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Impact of Nigeria's NCD Policy and Action Plan on Health Care Performance

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ABSTRACT

This study assessed the implementation of the National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases in Nigeria. A descriptive survey design was employed, and the population of this study consisted of employees of the Ministry of Health in the six states of the South-west geopolitical zones in Nigeria. The study used purposive sampling techniques to select 600 respondents. A structured questionnaire was used to collect data, and the data obtained were analysed with descriptive and inferential statistics. Findings revealed that social factors, individual behavioural habits, biological and genetic factors, environmental factors and health services are determinants of effective public health status in Nigeria. Not all relevant stakeholders were well captured and considered in the policy development, leading to the gap between the target and the outcome. Furthermore, the policy implementation has not been effective at the grassroots level (F=153.186, R=0.977; p=0.05). The study concluded that attaining the desired healthcare performance depends on health sector reforms geared towards reducing inequality in access to health services and ensuring that public health policy is a product of synergy between the government and all stakeholders.

Keywords: *Health; Disease; Policy; Development*

INTRODUCTION

The importance of health to the human race cannot be underestimated. It, therefore, requires all hands-on deck to ensure access to good health facilities and promote the health sector into a world-class category. In Nigeria, the Federal Ministry of Health is responsible for developing policies, strategies, guidelines, plans and programs that provide direction for the national healthcare delivery system (Bakare, 2021). In addition, the Federal Ministry of Health representing the Federal government is currently the major provider of tertiary healthcare services and various other health intervention programs aimed at promoting, protecting and preventing the ill health of Nigerians (Abubakar et al., 2022). The state and local government handle both the secondary and primary health care services since the health system is an item on the concurrent list (Ogundeji et al., 2023).

The Nigeria Health Sector Reform (HSR) is an ongoing and systematic process of implementing significant changes in policy, regulation, financing, provision of health services, reorganisation, management, and institutional structures. The government initiates and leads this process to enhance the health system's overall performance and citizens' overall wellness (Federal Ministry of Health, 2004).

The government noted that Non-Communicable Diseases (NCDs) are increasingly contributing to the national disease burden and a major public health problem in Nigeria. Among the chief NCDs in Nigeria are hypertension, diabetes mellitus, coronary heart disease, stroke, sickle cell disease, cancers, asthma, oral health diseases, mental health, alcohol, substance use disorders, road traffic injuries and violence. It was noted that the modifiable risk factors for NCDs include unhealthy diet, physical inactivity, use of tobacco and harmful use of alcohol. Other risk factors include climate change,

occupational exposure, advancing age and unhealthy reproductive or sexual behaviour. Thus, as part of the government's commitment to the fight against NCDs, and Nigeria being a signatory to the political declaration at the United Nations General Assembly High Level Meeting on NCDs in September 2011, the government came up with a National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases (NCDs) Control Programme Federal Ministry of Health in 2013.

Unfortunately, evidence shows that many Nigerians still need access to formal healthcare services. Of greater concern is the fact that health indicators have worsened over the years (Bakare, 2021). The health sector is equally plagued by a lack of effective leadership by the government, fragmented health service delivery, inadequate and insufficient financing and weak health infrastructure, maldistribution of the workforce and poor coordination of key players (Bakare, 2021). Experience with implementing policies in Nigeria is unpalatable and worrisome (Makinde & Popoola, 2022), and there is usually a high level of unresponsiveness of the policies to the desired target (Bakare, 2021). Thus, the full implementation and proper monitoring of the National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases requires empirical analysis to engender a desirable healthcare delivery and equity state.

In addition, few studies have been reported on the assessment of Nigeria's National Strategic Health Development Plan and the Health Sector Reform, its impacts on citizens' livelihoods, challenges faced during implementation, and the way forward. This study, therefore, attempted to bridge this gap by evaluating the implementation of the National Policy and Strategic Plan of Action on Prevention and Control (NCDs).

HEALTH

Oberteuffer (2010) asserted that within the more function-oriented perspectives, health has been defined either in terms of an adequate functional capacity which allows individuals to carry out their duties and responsibilities or in terms of a certain quality of life which enables individuals to live happily, successfully, fruitfully, and creatively (Hoyman, 2012). Parsons (2018) differentiated between physical and mental health functioning. Mental health level was defined as an individual's ability to carry out institutionalised social roles. In contrast, the evaluation of somatic health was based on the individual's effectiveness in accomplishing valued tasks.

