in the plan and implementation of basic health service delivery based on Ward Minimum Health Care Package (WMHCP). In fact, this new approach has been advocated by the GHI through NSHDP in Nigeria (Oyibocha et al, 2014). Similarly, Newman and Leep (2016) cited in Santinha (2016) have earlier advanced that local health officials contribute to establishing health care priorities, budget approval and supervising public health rules and regulations at local levels. Hence, even in Yobe state, the recent reforms indicate the willingness of the higher level of government to provide more powers to sub-national levels.

Another health policy development issue in the state related to leadership and governance is the declaration of "state of emergency" in the health sector by May 2013. It was reported that the decision to declare "state of emergency" in the health sector came into being after an official visit to various health facilities by Governor Gaidam who observed first-hand the facilities were generally performing sub-optimally (Ager et al., 2015). This declaration of "state of emergency" by the Gaidam's regime which was equally shared by most informants is therefore seen as a significant decision that sought to redefine and reshape the regime's current health development agenda over the years.

Fourthly, to develop human resource for health, the regime's aim was to achieve an equitable distribution, right mix and quality/quantity, gender sensitive and mid-level health workers that were needed in Yobe state (YBSG, 2010; YOSERA III). This was imminent because when the Gaidam's regime assumed power in 2009, records indicated that in Yobe state including all 17 LGAs, only 60 Medical Doctors and 40 Nurses and Midwives were available (YBSG, 2010). This means that with a total population of 2.3 million, each doctor and Nurse/Midwife is supposed to cater for 38,400 and 57,500 population respectively which invariably will affect the quality of service rendered due to high workload. Although health facilities continue to suffer shortages of health care workforce even in the United states of America (Yeager et al., 2016), in Nigeria, these challenges are eminent which Yobe state is not an exception. To address this challenge, the regime, therefore, targeted to recruit 40% of health manpower gap by 2015 (YBSG, 2010).

To make it work in practice, the first approach was lifting an existing employment embargo by this regime instilled by the immediate past governor in the state. However, the embargo lifting was seen as a short-term measure towards addressing the health manpower shortage as the medium and long-term plans were detailed in its SSHDP (YBSG, 2010). Also, recently, the regime with the help of stakeholders has in recent time developed and approved its first ever State Human Resource for Health Policy (HRFHP) in 2014. It contains updated plans and procedures on how to sponsor the state indigenes for medical and health courses both within and outside the country and how to make further amends towards strengthening the capacity of the state health training institutions (HTIs) to produce health personnel.

Fifthly, the regime planned to upgrade the state-owned health infrastructures and facilities and provide new ones in order to enhance access and expand the capacity of health facilities to cope with increased health care demands in Yobe state. This became necessary as when this regime came on board in 2009, the key health infrastructure and facilities were either overstretched or dilapidated and therefore not conducive for good health care service delivery. This priority agenda was not surprising as one major problem facing the healthcare system in Nigeria is the limited access to healthcare facilities by the people mostly occasioned by poor access and distribution of health facilities associated with growth in population, increase in poverty and inadequate resources (Nwakeze and Kandala, 2011; Ujoh and Kwaghsende, 2014). Hence, in Nigeria and by extension in Yobe state, health accessibility means creating the ease at which potential health seeker get access to health care facilities where good services are provided or delivered (Ujoh & Kwaghsende, 2014).

In Yobe state, in order to address this prevalence of non-functional health facilities, a target was set to rebuild health facilities by 50% by 2015 (YBSG, 2010; YOSERA III). To indicate its relevance in healthcare provision, Hota and Rout (2015) advanced that infrastructure remains an essential component for determining the nature of health output and its quality which governments must address. Cetorelli and Shabila (2014) also advanced that strengthening of health infrastructure increases overall access to health care services which in turn facilitates the legitimacy of the government.

Based on the preceding explanations, figure 1 below provides the strategic framework for improving health outcome through the proposed HDA in Yobe state.

