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Editorial Brief

We have in the second volume of IJMGS articles that were peer reviewed by scholars in the field. All, but one, were presented at various times on virtual weekly webinar organized by the Centre. They were then revised and independently reviewed as part of intellectual rigour the Journal editorial is noted for. The coverage is multidisciplinary in contents, and trans-global in analyses. The current world discourse is predicated on three main issues: health and development in the midst of ravaging COVID-19 pandemic; climate change; and food security. The commonality with the three challenges, and scholar's interrogation, is the phenomenal transdisciplinary Migration and its global context. The articles in this volume are rich in contents, informative in analyses; and refreshing in evidence. They are useful in all parameters and will add value to finding solutions to some of the issues raised on all topics.

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Edito

Public Health Intervention: The Role of Social Science Knowledge

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Abstract

The perspective of non-economic social sciences in designing and implementing development programmes is marginalized in discourse and practice. This paper examines the empirical role of social science knowledge in development programmes designed by official development agencies and implemented by governments in developing countries such as Nigeria. The focus is on programmes run by specialised knowledge-based organization, such as – the United Nations and World Health Organisation (WHO). Though the WHO defines health as a social goal, the study has found an exclusivity of biomedical approach and the neglect of social science perspectives in the design of public health interventions. Interventions remain vertical entities that are often divorced from the priorities and needs of beneficiaries and the national health system in Nigeria. The paper argues that mainstreaming social science knowledge in programme design and implementation is critical to effective delivery.

Comment [b1]: Keywords not included.

Introduction

A combination of social analytical skills and an awareness of people's social organisations, their institutions and interactions make it possible to understand the complex causal factors that drive development outcomes and social change in various settings, and how it is done. The use of Social Science Knowledge (SSK) has been evolving within Development Practice (DP) since the 1970s as lens to meet these needs, and to operationalise Social Science (SS) perspective more broadly within what is defined as 'development'[1] across all sectors (cf. Gardner and Lewis, 2015:64; Green, 2006:110; Eyben, 1995:46; Cernea, [1] 1996:11-13). The utility of Social Scientist is also growing, in the drive to 'putting people first' at the centre of development projects in order to enhance (positive) social impacts (WHO, 2008b). Plethora of sources, books and toolkits for social analysis developed in the last decade by major multilateral and bilateral institutions demonstrates growing demand for social analytical knowledge in development work. All of these instruments (see box 1 below) are justified in terms of the shortcomings of conventional development planning methods, viewed as lacking 'human', 'social', 'cultural', 'political', and 'institutional' dimensions (Hall and Midgely, 2005).

The paper takes as a starting point the explicit recognition that failure to incorporate analytical perspective from social sciences design and implementation of development projects generates inequities in the development process **(**Chambers, 1995, Cernea, 1991**).** Using a case study research, the paper attempts to interrogate the utility of social analytical knowledge in public health intervention in and within national health

authorities in Nigeria, an institutional arena where the applied role of Social Science knowledge (Social Scientists) is little known. It offers an empirical perspective on its application and contribution to public health programmes implemented by governments, supported by official development agencies, by specialised knowledge-based organizations, such as - the United Nations and World Health Organisation (WHO).

Delimiting the Field: Health and Development

Development is a nuanced phenomenon, its meanings are highly contested and its normative content is also evolving (cf. Hettne, 2009:1-3). The conception of Development to which I refer in this paper is the deliberate action of nation-states or International Development Organisations (IDOs) to 'develop' and 'transform' the economic and social structure of the 'Third World', to pre-emptively engineer 'progress', improve people's health status, living standards and eliminate poverty (cf. UNDP, 1949). Normative accounts of development remain clearly linked to economic progress with an insistent emphasis on economic growth as the primary goal and meaning of development, in spite of equally persistent claim by some social scientists that development is about more than just income and material wealth (Sen 1999:26, Cernea, 1993, 1991; Chambers, 1997, 1983). Rather, they argue that development is about people – their wellbeing, their freedoms, their social organisations and their institutions. In recent times, as the idea of 'development' takes on a narrow meaning of the practice aiming at eliminating poverty and meeting of international development goals. These

goals include those of the Millennium Development Goals (MDGs) (2000 – 2015) and the current Sustainable Development Goals (SDGs) (2015-2030).