Alternatively, Dubos (2015) stated that ecological approaches are more geared towards associating health with adaptation. Health has been conceptualised as individuals' capacity to adjust adequately to their environment. "The state of health and disease are expressions of the success and failure experienced by the organism in its effort to adapt to environmental changes". In a similar vein, Dunn (2009) extended the conception of health by introducing the notion of wellness as the integration of both people's capacity to function in their environment and their ability to adjust to environmental stresses.

The ecological views of health also present some difficulties. Individuals may adequately adapt, but, as Lewis (2013) mentioned, there are no clear distinctions between a healthy and an unhealthy adaptation. Individuals may adapt to a sick, morbid or disease-provoking condition. By the same token, individuals may indeed be sick, though able to carry out social responsibilities. Moreover, normality, proper functioning, and adaptation are socially and culturally constructed concepts. Consequently, as value judgement constructs, it becomes easy to conclude that what is considered healthy in one social context might not be in another (Parsons, 2018).

STRATEGIC HEALTH PLAN

The Oxford Dictionary defines strategy as planning and directing the whole operation of a campaign or war, plan, or policy. According to this definition, strategy is equivalent to plan and policy. Sometimes, the terms are synonyms, but there would be a slight difference between them. For instance, the World Health Organization's (WHO) definition of health policy is. A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures" (Scintee, 2015).

Strategic health planning represents an important step of the pre-planning phase for strategy development. It evaluates the profile of the population's health (it can be a "target" population) and the health care system regarding the internal and external environment. The assessment can be done based on available and reliable health indicators (Galan, 2015).

The main goal of this step is to identify priority health problems based on valid criteria. Another important goal is to provide data and information necessary to design goals and objectives for the strategy. Data and information collected during this step cover the following domains:

i). internal and external environment (review of economic, social and health objectives and policies) - SWOT analysis;
ii). health status and related determinants (mortality and morbidity rates, disability, burden of disease, life expectancy, lifestyle indicators, trends, etc.);
iii). health system (public/private institutions, accessibility for health care, population coverage with services, patient flow within the health care system, etc.) resources - human, material and financial (Kovacic & Jaksic, 2018).

If there is a functional and valid information system, health indicators constitute a fundamental tool that generates evidence of population health status and trends. Inequalities in health can also be evaluated, which may - in turn -serve as the basis for highlighting the population groups with the highest health needs and identification of critical areas. If existing, health indicators facilitate further monitoring and evaluation of health objectives and goals a strategy or program sets. A comprehensive review represents the main output of this step to inform the strategy, offering a comprehensive picture of the existing situation. Data obtained through the situation analysis also provide a benchmark against which to measure future trends (Galan, 2015).

The problem-identification and priority-setting process is based on existing health system indicators, special surveys, and consensus research. It is a process of comparisons and decision-making based on special methods and techniques for ranking the identified problems according to their importance. Limited resources require priority setting to address competing demands across the health system. To judge and prioritise the identified problems, three main criteria are commonly used:

i). *problem's dimension and severity* (incidence/prevalence, premature deaths, potential years of life lost, the burden of disease, trends, the size of the population at risk, the impact on medical services, family, society, etc.)

ii). *intervention capacity* (knowledge of the disease/associated risk factors, prevention possibilities);

iii). *existing resources for intervention* (existing services, qualified personnel, population accessibility to health services) (Micovic, 2008).

Strategy formulation is the process leading to the establishment of national health goals. It is crucial for a successful strategy that the goals are formulated through a democratic process involving continuous dialogue with the target population and the actors responsible for their implementation (Donev, 2015).

THEORETICAL FRAMEWORK

This study is hinged on Estonian political system theory. Easton's behavioural approach to politics proposed that a political system theory could be seen as a delimited (i.e. all political systems have precise boundaries) and fluid (changing) system of steps in decision-making. Greatly simplifying his model: Influence of computers on the discipline of political science and the political system work within an environment. The environment generates different demands from different sections of society, such as reservation systems in a certain group, demand for better transportation, etc.

Political system theory analyses interactions, structures, institutions, and processes in politics. Politics involves power, authority, physical coercion, and the allocation of values for society. Political system theory conceives public policy as the political system's response to demands from its environment. The political system consists of institutions that make the authoritative allocation of values binding on society as a whole.

EMPIRICAL REVIEW

Governments at all levels are expected to play a significant role in the general well-being of their citizens. Their role is not limited to providing jobs, securities, infrastructure, good education, basic amenities, and a sustainable economy; it also includes access to good health. Awofeso and Irabor (2020) reported assessing the government's response to Nigeria's socioeconomic impact of the COVID-19 pandemic. Results from the study find bearings between the COVID-19 pandemic and low socioeconomic livelihood in Nigeria.

