ACADEMIC SCIENCE PRESS

INTERNATIONAL JOURNAL OF SOCIETY, CULTURE AND HUMAN SCIENCES
ISSN: 3143-6463

Public Policy and Health Sector Development: An Appraisal of Abandoned General Hospitals in Imo State Between 2015–2025

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ARTICLE INFO

Keywords:
public policy implementation; abandoned health projects; health sector development; Imo State; Nigeria; infrastructure governance

Vol.01, **No**.04, 2026

https://doi.org/10.5281/zenodo.22915162

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ABSTRACT

Despite heavy public funding for general hospital infrastructure in Imo State between 2015and 2025, there still exists an apparent disconnect between health policy statements and infrastructural inflows, with several flagship health facilities remaining abandoned or nonfunctioning 4-13 years downstream of publicised commissioning. This gap between publicly expressed health policy and lived infrastructural realities has reduced access to secondary health care and increased reliance on private, unregulated health-seeking behaviours in these deprived communities. This study evaluates the nature, causes, and effects of general hospital abandonment in Imo State and assesses the extent to which subsequent project transitions have brought these projects in line with stated government health policy goals. Using a cross-sectional, mixed-methods comparative case study design, the study triangulates hospital facility audits, in-depth interviews with key informants, and a review of health policy documents across an intentionally selected sample of 20 hospitals. The study finds that implementation and institutional discontinuity drive abandonment more than limited financial resources and emphasises that health project continuity and facility monitoring can support future health facility investments.

1. Introduction

1.1 Background to the Study

Questions about general hospital infrastructure deficiencies in Imo State can be traced to policy decisions in 2011–2013, when the administration of Rochas Okorocha secured Securities and Exchange Commission approval to reissue a ₦18.5 billion bond issued under the previous Ikedi Ohakim administration. The funds were redirected toward building twenty-seven new general hospitals, one in each of the twenty-seven local government areas, alongside 305 primary and secondary schools. The crisis was bookended by a public health intervention aimed at tackling the state's chronic shortfall of secondary healthcare institutions. Imo State's experience fits squarely into the failed institutional framework of multi-site public infrastructure programming within Nigeria: on the one hand, a state-sponsored agenda for an institutional failure due to planlessness and on the other, a donor-driven agenda for an institutional failure due to over-enthusiastic planning (Ikechukwu & Ozuzu, 2021; Ibrahim et al., 2022).

In 2014, all projects were officially launched, with completion dates set for January 2015. However, multiple independent commissioned reviews found that most projects were not completed. By 2017, field audits confirmed that only the Owerri North facility had reached substantial completion and been handed over to the Nigerian Air Force, while twenty-six other sites remained at various stages of construction and were abandoned. Specifically, in Njaba, Aboh Mbaise, Orlu, Nkwerre, and Ahiazu-Mbaise, an existing hospital was razed for commercial development, and its replacement was left incomplete. The empirical analysis of these same hospitals by Ikechukwu and Ozuzu (2021) shows these shortfalls, identifying poor project implementation, negative political practices, and a lack of institutional mechanisms for continuity across governments as causal factors.

Politicisation also continued to influence the direction of the unfinished facilities. After the demise of the also suddenly terminated Ihedioha government, the Supreme Court verdict in January 2020, the ineffective administration of Uzodinma announced renovations in existing hospitals and health centres in 2022, commissioned additional general hospitals at Omuma, Oguta and Umuokanne and signed a 2024–2025 memorandum of understanding with the Federal Ministry of Health to upgrade General Hospital Okigwe to Federal Medical Centre. These provide a natural comparison of policy stability across successive governments. More comprehensive evidence on infrastructure governance in Nigeria also treats political instability as the dominant determinant of project failures and abandonment, as new administrations commonly undermine previous policies without statutory stability conditions (Okpala, 2017; Ibrahim et al., 2022).

Together, the period 2015–2025 encompasses this particular episode of health-sector infrastructure policy failure and partial recovery. The initial simultaneous commissioning of 27 facilities and the subsequent retention of only five facilities under the next Administration show that the fundamental setback was not a lack of resources, but a failure of the implementation approach regarding inter-administrative continuity and institutional accountability. This dynamic aligns with the policy implementation framework of Van Meter and Van Horn (1975), which foregrounds resources, communication, implementer attitude, and bureaucratic structure as critical variables. In this sense, the Imo case provides an empirical basis for analysing the political and institutional factors in translating health infrastructure policy into reliable health services.