Health on the other hand is an elusive concept, and although in its many facets, health status is changing with development, it is not necessarily changing for the better or leading to health improvements. Social, cultural, environmental, economic and structural changes are leading us to new health risks and these different dimensions must be addressed in practical ways if development is to be associated with healthy life, also to ensure a more successful public health intervention (effective and sustainable). The term 'Public Health' itself requires some clarification. As Sand explains, "In relation to the isolated individual, the art of preventing and curing disease is known as private medicine, in relation to the community as a whole, it is public medicine. In relation to those people and classes whose conditions call for special measures, it is social medicine" (Sands 1953:1477). It is these last two uses of the term that is referred to in this paper. The relationships between health and development remain complex. It is possible for development to occur in economic terms without alleviating poverty or reducing inequalities and health disparities (cf. Thomas 2000:38; Kothari and Minogue 2002:2-7).

Nevertheless, growing international attention on the links between health and development has pushed health high up in the international development debates. Albeit, premised on the view that fighting disease will essentially promote more sustainable and equitable global health architecture to stimulate economic development (cf. Brundtland, 1998a; Sachs, 2005, 2002; WHO, 2001). Overall, the contribution of social science perspectives to the

vision of development and health is ensuring that people, their priorities, their needs as well as the broader context of environment and health (including the health system) are at the starting point, the centre and the end goal of each development intervention (UNDP, 2010:2).

Social Analysis, Social Science Knowledge and Development Practice

Growing criticisms of the narrowness of economic growth paradigm and its one-size-fits-all approach along with the acknowledgement that concomitant levels of social development and poverty reduction have not accompanied economic development, fostered an enabling context for Social Development (SD) perspective within development practice from the 1970. Social development perspective emerged as a critique of mainstream development and attempted to push back the predominance of economic world view, and put people (humans) at the centre stage. This critique paved the way for integrating non-economic social science perspective into the mainstream of development planning and created an environment in methods of other social science discipline that could also evolve in development discourse and practice Cernea, 1991; Midgely, 1995). Social Analysis is the analytical framework used to operationalise **particularly the non-economic Social Science Knowledge** broadly within development practice. Social Analysis brings to bear the conceptual and research techniques of non-economic social sciences into programme planning (Cernea, 1996:4). It is multi-disciplinary and wide-ranging, an eclectic mix of methodologies from the contextualizing disciplines in social sciences with some adapted versions of development administration and management tools (Green, 2002:54). Jackson (2002),

coined the acronym SAP as a label for sociology, anthropology and political science, which she identified as the noneconomic social science disciplines deserving proper role as equal partners with economics in discourse and at the level of development planning and policymaking. This paper recognises historical perspectives as equally relevant within the same frame of analysis and uses the label History, Anthropology, Sociology, and Political Science (HASP) to denote the same point of reference. Just as the primary focus of social sciences (i.e. concern with people), methodologies of Social Analysis (see Table 1) brings to bear the conceptual and research techniques of non-economic social sciences (Cernea, 1996:4). By tradition, the social analyst in multidisciplinary team identifies, conceptualises, and deals with social and structural variables that make up the social dimension of development programmes. They are usually field-based-studies and qualitative analysis of social situations (Gardner and Lewis 2015:60, Green, 2006:111). Basic questions include: Does the existing social and institutional structures have the 'socio-political absorptive capacity' for the intervention being proposed?" (Guillaumont and Guillaumont, 2007). Can it function effectively at the accelerated pace of development projects often triggered by a large financial influx or funding from international development organizations reminiscence of the 'big-push model? What social adjustments are needed to keep step with the other elements of the intervention?

Table.1. Some methodological approaches and current techniques for Social Analysis

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Stakeholder Analysis	
Social Assessment	
Beneficiary Assessment	
Gender Analysis.	
Participatory Rural Appraisal (PRA),	
Sustainable Livelihoods Framework (SLF),	
Participatory Poverty Assessment	
Participatory Learning and Action (PLA)	
More Recent Approaches	
Social Determinants of Health (SDH) logic,	
Health Impact Assessment (HIA)	
Poverty and Social Impact Assessment (PSIA),	
Poverty Analysis	
Political and Social Analysis,	
Power Analysis.	
*** Source: World Bank, DFID, WHO**	

The demand for Social Analysis grew from the manifest failure of the main theoretical perspectives of development and its 'trickle-down' assumption to reduce poverty and inequality in the 1960s. It also arose from repeated failures and negative social consequences that resulted from many planned development programmes and involuntary resettlement schemes in developing countries from the late 1960s. These failures were widely acknowledged as resulting from 'largely sociologically ill-informed and ill-conceived' planned development interventions (Cernea, 1991:1, see also Kottaks, 1985; Lele, 1975). The input from Social Analysis is therefore seen as

a necessary contribution alongside the economic, technical, institutional and environmental analyses, which are also required as necessary input in the design and implementation of planned development (ODA, 1995:3).