The government introduced palliative measures to minimise the effect of the COVID-19 pandemic, which could be more effective owing to better coordination, human rights violations, and inadequate fiscal policy. Recommendations from the study draw on the need for the government to diversify the economy by promoting the informal and agricultural sectors, facilitating infrastructural development and improving health facilities to avoid the economic recession of the post-COVID-19 pandemic in Nigeria.

Boruchovitch and Mednick (2012) reported the meaning of health and illness and some considerations for health psychology. They stated that the importance of understanding individuals' ideas of health and illness is well acknowledged by research for its theoretical and practical implications for both health psychology and education. Insofar as researchers agree that individuals' ideas of health and illness impact their health attitudes and behaviour, people's thoughts of health and health and illness-related issues are increasingly being investigated. In consonance, the objective of this study is to critically review major ideas that underlie individuals' concepts of health and illness.

Anaemene (2016) studied the historical perspective of Nigeria's health sector reforms and sustainable development. He stated that the need to reform the health sector in Nigeria has been a major preoccupation of both colonial and post-colonial governments – a task undertaken to improve the health and well-being of its populations and ensure sustainable development. However, the country's poor health indicators and health status over the decades indicate that the desired results have not been achieved. This study undertakes a historical analysis of health sector reforms in Nigeria from the colonial era up to 2007. It further explores why Nigeria has failed to obtain optimal benefits from the reform programmes, such as inequality in access to health care, weak health systems, and corruption, among others. It concludes with recommendations on how Nigeria can fully maximise the benefits of health sector reform, which is key to sustainable development.

Shrikrushna *et al.* (2020) reported the review of corona virus (COVID-19). They stated that Coronaviruses are a group of enveloped viruses with nonsegmented, single-stranded, and positive-sense RNA genomes. Apart from infecting a variety of economically important vertebrates (such as pigs and chickens), six coronaviruses have been known to infect human hosts and cause respiratory diseases. Among them, severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome coronavirus (MERS-CoV) are zoonotic and highly pathogenic coronaviruses that have resulted in regional and global outbreaks Coronaviruses possess a distinctive morphology, the name being derived from the outer fringe, or – corona‖ of embedded envelope protein – members of the family *Coronaviridae* cause a broad spectrum of animal and human diseases.

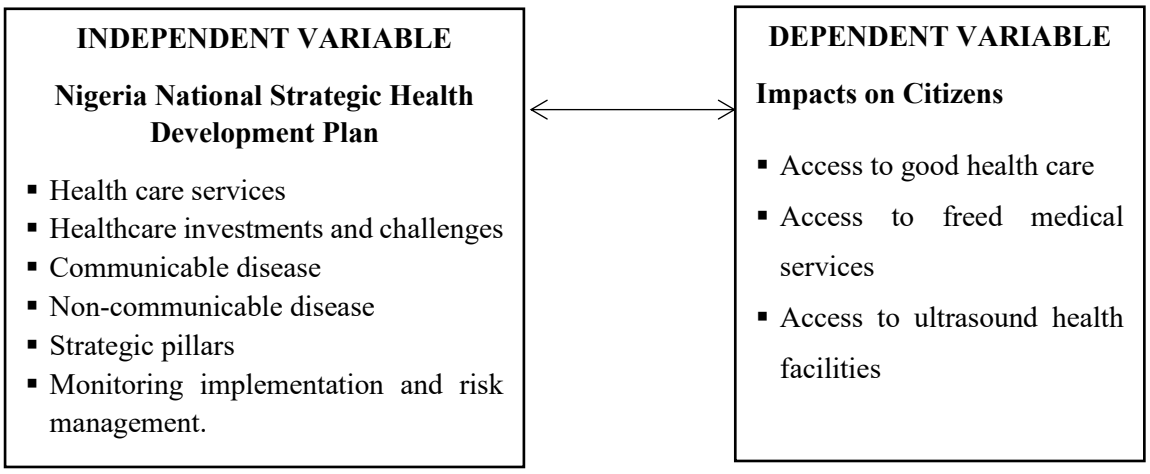
Uniquely, replication of the RNA genome proceeds through the generation of a nested set of viral mRNA molecules. Human coronavirus (HCoV) infection causes respiratory diseases with mild to severe outcomes. In the last 15 years, we have witnessed the emergence of two zoonotic, highly pathogenic HCoVs: severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome coronavirus (MERS-CoV). A diversity of host factors regulates the replication of HCoV and induces drastic alterations in cellular structure and physiology. In this review, all (as we are possible) information about Coronaviruses is given.