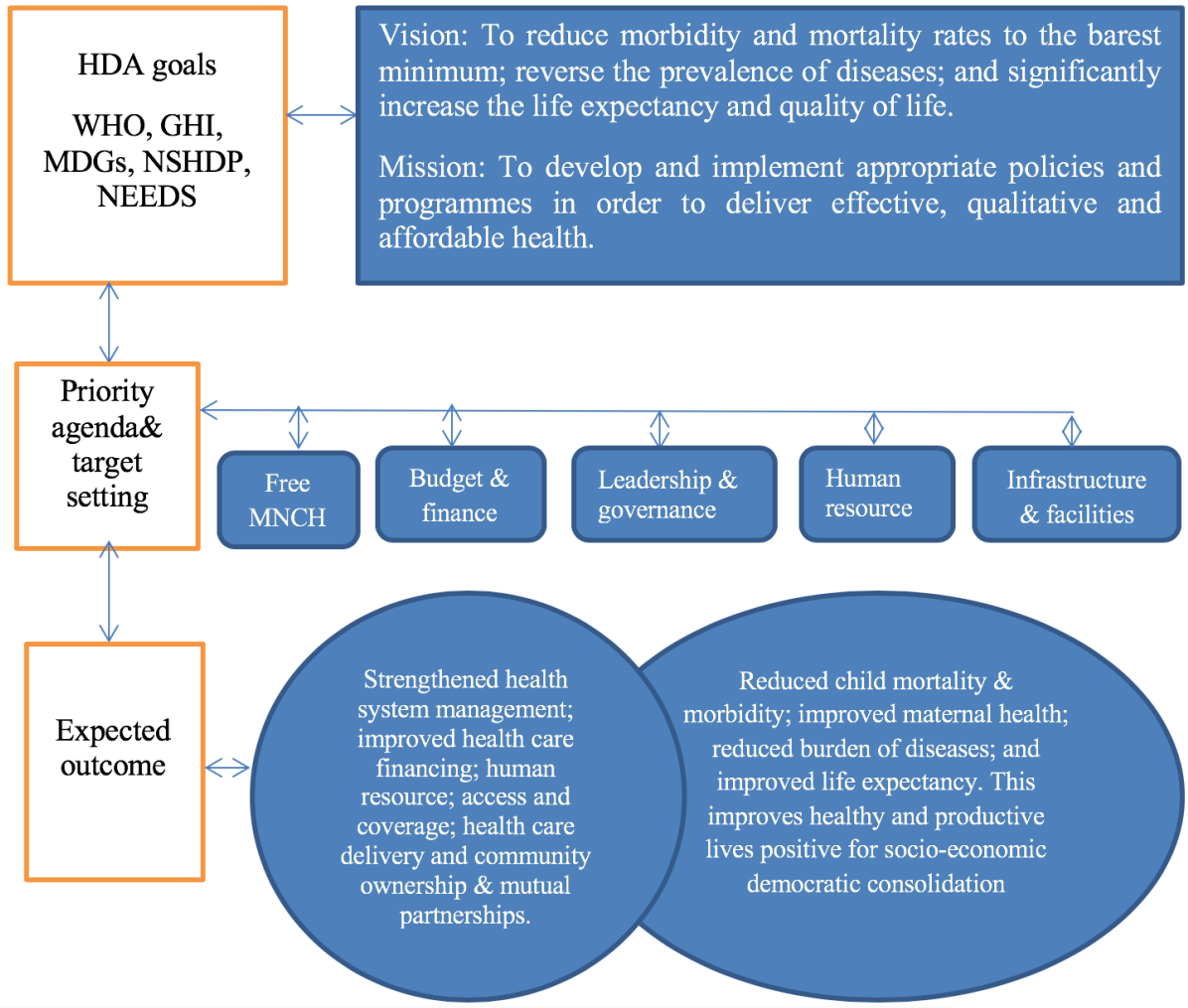

Figure 1: Strategic framework for improving health outcome through proposed HDA in Yobe state