More recently, insights drawn from people-centered discourses, such as Robert Chamber's promotion of 'bottom–up' perspective, Michael Cernea's advocacy for 'putting people first' and Amartya Sen's capability approach promote Social Analysis in the planning and implementation of development programmes, especially project of international assistance. Their theses which drew attention to the need to broaden development analytics around the social dimension of development further pushed development planners to establish criteria of incorporating Social Analysis in project design and programme implementation. Key areas of interest include, assessment of social processes and issues relating to poverty, vulnerability, gender and marginality.

As a result, Social Analysis has become central to the repertoire with which development practitioners and official development aid agencies have sought to address social and contextual issues, build people's participation into development programmes and improve development effectiveness. The current goal of Social Analysis is to ensure that poor and vulnerable groups either benefit directly from development intervention, or are not disadvantaged and made poorer as a result of their engagement with the development process (ODA, 199:18; Green, 2002:53).

Contemporary Social Science perspective finds expression in dominant development planning frameworks (see table 1) and international development agenda. Such as the World Bank's Comprehensive Development

Framework (CDF), in its recognition of the importance of social institutions, and processes in meeting human needs (cf. World Bank, 2000/01), the Poverty Reduction Strategy Papers (PRSP), the MDGs and currently the SDGs. All take the idea of the 'social' as the starting point from which to 'attack' poverty explicitly and recognize Social Analysis (SA) and the role for non-economic social analysis as a prerequisite to planning (World Bank, 2003, 2000, UNDP 2011, 2000). Thus, indicating that Social Analysis has been integrated into the mainstream of development policy design and implementation.

Yet, for all the rhetoric and plethora of sourcebooks and toolkits the inability of Social Analysis to fulfil its key potentials have remained. The sense of optimism shared amongst development practitioners and development aid agencies that integrating Social Analysis into the mainstream of development planning will enhance social impact and produce a more successful, and equitable pattern of development has been challenged. Social Analysis has proved to be of limited effectiveness in enhancing social impacts and improving development outcome. Indeed, while development takes place in some places as measured by an increase in economic growth, social development indicators highlight the fact that for many, deprivation has increased and inequality in the distribution of the benefits of economic growth is widening. Likewise, disparities in health outcomes for a large number of people in sub-Saharan African have also increased particularly among the poorest, facing threats from neglected tropical diseases, climate change, disease epidemics and their impact on health (WHO, 2008b, UNDP, 2010). And even as the UN agencies promoted Social Development and

people-centered approaches, the mainstreaming of Social Analysis ebbs and flows within institutional practice and development discourse.

The marginalisation of Social Analysis within development agencies and discourse was identified as the most critical constraint that limits its effectiveness and the potential impact on development outcomes (cf. Green, 2002:59). Yet, critical insights into the Social Analysis discourse tend to focus on conceptual and ideological examination of its theory, methods and practices (cf. Mosse 2011; 2001; Cooke and Kothari, 2001).

Evidence based on an examination of public health intervention in Nigeria indicates that thus far, so little non-economic social science knowledge is included in programming (Mamman, 2017). The empirical application of social science knowledge or its applied role in public health interventions and the mechanisms by which it contributes to programme planning and implementation is sparse. Besides, the actual processes (social, political and economic) that includes social science-oriented change in institutional structure are so little understood. This knowledge shortfall is a flaw in the literature and it is to this shortfall that this paper has sought to make an empirical contribution through an examination of the applied role of Social Analysis in national public health practice. These tensions are explored more fully in subsequent sections.