Saka *et al. (2012) reported a study on health*-related policy reform in Nigeria and the empirical analysis of health policies developed and implemented between 2001 and 2010 for improved sustainable health development. Multiple data collection was used to generate the findings. Only a maximum of 21 States in Nigeria has either started or are implementing various types of health reforms. National, State and Local Government Areas (LGAs) levels elite had dominated policy by controlling resources. The national policy network on health sector reform had been narrowly based on several institutions. We concluded that with continued and sustained institutional or structural policy reform in health, it is likely that existing organisational structures and management systems in the health sector will be able to deal adequately with the weak National healthcare delivery system. Therefore, it is recommended that health sector reform be concerned with defining priorities, refining policies, and reforming the institutions through which those policies are implemented.

CONCEPTUAL FRAMEWORK

Sustainable performance in the Nigerian health sector can be achieved through efforts to create, monitor, implement, and evaluate feasible health policies and strategic health development plans. The conceptual framework of these studies was a guide to how the variables are interrelated.

Figure 1: Conceptual framework showing the dependent and independent variable



Although studies have been reported on the historical perspective of health reforms in Nigeria, the impacts of the health reforms on sustainable health development have also been discussed. However, more studies have yet to be reported on the role of the National Strategic Health Development Plan in preventing communicable diseases and the challenges associated with implementing it. This study bridges such a gap in the literature.

METHOD

The study employed a descriptive survey design. This was adopted to understand respondents' attitudes, opinions, behaviours or characteristics concerning the research topic. The population of this study comprises three categories: healthcare practitioners, physicians and health officers of tertiary institutions in Southwest Nigeria; employees of Ministries of Health in the six states of the South-west geopolitical zones (Osun, Ogun, Oyo, Lagos, Ondo and Ekiti states); as well as Civil Society Organisations that major on health matters. The study used purposive sampling techniques to select two hundred and fifty (250) respondents from each of the three categories of respondents, totalling 750.

A structured questionnaire was used for the collection of data. It was divided into six sections, each highlighting each study objective except the first section, which gave information on the respondents' demographic details. The study variables include health system performance as the dependent variable and health policy implementation as the independent variable. The questionnaire was designed and administered to the selected respondents. It was retrieved back for further analysis. For proper analysis of the data gathered from the questionnaire, all responses were represented with a code in Microsoft Excel and analysed using descriptive frequency. The results were organised using descriptive techniques such as percentage and standard deviation and inferential statistics such as linear regression. with the use of Statistical Package for Social Science (SPSS). This research considered some ethical concerns such as anonymity (putting all respondents as anonymous), confidentiality (treating all responses with the utmost secrecy) and informing the organisation's authority. However, out of the 750 copies of questionnaires distributed, 600 were received, representing an 80% response rate, considered valid for making inferences.

FINDINGS

Sociodemographic characteristics of the respondents

Table 1 above presents the socio-demographic representation of the respondents. As contained in the table, the gender of respondents revealed that 58.3% of the respondents are female while 41.7% are male. This indicates that the majority of the participants in this study are females. The respondents who participated in this study are between the ages of 41-50years with a percentage value of 41.7%. This indicates that most participants are mature staff. The result of the marital status of the respondents indicated that most participants are married, with the highest percentage value of 63.3%. most of them have at least a Bachelor's degree, with a percentage of 46.7%. The result of respondents' years in service indicated that most respondents had spent between 11 and 15 years in service, with a percentage value of 33.3%. the results show that the respondents are all in a vantage position to understand and provide relevant information for the realisation of this study.

Assessing Healthcare Performance in the Country

This section assessed health care performance in the country, and the results are in Table 2. Under health outcome, the reduction of the level of risk was assessed. It was revealed that the country's

healthcare system reduces risk. This is confirmed by the mean value of 2.5, equal to the threshold value of 2.5. thus, we accept the assertion. The reduction of the level of disease or impairment (adverse events or treatment complications) was assessed. Findings revealed no reduction in disease or impairment (adverse events or treatment complications. This is confirmed by the mean value of 2.3, less than the threshold value.