While the regime's HDA was optimistic in content, there were criticisms shared by some informants. One such criticism is the unrealistic high target setting (90%, 75%) considered overambitious to be achieved within 6 years (2009-2015) just within the primary responsibilities of SMoH. For instance, such reduction of mortality (infant, childhood and maternal) by 90%, may possibly require strong policies, programs and funding to improve female literacy, women empowerment and autonomy, safe disposal of human waste and refuse; food security through zero tolerance to hunger and abject poverty. It will also require access to potable water (within 200 meters from each household) and vaccination coverage, good obstetric, prenatal and neonatal services (WHO, 1985). Similarly, there are concerns about the reliability of data used to set the health targets in Yobe state. Some informants argued that no research was conducted prior to setting these health targets and that the Heath Management Information System (HMIS) in the state was weak and therefore lacking the capacity to set the baseline data. One development partner like most others shares this concern.

> First of all, I do not believe any research was conducted to get the baseline of this target or even ask Yobe citizens what their real health problems are? To me, this will serve as citizen's input in setting the health development agenda and target. Secondly, while in Yobe state, we have a director of planning, research and statistics in the SMoH, there has been a lack of accurate and reliable data from the ministry. Data from different sources in the ministry contradicts itself; hence there is a need for an updated HMIS.

Further, a review proves this suspicion. There is for instance lack of clarity or consistency on some agenda and targets set by the regime. For example, the percentages captured in the health targets may be misunderstood as it was not clearly defined or explained. This may, therefore, pose challenges while making efforts to measure the regime's performance or impact on health development. Similarly, in terms of target setting, while YOSERA III, for instance, proposed certain percentages as its target, another major health policy document of this same regime (SSHDP) on the contrary, proposed yet another percentage. In fact, in most cases, inconsistencies were observed in the regime's most acclaimed health care policy document (SSHDP) if compared with specific health agenda as captured in other documents. Overall, based on the opinion of informants only five priority areas (free MNCH, budget and finance, leadership and governance, human resource and infrastructure and facilities) were emphasised therefore neglecting other key issues.

The power play of the key health stakeholders

Although the officials of the SMOH are the engine room for initiation and realisation of health objectives in Yobe state, under this regime the contributions of other health stakeholders while developing its HDA were considered. In fact, the emphasis was made on a mutual partnership with private sector, non-governmental organisations, communities and development partners and other political, social and economic sectors to meet the health needs on a sustainable basis in Yobe state. To advance this position, a director in the SMoH shared that "for the first time at least you find that, stakeholder are communicating and interacting freely through sharing of fruitful ideas." To add to this earlier point, a development partner similarly provided an example such collaboration in practice.

> The establishment of the Stakeholders Committee on Health (SCH) headed by the Honourable Commissioner for Health to deliberate on related health interventions at a higher level through meetings scheduled monthly (but not held regular due to security challenges) is quite encouraging to us.

In Yobe state, although, the regime's HDA was developed through collaborations with stakeholders, the emphasis was however made on the contribution of international development partners. The major contributors over the years included World Health Organisation (WHO), United Nation Children Fund (UNICEF), Department for International Development (DFID), Partnership for Reviving Routine Immunisation in Northern Nigeria (PRRINN), Maternal, Newborn and Child Health (MNCH), HIV//AIDS Programme Development Project (HPDP), and Women for Health (W4H) among others. This entails that several international development partners have somewhat dominated the agenda-setting of the HDA.

It should, however, be noted that while there appear to be indications of engagement of health stakeholders at higher levels in Yobe state in identifying and planning health care initiatives, some informants reveal lack of engagements of critical stakeholders especially at the lower levels. To validate this claim, one leader of the health union workers reveals a lack of engagement of operational members of staff in making key health policy decisions.