The Public Health Paradigm

Within the discipline of Public Health,[1] two epistemologically opposed paradigms can be broadly distinguished as follows: the biomedical approach or biomedicine which sees health and well-being from 'external' 'observation-oriented' perspectives. The biomedical approach relies on epidemiological analytic and on other scientific disciplines like biology, statistics, and engineering, using methods such as surveillance and clinical trials to understand disease etiology. The approach narrows the analytic of population health to individual's behaviour, biology and the risk factors for illnesses. The biomedical approach is reductionist and unsurprisingly falls on the same divide as observation-oriented subjects such as economics (cf. Sen, 2004:261). On the other hand, its alternative is referred to as the developmental approach or social model of health or social medicine. This approach sees health and well-being from an 'internal' 'perception-oriented' perspective. This view of health is underpinned by philosophical perspectives from non-economic social sciences (Sen, 2004:261). The analysis of population health in this context is often seen in terms of the wider political, historical, social and cultural determinant of health, and related events including disease and other sources of epidemiological variations (cf. Farmer, 2006:535).

As it currently stands, the biomedical approach is the dominant model through which public health interventions are articulated and implemented in ID practice. Its epidemiological analytics shape policy formulation, institutional practice and target health care delivery, and remain as the cornerstones of public health ideology. The holy grail of modern medicine

remains the search for the molecular basis of disease, increase 'desocialization' of scientific inquiry: a tendency to ask only biological questions about what are in fact biosocial phenomena" (Farmer et al., 2006:1686). Social sciences knowledge is used only to better understand the proximate causes and distribution of disease conditions in a defined population. Social Model of Health or the Social Determinant of Health (SDH) logic provides the intellectual foundation that sustains the applied role of Social Analysis (SA) in field of public health. Terms such as Social Determinants of Health (SDH): 'SDH policies', 'SDH logic' are used to denote the same frame of reference that addresses core postulate of Social Development perspective in public health, such as, community participation and involvement in planning and implementing public healthcare services. Others include key dimensions such as the economic, the political and the environmental, as well as Intersectoral Action for Health (IAH). Social Analysis creates the understanding and awareness of the social and economic issues that accelerate or facilitate preventable morbidity and inescapable mortality, remedying deprivation and disparities (Farmer, 2005:7).[1] The discourses of the biomedical and developmental models paralleled the economic versus socially-oriented approaches and are reminiscent of the broader debates within mainstream development thinking about social and economic development. Much of the criticisms particularly focus on the unravelling of social science disciplines and 'the desocialisation" of public health policies which have largely been brought about by the narrow focus of the biomedical approach and its failure to take due account of "many socioeconomic" factors (Farmer et al., 2010; 2005; Sen 2004; Kleinman 2004 Marmot, et al. (2004, 1995). 'Resocialising' the understanding of disease

distribution by linking ethnographic and clinical-epidemiological research through 'unflinching Social Analysis' helps to ensure that the poor are not disadvantaged by disease and intervention therapies are implemented where they are needed the most (Farmer, 1997:125).

Public Health Intervention: World Health Organization (WHO) and Social Analysis

The World Health Organization (WHO) is a leading global health agency formally established in 1948 into the fold of the UN in the immediate aftermath of the Second World War to provide the technical means of supporting the so-called 'underdeveloped areas'. The WHO constitution (see Box 1) defined its first function as, "to act as the directing and coordinating authority on international health work" (WHO, 1948:2). The WHO has 194 Member States including Nigeria. The Organization's core functions include working with the Member States and appropriate specialised agencies to achieve health progress. The WHO Constitution went beyond the technocentric meaning of health by defining health more broadly, as an ideal state encapsulated as:

> "State of complete physical, mental, and social well-being (Emphasis added) and not merely the absence of disease or infirmity" (WHO, 1948:2)

By giving health the meaning of physical, mental, and social well-being of the individual, the WHO constitution reflected a concern with health in its broadest sense. It also underscores the interplay between the scientific and social-political dimension of health (cf. Bonita et al., 1997:269). Through the assertions that "health [is] one of the fundamental rights of every human

being"; the "healthy development of the child" and active cooperation on the part of the public [is] of utmost importance"; and the recognition that "Unequal development in different countries [...] [is] a common danger" (see Box 1). These assertions necessarily situate public health as a Social Development goal and reinforces organisation's commitment to promote a concept of health that is multidimensional and requires action on broader determinants of health, and the social factors that underpin health and diseases. WHO's core responsibilities include global vaccination campaigns, responding to public health emergencies, defending against pandemic influenza, and leading the way for eradication campaigns against life-threatening diseases like polio and malaria (WHO, 2016). As a result, the organization's programmatic decisions and institutional planning procedures have significant impact on the beneficiaries of internationally driven medical interventions and on the outcome of the process, illustrated in the recent cases of Ebola, Zika virus and Covid 19 Pandemic.