The improvement in the quality of life of users and carriers was assessed, and it was revealed that the quality of life of users and carriers has remained the same. This is confirmed by the mean value of 2.2, less than the threshold value. The reduction in premature deaths (infants' deaths, survival rates of cancer patients, avoidable deaths, hospital premature deaths) was considered. Results revealed that there is a reduction in the rate of premature death. This is confirmed by the mean value of 2.7, greater than the threshold.

Under the access stage, we considered whether people have wide and free access to health facilities. Findings revealed that people have wide and free access to health facilities. This is confirmed by the mean value of 2.7, which is greater than the threshold value. Hence, we accept the assertion.

Under the coverage stage, we considered whether there is an available health facility that meets the people's needs and aspirations. It was revealed that there is a facility that meets these needs and aspirations. The mean value of 3.2, greater than the threshold, confirms this. Hence, we accept the assertion.

Under the equity stage, we considered whether there is a basic minimum of care regardless of people's ability to pay. The results revealed that there is no basic minimum of care regardless of people's ability to pay. This is confirmed by the mean value of 1.8, which is less than the threshold value.

Under the efficiency stage, we considered whether the government provides overall direction and timely intervention to the health system through clear legislation, policies and regulations. Results revealed that the government provides overall direction and timely intervention to the health system through clear legislation, policies and regulations. This is confirmed by the mean value of 2.8, greater than the threshold value.

Under quality, we considered whether procedures exist for reporting, investigating, and adjudicating misallocation or misuse of resources. The result revealed that no procedures exist. This is confirmed by the mean value of 2.2, which is less than the threshold value.

Under the safety stage, we considered health sector regulation codes. It was revealed that health sector regulations and codes need to be known and enforced in training institutions and health facilities. This is confirmed by the mean value of 2.0, less than the threshold value. Thus, we reject the assertion. Under the sustainability stage, we considered whether health services are designed to benefit the present without jeopardising the future. It was revealed that Health services are not designed to benefit the present without jeopardising the future. This is confirmed by the mean value of 2.2, which is less than the threshold value.

Table 2: Perceptions of the respondents on the healthcare performance of the country

S/N	Items	Mean	Std. Deviation	Std. Error Mean	Status
1.	Reducing the level of risk (disease)	2.5000	1.21432	.15677	Accepted
2.	Reducing the level of disease or impairment (adverse events or treatment complication	2.3167	1.15702	.14937	Rejected

3.	Improving the quality of life of users and carriers	2.2667	.91812	.11853	Rejected
4	Reducing premature deaths (infants' deaths, survival rates of cancer patient, avoidable deaths, hospital premature deaths	2.7167	1.05913	.13673	Accepted
5	There is wide and free accessibility of health facility by the people	2.7667	.96316	.12434	Accepted
6	The available health facility covers the needs and aspiration of the yearnings of the people	3.2833	1.04300	.13465	Accepted
7	There is basic minimum of care regardless of ability of the people to pay	1.8333	.99433	.12837	Rejected
8	The government provides overall direction and timely intervention to the health system through clear legislation, policies and regulations	2.8833	1.00998	.13039	Accepted
9	Procedures exist for reporting, investigating and adjudicating misallocation or misuse of resources	2.2167	1.12131	.14476	Rejected
10	Health sector regulations are known and enforced in training institutions and health facilities	2.0833	1.12433	.14515	Rejected
11	Health services are designed to benefit the present without jeopardising the future	2.2833	1.09066	.14080	Rejected

Source: Field Survey, 2024

Implementation of the National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases

This section evaluated the implementation of the National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases. The specific determinants considered are awareness creation, social mobilisation, and roles. The respondents' views on the effectiveness of this policy and strategic actions are contained in Table 3.

Table 3: Evaluating the implementation of the National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases

Items	Mean	Std. Deviation	Std. Error Mean	Status
Ensure the availability of screening facilities for early detection of certain cancers in specialised centres. Mammography/USS for breast cancer, pap smear for cancer of the cervix, PSA for cancer of the prostate, check for evidence to include PSA for prostate cancer, colonoscopy for colonic cancers and velscope for mouth cancers	3.8333	1.16687	.15064	Accepted
Ensure the establishment of appropriate units for the management and training of health professionals in alcohol and drug addiction as well as tobacco cessation.	2.5167	1.09686	.14160	Accepted