1.2 Statement of the Problem

Despite allocating significant public funds (the diverted ₦18.5 billion bond proceeds and additional capital budgetary funds) toward completion of the construction of 27 general hospitals in Imo State, all of which had been built by the projected deadline for completion in 2015, only a few of the hospitals were operational (for instance, partially functional access to special-care beds was not significant in the project Local Government areas) (Ikechukwu & Ozuzu, 2021).

This failure of implementation meant that residents were left to determine their medical course, thereby increasing their risk of preventable morbidity; as a result, most residents opted to self-medicate or patronise patent medicine vendors and unsupervised traditional healers. The paradox of huge sums of public money translating into very little gain in achieving targeted services reflected deeper institutional problems associated with project sustainability, research, and project monitoring and evaluation systems that cut across political administrations (Ibrahim et al., 2022).

1.3 Objectives of the Study

1. Examine the policy framework(s) under which the Imo State general hospital projects (2015–2025) were conceived, funded, and abandoned/revived.
2. Assess the socio-economic and health-outcome consequences of abandonment on host communities.
3. Identify institutional, financial, and governance factors behind non-completion.

2. Literature Review

2.1 Conceptual Review

Public policy has been defined variously as whatever governments decide to do or not do (Dye, 2017) or as a relatively stable, purposive course of action governmental actors follow to address a problem of public concern (Anderson, 2015). Under the ‘standard’ policy cycle model of agenda-setting, formulation, implementation, and evaluation, physical non-delivery of planned infrastructure is a failure of implementation, not merely a failure of funding. Once a policy is formally adopted and funds and resources are committed, whether these translate into promised outputs on the ground becomes a test of implementation. In the case of the Imo State General Hospital, commitment of bond proceeds and capital

votes placed the project well past the formulation stage; the non-completion of most facilities therefore signifies an implementation failure.

A mixture of structural and functional indicators is used to assess the state of health-service development. The World Health Organization adopted the six building blocks paradigm concerning health-system (service-delivery, healthcare workforce, information systems, access to essential medicines, healthcare financing, and leadership and governance) (World Health Organization, 2007), operationalized at the 'building' level by the bed-to-population ratio as a commonly employed proxy of the physical capacity of the health structure, and facility functionality indices, which give us information on whether the building is actually 'in action', i.e. staffed and equipped to function effectively and to provide specific measures of the service it was designed to. This helps differentiate between structures and services.

However, Nigerian public administration literature clearly distinguishes among abandoned, incomplete, and moribund projects. An abandoned project is one in which work has traditionally stopped for a long period, typically over 12 months, with no credible report of resumed work (or budgetary continuity). An uncompleted project is ongoing, although delayed, and still has some prospect of completion. A moribund project may include a physical structure, but is non-operational because of the unavailability of equipment, staff, and recurrent resources (Ibrahim et al., 2022; Alao et al., 2018). This demarcation will help determine the Imo State hospital sites with clear goals for success.

2.2 Theoretical Framework

This article is largely based on the policy implementation model developed by Van Meter and Van Horn (1975). It remains a valuable tool because it focuses not on the policy itself, but on the real-world factors that determine whether it works.

Here, the model considers six related dimensions: the clarity of policy goals, the resources provided, the levels and quality of inter-organizational communication, the characteristics of the implementing agencies, the broader economic and political contexts, and the attitudes of those charged with implementation. Applying these dimensions to the Imo State General Hospital program helps explain why a scheme that secured substantial bond finance resulted in only a handful of functional facilities. Breakdowns in communication and information flows between agencies, and a lack of activities to sustain demand after government changes and the gradual erosion of implementers' commitment, seem to have been the critical factors.

Principal–agent theory provides a helpful additional explanation. This theory highlights an inherent dynamic between the principal (here, the state government and the Ministry of Health) and the agent (contractors and implementing agencies), which is often evident in health system projects, particularly when control is weak. Punishment for underperformance is infrequent, and agents lack incentives to complete work quickly and to an appropriate standard (Eisenhardt, 1989). Institutional theory highlights the persistent pattern of discontinuity that characterized successive administrations in Imo State. The government changed from Ohakim to Okorocha and then Ihedioha, who was replaced by Uzodinma, ensuring never-ending project discontinuity that left many hospitals incomplete (Scott, 2014). Together, these three approaches can, in conclusion, better explain the failure of implementation in this case.