Since the mid-1970s (in the search for alternatives to vertical disease control), the WHO and UNICEF actively promoted the Alma-Ata declaration in 1978, which adopted the "Health for All (HFA) by the Year 2000" through Primary Health Care (PHC). The HFA/PHC strategy (Box 2) marked a forceful rejuvenation and acknowledgement of Social Development approach as a major prerequisite for more effective programme delivery. It also marked the beginning of a new role for other development actors in public health and the need for health improvement to work as a poverty reduction strategy. In the institutional context the Primary Health Care provides the ideological foundation that sustained Social Development Perspective in public health.

The HFA/PHC strategy further popularised social science methods and approaches in international public health policy.

Box 1 Constitution of the World Health Organization: Principles

'NOT MERELY THE ABSENCE OF DISEASE'

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active cooperation on the part of the public are of utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures.

Source: the WHO Constitution, 1948:2

Box 5.3. Declaration of Alma-Ata: principles "Health for All" (HFA) by the Year 2000 with "Primary Health Care" (PHC), USSR, September 1978 Declaration of Alma-Ata.

I. The Conference strongly reaffirms that health is a fundamental human right and that the attainment of the highest possible level of health requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people is politically, socially, and economically unacceptable.

III. Economic and social development is of basic importance to the fullest attainment of health, and the health of the people is essential to sustained economic and social development and contributes to a better quality of life and world peace

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare

V. Governments have a responsibility for the health of their people. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health-care process.

VII Primary health care: **(1)** reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical, and health services research and public health experience; **(2)** addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly; **(3)** includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs; **(4)** involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors; and demands the coordinated efforts of all those sectors; **(5)** requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care, making fullest use of local, national, and other available resources; and to this end develops through appropriate education the ability of communities to participate; **(6)** should be sustained by integrated, functional, and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; **(7)** relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII All governments should launch and sustain primary health care as part of a comprehensive national health system in coordination with other sectors

IX All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefit every other country.

X An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

Abridged from WHO Declaration of Alma-Ata, 1978.

Today, promoting Social Determinants of Health (SDH) enjoys an unprecedented prominence on the WHO's policy agenda (WHO, 2012). For instance, the organisation continues to make the argument that:

> "the most 'powerful' cause of disease and health inequalities in the world's poorest and most vulnerable communities are the social conditions in which people live and work, referred to as the Social Determinants of Health (SDH)." (WHO, 2005:4).

Currently, the SDH agenda is the normative and institutional basis that sustains the utility of Social Analysis (SA) and social science perspective in the formulation and implementation of public health interventions. [1] The narrative of crosscutting SDH logic in planning or programmatic activities occurs consistently in official UN records. For instance, in its latest policy document 2014-2019 Twelfth General Programme of Work (GPW), the WHO maintains its usual commitment to health as an aspect of social development and followed by a renewed commitment to action on SDH. According to the GPW:

> addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries is not new in WHO… its origins can be traced to the Alma-Ata Declaration on Primary Health Care" (WHO 2014a:35).

The document further reiterates that:

> The concept of social determinants of health constitutes an approach and a way of thinking about health that requires explicit recognition of the wide range of social, economic and other determinants associated with ill health, as well as with inequitable health outcomes… The wider application of this approach ... is, therefore, a leadership priority for the next six years in its own right (WHO, 2014a:35).