Establish sustainable research framework to facilitate basic and translational research in NCDs prevention and control	2.5000	1.15714	.14939	Accepted
Establish an effective and efficient monitoring and evaluation mechanism for NCDs programme	2.6000	1.39247	.17977	Accepted
Ensure the availability of facilities for newborn screening for detection of haemoglobinopathies e.g. sickle cell hemoglobin and enrolment into comprehensive care for affected individuals	3.0167	1.24181	.16032	Accepted
Provision of adequate budgetary allocation for the control of NCDs through increased support (financial/technical) by the FMOH	2.7000	1.19745	.15459	Accepted
Establishment of a mechanism to reduce risk factors for NCDs arising from among others tobacco use and exposure to tobacco smoke, unhealthy diets, harmful use of alcohol, physical inactivity and other modifiable risk factors	3.1333	1.21386	.15671	Accepted
Establish a mechanism to reduce risk factors for NCDs arising from among others tobacco use and exposure to tobacco smoke, unhealthy diets, harmful use of alcohol, physical inactivity and other modifiable risk factors	2.3000	1.07829	.13921	Rejected
Sensitising the general public on NCDs control through knowledge of risk factors and risk reduction	1.9167	.99646	.12864	Rejected
Creating awareness among health workers on the proper treatment of NCDs and their complications	1.9833	1.12734	.14554	Rejected
Active involvement of the media and all other stakeholders (trade and commerce, Industry, Youths and Sports, Women Affairs, National Orientation Agency and Justice) in all advocacy and social mobilisation issues elaborated in this policy	2.3667	1.16396	.15027	Rejected
Capacity building workshops on risk factor reduction, smoking cessation/WHO FCTC, control of harmful use of alcohol, diet and physical exercise/activity shall be conducted for states and LGA health workers from time to time.	2.2833	1.05913	.13673	Rejected
Training of health workers in the areas of palliative care of the terminally ill and the care of the elderly.	1.8333	.94181	.12159	Rejected
Ensure access to essential medicines, basic technologies, consumables and services for the prevention and control of NCDs at state and local government levels	2.1333	1.04908	.13544	Rejected
Ensure effective linkages and referrals between Primary Health Care and higher levels of care.	2.9833	1.08130	.13960	Accepted

Source: Field Survey, 2024

Under awareness creation, the availability of screening facilities for early detection of certain cancers in specialised centres was considered. It was revealed that screening facilities in specialised centres are available for early detection of certain cancers. This is confirmed by the mean value of 3.8, greater than the threshold value of 2.5. hence, we accept the assertion. The establishment of appropriate units for the management and training of health professionals in alcohol and drug addiction, as well as tobacco cessation, was considered. It was revealed that the establishment of appropriate units for the management and training of health professionals in alcohol and drug addiction, as well as tobacco cessation, is ensured. This is confirmed by the mean value of 2.5, equal to the threshold value. Thus, we accept the assertion.

Establishing a sustainable research framework to facilitate basic and translational research in NCD prevention and control was considered. It was revealed that a sustainable research framework to facilitate basic and translational research in NCD prevention and control was established. This is confirmed with the mean value of 2.5, which is equal to the threshold value. Thus, we accept the assertion. Establishing effective and efficient monitoring and evaluation mechanisms for NCD

programmes was considered. Results revealed that an effective and efficient monitoring and evaluation mechanism for the NCD programme has been established. This is confirmed by the mean value of 2.6, greater than the threshold value. Hence, we accept the assertion. The availability of facilities for newborn screening for detecting haemoglobinopathies was considered. Results revealed the availability of facilities for newborn screening to detect haemoglobinopathies and enrolment into comprehensive care for affected individuals. This is confirmed by the mean value of 3.0, which is greater than the threshold value. Thus, we accept the assertion.

We considered whether the FMOH provides adequate budgetary allocation to control NCDs. The result revealed that the FMOH provides adequate budgetary allocation through increased support (financial/technical). This is confirmed by the mean value of 2.7, which is greater than the threshold value. Thus, we accept the assertion.

Under social mobilisation, the establishment of a mechanism to reduce risk factors for NCDs was assessed. The result revealed that a mechanism has been established to reduce risk factors for NCDs arising from, among other things, tobacco use and exposure to tobacco smoke, unhealthy diets, harmful /use of alcohol, physical inactivity, and other modifiable risk factors. This is confirmed by the mean value of 3.1, greater than the threshold. We, therefore, accept the assertion.

The sensitisation of the general public on NCD control through knowledge of risk factors and risk reduction was assessed. Results revealed that sensitisation of the general public on NCD control through knowledge of risk factors and risk reduction needs to be carried out. This is confirmed by the mean value of 1.9, which is less than the threshold value. Thus, we reject the assertion.