> In policy formulation, nobody is an island of knowledge. This means that all stakeholders in the health sector in Yobe state need to be carried along. At the moment, only higher-level officials and development partners are being engaged. In truth, the Governor has to equally create a way of getting information from people in the field and clinical sites as the information provided by top executives to the Governor are not enough (Health civil society member).

The lack of involvement of key stakeholders especially at the lower levels may lead to the absence of vital information that may be useful for a robust and well articulated HDA in Yobe state. In addition, the implementation may likely become a challenge since it is mostly the operational and clinical members of staff that do the real job on the ground. Beyond the indication of low engagement of local and operational stakeholders, this opinion seems to encourage principle of democratic participation that is now considered

relevant in promoting health ownership as community involvement in the development of health care policies is at the top of the agenda in many places (Font et al., 2016). In addition, the partnerships between health care providers and community-based organisations through data collection and assessment are associated with exceptional maternal and child health outcomes (Kleiman et al., 2016) that must be emphasised even in Yobe state. This means that the participation of stakeholders in policy formulation instead of working in isolation is expected to be promoted by democratic regimes such as under Gaidam's regime in Yobe state. Santinha (2016) had earlier advanced that, key health actors and institutions must work through mutual collaborations in order to strengthen cross-sectoral and symbiotic relations and engagements for better health service deliveries.

Overall, this new approach of the involvement of key stakeholders from every sector at every level must entail consultation, participation, and involvement through the mobilisation of various key actors so that objectives and goals of public health can be achieved (Santinha, 2016). To further buttress the contribution of stakeholders in developing public health care objectives in current democratic set up such as in Yobe state like elsewhere, Newman and Leep (2016) had advanced that, local health officials serve important roles in the public health care system as they contribute to the establishment of health care priorities, budget approval and supervising public health rules and regulations. It is therefore only proper and appropriate that even in Yobe state if these health partnerships are to be properly harnessed, it is expected to provide mutual collaborative efforts towards improving health systems that involve all for the benefit of all.

4. Conclusions

The purpose of this article was to provide the description and analysis of HDA of Gaidam's regime from 2009-2015 through the perceptions and experiences of health stakeholders. Evidenced from the opinion of stakeholders showed that, although the HDA were home-driven, the motivations majorly comes from local health problems mostly related to health goals significantly advocated by WHO, HDI, MDGs, and the nation's NSHDP. The informants advanced that the HDA overall aimed to reduce IMR, UMR, MMR, malnutrition, the prevalence of HIV/AIDS and other communicable diseases all by 2015 through salient policies and programmes that will provide affordable health care for all in the state. To achieve this key objective, it was revealed that the regime's priority agenda included plans to provide free MNCH; strengthen health leadership and governance; increase health sector budget and finance; recruit, develop and retain health workers; and upgrade existing and provide new health infrastructure and facilities. Hence, with emphasis to improve health access, quality and coverage, the expectation is that the regime's crafted HDA will affect its overall health outcome. Although the SSHDP like Nigeria's NSHDP provided 8 priority areas of key interventions in documents, in practice only 5 priority areas were prominent as revealed by the stakeholders. This indicates that the regime paid less emphasis on health partnership, health management information system, research for health and health ownership and community participation in its HDA despite their importance. Similarly, some of the targets and indicators set by the regime are ambiguous, flawed and inconsistent. Although these challenges are imminent, this study provides a baseline, through which health development goals in Yobe state and elsewhere could be further evaluated, measured and reformed. The targets identified in this study will also serve as the justification to assess the regime's accountability since its intentions and goals could be judged from the extent of its performance. The contribution of this study lies in the premise that previous studies in developing societies do not produce local health issues and priorities thereby exposing the information gap in health care policy and practice. Since, this study using the Kingdon's framework has mapped out the responsibilities, mandates, strategic objectives, priority agenda setting and the power play by a key stakeholder in this regime, future studies could assess these declarations against their performance in health outcomes.

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