In particular, the WHO GPW 2014-2019, echoes a shift in emphasis away from categorical, disease-focused programmes, and biomedical-centric approaches, reflecting concern for more people-centred approaches. However, since it was established in 1948, various sources of tension – historical, political, institutional, and epistemological – have appeared from its formative years to define how the WHO pursues its constitutional mandate (cf. Lee, 2009: 12-17; Chorev, 2013: 638). In its first three decades, international political climate, the Cold War, geopolitics and scientific breakthroughs (new antibiotics, vaccines) dictated that it holds off social models of health (Lee 2009:45; Irwin and Scali 2005:8). The WHO pursued a biomedical model of health with technology-led vertical disease programmes. Albeit with little emphasis on social considerations, this approach achieved notable successes in particular the historic eradication of smallpox in the 1970s and other diseases such as yaws. Nevertheless, costly failure of global malaria eradication programme[1] promoted by WHO-UNICEF and US agencies in the late 1950s revealed the limitations of the biomedical approach (Packard, 2009:51). Tensions also arise in the organisation between those concerned with improving population health status through biomedical (therapeutic), cost-effective technologies designed to reduce disease and at the lowest cost and those who favoured a broader developmental approach. Also referred to as the supporters of vertical versus the horizontal 'comprehensive' approach health. These sets of tensions, (epistemic and ideational), have substantially defined how the organisation grapples with its constitution's commitment to Social Development principles and approaches to public health interventions. Yet, the perception of the WHO and the way the organisation is presented in the public health literature (as intently focused on the broad and inclusive vision

of health), such as the PHC strategy, the SDH rhetoric appears to make self-contradictory assertions with the experience on the ground. As a result, it diverts scholarship away from interrogating the WHO as specialised development agencies and their implementing partners (governments) in developing countries such as Nigeria and sees SA as an important mandate to fulfil. As the discussion in the next session shows, (sadly) the vision for a social model of health promoted in the WHO Constitution and applied methods of social sciences has often come unravelled. As a result, Social Analysis is not often seen in practice in public health development programmes

Public Health Programme Planning in Nigeria: The Role of Social Science Knowledge and Social Analysis

Nigeria is a federation of 36 semi-autonomous states with a combined population estimated at about 171 million making it the most populous country in Africa. There are 3 tiers of government; a central federal government, state governments, and local governments. The Federal Ministry of Health (FMoH) through the National Council on Health (NCH), which is the highest decision-making body in the country on health matter lead the States and Local health authority to coordinate other actors in the health sector including the WHO and its development partners. Nigeria remains deeply fractured by the extreme disparities in health, wealth and development, across the geopolitical zones and cultural and religious differences. Disparities in social indicators and health outcomes between men and women, rural versus urban areas, and between the different parts and geopolitical regions of Nigeria also persist. The unevenness is particularly marked in the

Muslim North compared to Christian Southern Nigeria (UNDP, 2015:100). This lack of security, which is found across the different domain of health, the economic, education, gender food and child malnutrition are more prevalent among families in the northern zones of Nigeria. Although, gender inequality persists across Nigeria, it is more pronounced in the northern parts of the country than in the southern part (UNDP, 2015). A selection of key statistics for Nigeria is provided in the table below.

A Selection of Key Statistics for Nigeria	
Key Statistics	**Achievements**
Child health	
Infants exclusively breastfed for the first six months of life (%)(2013)	17.4
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016)	49
Demographic and socioeconomic statistics	
Life expectancy at birth (years) (2015)	55.6 (Female) 53.4 (Male) 54.5 (Both sexes)
Population (in thousands) total (2015)	182202
% Population under 15 (2015)	44
% Population over 60 (2015)	4.5
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2011)	54.4
Literacy rate among adults aged >= 15 years (%) (2007-2012)	61
Gender Inequality Index rank (2014)	....
Human Development Index rank (2014)	152
Health systems	
Total expenditure on health as a percentage of GDP (2014)	3.67
Private expenditure on health as a % of total expenditure on health (2014)	74.85
General government expenditure on health as a percentage of total government expenditure (2014)	8.17
Physicians density (per 1000 population) (2009)	0.376
Nursing and midwifery personnel density (per 1000 population) (2008)	1.489
Mortality And Global Health Estimates	
Neonatal mortality rate (per 1000 live births) (2016)	34.1 [24.7-46.3]
Under-five mortality rate (probability of dying by age 5 per1000 live births) (2016)	104.[77.4-139.5]
Maternal mortality ratio (per 100 000 live births) (2015)	814 [596 - 1 180]
Births attended by skilled health personnel (%) (2013)	35.2
Public Health and Environment	
Population Using Safely Managed Sanitation Services (%)	
Population using safely managed drinking water services (%)(2015)	19 (Total)
Sources of data: Global Health Observatory 2017 http://apps.who.int/gho/data/node.cco	