The creation of awareness among health workers on the proper treatment of NCDs and their complications was assessed. Results revealed that health workers need more awareness of properly treating NCDs and their complications. This is confirmed by the mean value of 1.9, which is less than the threshold value. Thus, we reject the assertion.

The active involvement of the media and all other stakeholders in all advocacy and social mobilisation issues elaborated in this policy was assessed. The result indicated no Active involvement of the media and all other stakeholders (trade and commerce, Industry, Youths and Sports, Women's Affairs, National Orientation Agency, and Justice) in all advocacy and social mobilisation issues elaborated in this policy. This is confirmed by the mean value of 2.3, which is less than the threshold value. Thus, we reject the assertion.

Under the reduction of risk factors, the capacity-building workshops on risk factor reduction, smoking cessation/WHO FCTC, control of harmful alcohol use, diet, and physical exercise/activity were assessed. Results revealed that there are no capacity-building workshops on risk factor reduction, smoking cessation/WHO FCTC, control of harmful alcohol use, diet, and physical exercise/activity. This is confirmed by the mean value of 2.2, which is less than the threshold value. Thus, we reject the assertion.

The Training of health workers in palliative care of the terminally ill and the care of the elderly was assessed. The results revealed that training in these areas needed to be ensured. This is confirmed by the mean value of 1.8, which is less than the threshold value. Thus, we reject the assertion.

Under the roles, we access the availability of essential medicines, basic technologies, consumables and services for the prevention and control of NCDs at state and local government levels. Results revealed that essential medicines, basic technologies, consumables, and services must be ensured to prevent and control NCDs at state and local government levels. This is confirmed with the mean value of 2.1, which is less than the threshold value. Thus, we reject the assertion.

The effective linkages and referrals between Primary Health Care and higher levels of care were assessed. It was revealed that effective linkages and referrals between Primary Health Care and higher levels of care are ensured. This is confirmed by the mean value of 2.9, greater than the threshold value. Thus, we accept the assertion.

Inferential Analysis

Tables 4 and 5 show the relationship between NCD implementation and healthcare performance in Nigeria, determined using simple regression and correlational analysis.

Table 4: Effect of NCDs implementation on health care performance in Nigeria

Model Summary				
Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.977[a]	.954	.948	.27818

ANOVA[a]						
Model		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
1	Regression	82.976	7	11.854	153.186	.000[b]
	Residual	4.024	52	.077		
	Total	87.000	59			

The model summary table reports the strength of the relationship between the model and the dependent variable. A study result is said to be statistically significant if the p-value of the data analysis is less than the prespecified alpha (significance level). That is, a p-value greater than 0.05 means no effect was observed.

Therefore, from the above table, the result of the regression analysis revealed no significant outcome (F=153.186, R=0.977 > p=0.05). This, therefore, implies NCD implementation has no significant effect on healthcare performance in Nigeria. The result also revealed that the predictor variable accounted for 95% (R^2 =0.954) of the variance in healthcare performance. Hence, we reject the alternative hypnosis and accept the null hypothesis, which states that it is concluded that NCD implementation has no significant effect on healthcare performance in Nigeria.

Table 5: Correlational Analysis of the relationship between NCDs implementation and health care performance in Nigeria

Correlations			
		Healthcare performance	NCDs policy
Healthcare performance	Pearson Correlation	1	.897**

	Sig. (2-tailed)		.000
	N	60	60
NCDs policy	Pearson Correlation	.897**	1
	Sig. (2-tailed)	.000	
	N	60	60
**. Correlation is significant at the 0.01 level (2-tailed).			

The Pearson Product Moment Correlation Coefficient above shows the relationship between the country's healthcare performance and the implementation of the NCD policy. The result revealed a strong relationship between the variables, with a correlation coefficient of 0.897 > 0.05, statistically significant at p=0.01. It is therefore concluded that there is a significant relationship between healthcare performance and the implementation of NCD policy.

DISCUSSION

This study's findings have revealed that social factors, individual behavioural habits, biological and genetic factors, environmental factors, health services and habits are determinants of effective public health status in Nigeria. It is disheartening to state that these basic factors are lacking in society and, by this means, have contributed to the deterioration of the health system in the country.

Rashkis (2015) opined that there is a lack of appropriate targeting strategies for reaching poor and under-served populations, large disparities in health status between the poor and non-poor, inadequate quality of government health services, which stems from lack of drugs, limited human resources and managerial capabilities; lack of an enabling environment to allow private sector providers to build partnerships with the public sector; low levels of public funding combined with shortcomings in the way resources are allocated, spent and managed; and poor delineation of roles and responsibilities within the three tiers of government concerning the provision and financing of health care are the factors contributing to the poor health status in Nigeria.