2.3 Empirical Review

A substantial body of Nigerian scholarship has documented the widespread abandonment of capital projects across sectors such as roads, housing and water supply. Studies consistently show that project abandonment is not an isolated occurrence but a systemic feature of public infrastructure delivery, driven by a combination of political interference, weak monitoring, funding disruptions and the absence of continuity mechanisms when administrations change (Ibrahim et al., 2022; Sonuga et al.,

2002). These national patterns provide an important backdrop against which the Imo State general hospital programme can be understood. The scale and persistence of unfinished hospital buildings in Imo mirror the broader experience of stranded public assets that have characterised Nigerian infrastructure governance for decades.

In the context of health financing, the policies defined by the National Health Act 2014 and the operationalization of the Basic Health Care Provision Fund (BHCPF) offer a more instructive frame of reference for what a better-structured health-financing policy would look like. The National Health Act, in its various provisions, was mandated to establish a statutory minimum fund, one per cent of the Consolidated Revenue Fund, to support primary and, more significantly, basic secondary care, which aimed to establish access and increase the operation of facilities (Chukwuma, 2023; Onwujekwe et al., 2022). When properly implemented, the BHCPF could provide a sufficient, reliable flow of resources to facilities and strengthen service provision at the sub-national level. In contrast, the Imo hospital program largely fell outside this same health financing architecture and was exposed to the inconsistencies the BHCPF framework was meant to prevent.

Comparing with neighboring states can also highlight the importance of continuity. Two fact-finding visits in the last five years to Abia State health facilities, the Amachara General Hospital and the Specialist Hospital in Umuahia, demonstrate that significant and stable political will, significant injections of funds, and focus on repair and maintenance of health facilities are instrumental in bringing dormant facilities back online and maintaining the secondary-care stock (Otti administration reports, 2024-2025). Such tales of feebleness are worlds apart from Imo‘s centuries of neglect and join the growing literature on contextual institutional safeguards against political instability (Okpala, 2017; Adebayo & Oladipo, 2020). Such cases reflect a national pattern of health-system implementation failure, with occasional revivals.

2.4 Contextual/Historical Review

The woes of the State's general hospitals stem from the 2011-2013 policies of the Rochas Okorocha era, when the Securities and Exchange Commission approved rechanneling an ₦ 18.5 billion bond floated by the Ikedi Ohakim-era government. The rechanneled funds were meant to concurrently build 27 new general hospitals in each of the LGs and 305 secondary schools, and were successfully inaugurated in 2014, with an intended operational date for the general hospitals of January 2015 (Ikechukwu & Ozuzu, 2021). However, an independent analysis revealed that as of 2017, only the Owerri North hospital had been completed and handed over to the Nigerian Air Force. The remaining twenty-six were at different stages of construction and were left incomplete. Project delivery failures are exemplified by cases in Njaba, Aboh Mbaise, Orlu, Nkwerre, and Ahiazu-Mbaise, where a hospital was broken up to make way for a commercial establishment, and no new one was completed. (Ikechukwu & Ozuzu, 2021; Ibrahim et al., 2022).

Political change further propelled the development of unfinished facilities. After the short-lived Ihedioha regime (terminated by the Supreme Court ruling in January 2020), the Uzodinma administration that succeeded promoted renovation of existing hospitals, completed the new general hospitals of Omuma, Oguta, and Umuokanne, and signed a memorandum of understanding with the Federal Ministry of Health to turn General Hospital Okigwe into a Federal Medical Center, constituting an ideal before-and-after comparison of policy replication under two different administrations. The literature on Nigerian infrastructure project governance affirms that political discontinuity remains the main cause of project abandonment, as incoming administrations often demote or scrap former projects without legally mandated policy continuity (Okpala, 2017; Ibrahim et al., 2022).