Security remains an important issue in the country. Since 2014 there has been an upsurge in violent attacks including, bombings, abductions and shooting sprees. Since 2009 the Boko Haram terrorist group has led insurgency in the North-East and the Banditry attacks in North West and North-Central Nigeria, killed thousands of people, and displaced millions more, particularly, including several devastating incidents in major cities of Northern Nigeria. Nigeria perennially experiences multiple public health events, which mostly features epidemics of highly infectious nature, killer diseases and public health emergencies. As at the time of this writing, between the 2014-2015, there was the Ebola outbreak, Covid 19 Pandemic as well as, two other WHO graded emergencies, including the Lassa fever outbreak. Even as, demographic and health indicators have shown improvement over the years these harmful social conditions, specifically, terrorist attacks, religious and ethnic conflicts and related crimes pose threats to development programmes in Nigeria

Nigeria became Member state of the WHO on 25th November 1960 and the WHO Country Office (WCO) opened in Lagos in 1962. WHO-Nigeria is the second largest country operations after India, related specifically to facilitating effective coverage for Global Polio Eradication Initiative (GPEI) in Nigeria. Nigeria national health authorities is a recipient of Global Fund for AIDS Tuberculosis and Malaria (GFATM) and Global Alliance for Vaccines and Immunization (GAVI). The Nigeria's National Health Act 2014 (FMOH, 2014) provides a legal framework for the regulation, development, and management of Nigeria's Health System. This new act advocates Primary Health Care (PHC) approach. The Country Cooperation Strategy (CCS) which is the current main

joint planning and programming framework with the Federal Ministry of Health (FMOH) reflects WHO's vision in alignment with national health priorities (cf. 2015:47). The CCS document (2014-19) links "disease etiology in Nigeria to the social determinants of health [SDH] such as, socioeconomic status, education, gender, access to water and sanitation" (WHO, 2014b: xii).

WHO's interventions in Nigeria have had mixed results. In 1986, following the country's endorsement of the 1978 HFA/PHC strategy in Alma-Ata the Federal Ministry of Health rolled out PHC delivery services including in rural areas. A National Primary Health Care Development Agency (NPHCDA) was established in 1992 to carry out the PHC programmes as set out in the PHC philosophy. Unfortunately, the introduction of the IMF's Structural Adjustment Programmes (SAPs) coincided with the implementation of Primary Health Care (PHC), resulting in stagnation. The PHC however, remains at the foundation of the National Health System, which is largely public sector driven, with private sector involvement. Following some crucial interaction between the context, the actors, the targets and shifts in health policies, under the pressure of an ascendant neo-liberal market-oriented policy by the 1980s, the PHC ran up against strong hostilities. This led to the development of an alternative, narrower model and a neoliberal-friendly version "Selective Primary Health Care" (SPHC). These splits hampered the effort to institutionalize a Social Analysis into public health planning (Cueto, 2004, Lee, 2009).

In 2013, the transmission of Guinea worm was eradicated. However, the government and its development partners have also been less successful with some national programmes that require changing attitudes and behaviour.

Attitudes and behavior remain central in the spread of diseases and ill-being such as family planning and contraceptive use. The southern states of the country, for instance transmission of wild poliovirus was interrupted. Yet, interrupting and eradicating the poliovirus from the northern states faced significant push-back from the community (Birukila et al., 2016:1), described in the words of one observer, as "ill-conceived ill-designed and neglected the views of the community and beneficiaries" (indicative that lessons have still not been learnt).

Empirical evidence emanating from four distinct levels uncovers the institutional process, culture and various factors that currently hinder the inclusion of Social Development perspective and undermine the utility of Social Analysis (SA) in public health development practice. The rhetoric around SDH, Social Development and Social Analysis still far outweighs the practice in official development institutions. In reality, the national authorities planning procedure did not necessarily shift towards mainstreaming SDH logic as emphasized in its latest WHO policy document for a number of reasons.

The first, is that the aid architecture and funding mechanisms of development programmes create vertical programmes and silos, which divide what, should be a multidisciplinary and integrated planning in development work. As a result, it has become a 'beauty contest' amongst public health planners and programmes officers under immense pressure and budget-cuts to attract donor funding. Most donors, on the other hand, are under pressure to demonstrate value for money and thus want quick results. This creates a lack of appetite to invest in procedures such as Social Analysis and SDH that seek to tackle health problems on a wide front and on a long-term.