Results revealed that the input stage of state and stakeholder's involvement in the NPSD is taken with cognisance; the processing stage of the NPSD is not being monitored properly, while the outcome stage of the Health Policy is very poor. It is true that when a system is introduced at the initial stage, it can collapse before the final stage if not monitored properly, as no effective policies could stand without proper monitoring and implementation. Thus, as stated by Doney (2015), strategy formulation is essential for establishing and implementing national health goals. It is also crucial that for a successful strategy to be achieved, the goals are formulated through a democratic process involving a continuous dialogue with the target population and the actors responsible for its implementation.

Findings further indicated that the health care performance of Nigeria is extremely low and poor, as the people's basic needs still need to be achieved. It should be noted that poor health care delivery in a country predominantly increases the tendencies of an increase in poverty and mortality rate. This is attributed to the fact that citizens cannot have access to free, quality, sustainable health services. This agrees with Hoyman (2012), who stated that high infant and child mortality and morbidity rates, poor nutritional status, and high fertility rates are the indicators of the adverse effects of poor sanitation, low incomes and other determinants of pervasive poverty in Nigeria.

Stanley (2019) further stated that the major causes of mortality and morbidity among children under five in Nigeria are intake of dirty water and malnutrition, which by extension causes diarrhoea, respiratory infections, malnutrition, vaccine-preventable diseases, and malaria due to lack of good and basic amenities especially clean water and good nutrition.

Findings also revealed that implementing the National Policy and Strategic Plan of Acton on Prevention and Control of Non-Communicable Diseases has not been effective at the grassroots level. However, according to FMOH (2016), part of the Health policy's objective was to collaborate with the lowest level of government, which is the Local Government Area, since it is closer to the people. However, efforts have not been intensified to implement health policies down to the grassroots level due to corruption and the employment of incapable hands to oversee these affairs.

Implementation of the Health Policy in Nigeria should, therefore, be taken seriously and monitored properly to achieve its objectives and goals as stated in the National Health Policy (2016): *"To provide stakeholders in health with a comprehensive framework for harnessing all resources for health development towards the achievement of UHC, as encapsulated in the National Health Act, and in tandem with the SDGs".* while the goal is: "*To strengthen Nigeria's health system, particularly the Primary Health Care subsystem, to deliver quality, effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians".*

Finally, the findings of the hypothesis revealed that policy implementation has no significant effect on healthcare performance in Nigeria. This is obvious in the sense that implementing a Non-Communicable Disease policy may not affect the country's healthcare system since those in charge need to discharge their duties appropriately. Hence, implementing the NCDs policy may not significantly contribute to eradicating the poor healthcare system in Nigeria.

CONCLUSION

This study has analysed issues relating to implementing the National Policy and Strategic Plan of Acton on Prevention and Control of Non-Communicable Diseases and its outcomes. Specifically, the study examined determinants of public health status in Nigeria, evaluated the extent of stakeholders' involvement in the development of the National policy and strategic design for disease prevention and control in Nigeria, and evaluated the implementation of the National Policy and Strategic Plan of Action on Prevention and Control of Non-Communicable Diseases (NCDs).

The study revealed that social factors, individual behavioural habits, biological and genetic factors, environmental factors, health services and individual habits are determinants of effective public health status in Nigeria. The input stage of state and stakeholder's involvement in the NCDs is taken with cognisance; the processing stage of the NPSD is not being monitored properly, while the outcome stage of the Health Policy is very poor. Nigeria's health care performance is extremely poor, as people's basic needs are unmet. Implementing the National Policy and Strategic Plan of Acton on Prevention and Control of Non-Communicable Diseases has not been effective at the grassroots level.

The study has demonstrated that the Nigerian government has persistently instituted health sector reforms to improve the country's parlous health care delivery system. However, the health sector needed help to produce the desired results. This was due largely to inequality in access to health care, weak health systems, corruption, poor environmental factors, and poor implementation of policies, among others. As a corollary, Nigeria still needs to maximise the opportunities these reforms provided fully. There is a need for creative solutions to deal with urgent and intractable problems arising from the rights and wrongs of health policy strategies. All stakeholders should properly engage in designing and

implementing the National Policy and Strategic Plan of Action. There is equally a need for rational debate and systematic analysis. In the first instance, this requirement must be addressed by descriptive information on reforms using a taxonomy that aids the analysis of the implementation and impact of reforms.

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