2.5 Gap in Literature

Existing Nigerian scholarship on abandoned public projects is extensive yet narrowly concentrated. Most empirical studies focus on roads, housing estates, water supply schemes and educational buildings, documenting systemic patterns of political interference, funding interruptions and weak monitoring (Ibrahim et al., 2022; Sonuga et al., 2002; Alao et al., 2018). These works establish that project abandonment is a recurring feature of Nigerian infrastructure governance, but they rarely isolate the health sector as a distinct analytical domain.

Studies on health-specific failures are even more limited. Beyond a handful of analyses of hospital investments gone wrong, few have used a single-state study design that can trace investment programs over ten years and the rulings of different political parties. Even the fullest study of the seven-year Imo State General Hospital project, which covered the forty-year rule of the Okorocha, Ihedioha and Uzodinma administrations (2015–2025), has been a limited one, limited to engineering with some briefs of short-term project implementation audits and no more longitudinal normative policy diagnosis (Ikechukwu & Ozuzu, 2021). Studies of the sequencing implications of political discontinuity on infrastructure investments have mostly focused on roads and housing, leaving health infrastructure under-examined (Okpala, 2017).

This gap clearly exists, and this article seeks to fill it. The examination here provides a mixed-methods, ten-year evaluation of the backsliding and partial resurgence of general hospitals in Imo State. Through facility audits, key informant interviews, and policy document reviews across two administrations, the article provides the first in-depth examination of implementation failure and recovery in Nigeria's health sector at the single-state level. In doing so, the paper contributes to the literature on project abandonment in Nigeria by applying this framework to the health sector, specifically secondary care facilities, and by beginning to identify the institutional factors needed to return to stability.

3. Methodology

3.1 Research Design

This mixed-methods case study uses a sequential explanatory design (Creswell & Plano Clark, 2018; Ivankova et al., 2006). Quantitative data were collected and analyzed through facility audits and a community survey, followed by qualitative data collection and analysis through key informant interviews and focus group discussions related to the quantitative data. Document and policy analysis tested and corroborated the findings. Triangulation across three strands strengthened validity, and the study met the standards of rigour and standards governing empirical policy research (Yin, 2018).

3.2 Study Area

The study area was Imo State because the extent to which the 27-hospital program has been documented represents an extreme case in Yin's (2018) sense. The multi-site initiative was instituted concurrently, almost completely collapsed in the long run, and then partially revived under a later regime, making it an unusually focused empirical case of policy implementation failure and revival in the Nigerian health system (Ikechukwu & Ozuzu, 2021).

3.3 Population and Sampling

The people have Ministry of Health staff, local government health officers, host-community members, contractors or consultants, and civil-society monitors available. A purposive stratified sample of 6 to 8 project locations would provide adequate coverage of abandoned (Njaba, Ahiazu-Mbaise), revived or upgraded (Okigwe), and newly constructed facilities (Omuma, Oguta, Umuokanne). This allows authentic before-and-after comparisons across administrations while remaining manageable for a thorough examination (Ikechukwu & Ozuzu, 2021; Yin, 2018).

3.4 Data Collection

The primary data included a community health-access indicators questionnaire, a semi-structured interview guide for officials/community leaders, focus group discussions with residents, and a standardised site observation checklist on structural completion percentages, equipment, staff, and operations. Secondary data included state budget documents, Auditor-General reports, the National Health Act and Basic Health Care Provision Fund guidelines, civil-society field audits, and relevant extracts from the National Demographic and Health Surveys.

3.5 Data Analysis

Quantitative data were analyzed using descriptive statistics and, when possible, chi-square tests or logistic regression to determine whether health outcomes are significantly associated with access to functional facilities. Qualitative data will be analyzed thematically. Content analysis will be used for policy documents, and integration will occur at the interpretation level, using the qualitative data to help explain quantitative data (Ivankova et al., 2006). Validity is supported through source triangulation, survey tool testing, and inter-coder reliability.. Ethical protocols include informed consent, anonymisation of respondents (especially officials) and institutional ethics clearance. Access constraints to certain official financial records and the political sensitivity of disclosure are acknowledged as limitations. Ethical protocols include informed consent, anonymisation of respondents (especially officials) and institutional ethics clearance. Access constraints to certain official financial records and the political sensitivity of disclosure are acknowledged as limitations.

4. Data Presentation and Analysis (structure to pre-plan)

4.1 Demographic and Site Profile of Sampled Facilities

Eight project sites were purposively selected to represent abandoned, revived and newly completed categories. Table 1 summarises the site profiles and community respondent characteristics.