The rise of economism in the international public health sector, particularly the entry of the World Bank as a competing multilateral public health agency and the leading source of health development finance in the 1990s heralded the rise of economistic interpretation in programme planning. New insights into key links, better health and improved economic performance, which found expression in the following influential publications unravelled health from its social development underpinning and anchored it on the political economy agenda. World Bank Report (1993) *Investing in Health*, Commission on Macroeconomics and Health (CMH) "*Investing in Health for Economic Development* (WHO, 2001). Health Systems*: Improving Performance* (WHO 2000), Reducing Risk: *Promoting Healthy Life* (WHO 2002).

The new universalism and the cost-effectiveness calculus planning model presented in these publications appear to have taken a hold in the organization and increasingly set the terms of WHO work in international public health. For instance, the strategic recruitment of economists to public health programming to adapt this new thinking proved antithetical to the PHC framework, to the degree that supplants Social Development perspectives and has eclipsed the application of SA in programme planning. For instance, the World Bank's contentious Disability Adjusted Life Years (DALYs) framework endorsed by the 2000 World Health Report is criticized for lacking built-in concern for equity, which often leads to corollaries that are at odds with principles of equity (Anand and Hanson, 2004:197).

The Epistemic Communities (epicoms) culture, a positive force for progress 'as agents of policy changes' defined by the fact that their members hold a set of common practices associated with specific policy areas (Haas 1992),

paradoxically contributed to the institutional marginalization of Social Analysis. Epicoms, for instance have positioned Randomized-Controlled Trial (RCTs) and formal statistical methods as the gold standard to the degree that it fosters the sense that medical science holds the answer to population health problems. Such assertion also paradoxically downplays the need for other perspectives in programme development and planning. Such that, Social Analysis with its qualitative people-centred approach, normatively driven by anthropological and sociological perspectives is perceived as epistemologically limited in terms of epistemic relevance and consequently side-lined.

The aid architecture and funding mechanisms of development programmes creates vertical programmes and silos, which divide what, should be a multidisciplinary and integrated planning in development work. These form of inflexibilities within the context of the public health, further complicates the capacity for programmes to initiate Social Analysis, based on current needs of beneficiaries on the ground, particularly when it is not in the funding agreement. The appeal of neoliberal and 'magic bullet' thinking, and the exclusivity of biomedical approach particularly with more recent success with eradicating guinea-worm push planners and public health professionals to favour biomedical approaches. Moreover, the availability of treatment and reliance on technology meant that for many public health professionals (or health workers), understanding the complex social structure, social relations or factors that drive effective programme delivery was unnecessary. Although these factors as outlined here all help to unravel and eclipse Social Analysis, other institutional culture and barriers come in this direction:

1. The privileging of economic interpretations over non-economic social science disciplines.

2. The disregard for social perspectives and developmental approaches in international public health programmes and the focus on commodities and technologies.

3. Indifference towards social relations and people's knowledge and predicating possible community engagement in development planning on political structures and actors, rather than social organisation and social actors.

Conclusion

In light of the outcomes and conclusions drawn in this study, the reader is reminded that if the neglect of Social Analysis and the centrality of social actors in development planning persist, it will be impossible to overcome widening disparities and unevenness in the development process. However, this critique is not a rejection of the biomedical paradigm. Indeed, it is a critique in full recognition of the strengths of the paradigm, and of its achievements in public health. Rather, it is a plea to afford other disciplines, particularly the social sciences their proper role in public health analysis and policy interventions responses in ID practice.

However, the reductionism of the social dimension of development to economic benefits is a flaw. It can hide the absence of a thoroughgoing application of Social Analysis and the adverse effect on the sustainability and effectiveness of public health interventions cannot be ignored.

The future effectiveness and impact of social science perspective will depend on the willingness of practitioners to recognize that if development is about people, their lives, values and institutions and public health is about health life to the community as a whole, then Social Analysis should be at the heart and not at the margins of development practice. Indeed, social science knowledge instrumentalized as Social Analysis and SDH logic must be integrated into policy formulation principles and institutional planning procedure across all sectors.

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