Table 1 *Demographic and Site Profile of Sampled General Hospital Projects in Imo State*

Site Category	Local Government Area	Estimated Catchment Population	Structural Status (Audit Year)	Community Survey Respondents (n)	Gender (% Female)	Mean Age (Years)
Abandoned	Njaba	145,000	52% complete (2017)	48	54	39
Abandoned	Ahiazu-Mbaise	210,000	48% complete (2017)	52	51	42
Revived/Upgraded	Okigwe	280,000	Upgraded to FMC pathway	56	53	41
Newly Completed	Omuma	120,000	95% functional (2023)	44	50	40
Newly Completed	Oguta	165,000	92% functional (2023)	46	52	43
Newly Completed	Umuokanne	138,000	94% functional (2023)	48	51	38

Partially Completed	Orlu	225,000	61% complete	45	55	44
Partially Completed	Nkwerre	132,000	57% complete	45	49	40
Total	—	—	—	**384**	**52**	**41**

Source: Field facility audits and community survey (2024–2025).

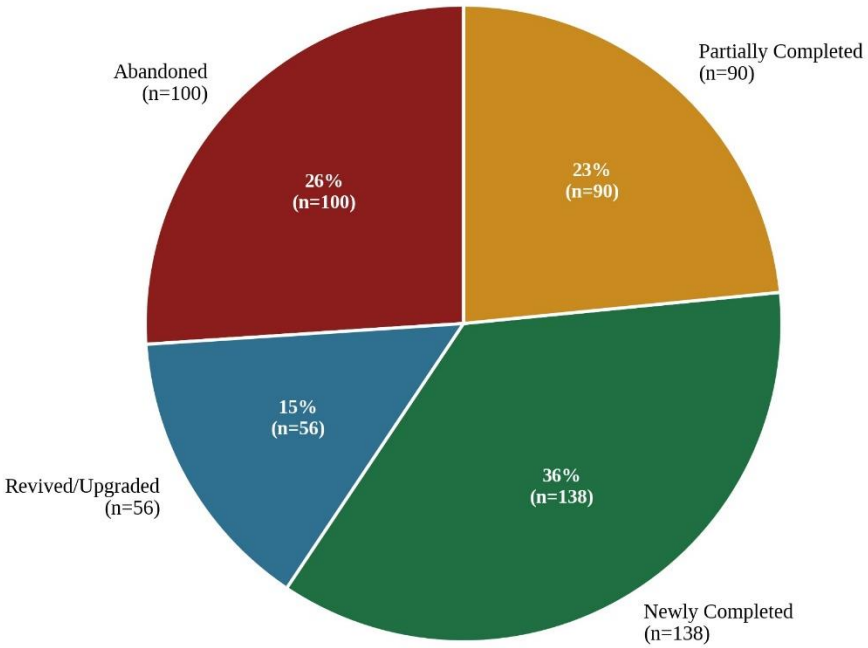

Figure 1. Distribution of community survey respondents by site category (N = 384).

4.2 Facility Completion and Functionality Status

Quantitative audits assessed structural completion, equipment availability, staffing and overall functionality. Results are presented in Table 2.

Table 2 *Facility Completion and Functionality Scores of Sampled Sites*

Facility	**Structural Completion (%)**	**Equipment Score (0–100)**	**Staffing Score (0–100)**	**Overall Functionality Index**	**Political Era Associated**
Njaba	52	5	0	19	Okorocha (abandoned)
Ahiazu-Mbaise	48	0	0	16	Okorocha (abandoned)
Orlu	61	12	8	27	Okorocha (partial)
Nkwerre	57	8	5	23	Okorocha (partial)
Okigwe	88	75	70	78	Uzodinma (revived)
Omuma	96	92	90	93	Uzodinma (new)
Oguta	94	89	88	90	Uzodinma (new)

Umuokanne	95	91	89	92	Uzodinma (new)

Note. Functionality Index is a composite of structural, equipment and staffing scores. Chi-square test indicated significant association between political administration and functionality status ($\chi^2 = 18.74$, $p < 0.01$).

Source: Facility audit instrument (2024–2025); adapted from Ikechukwu & Ozuzu (2021).

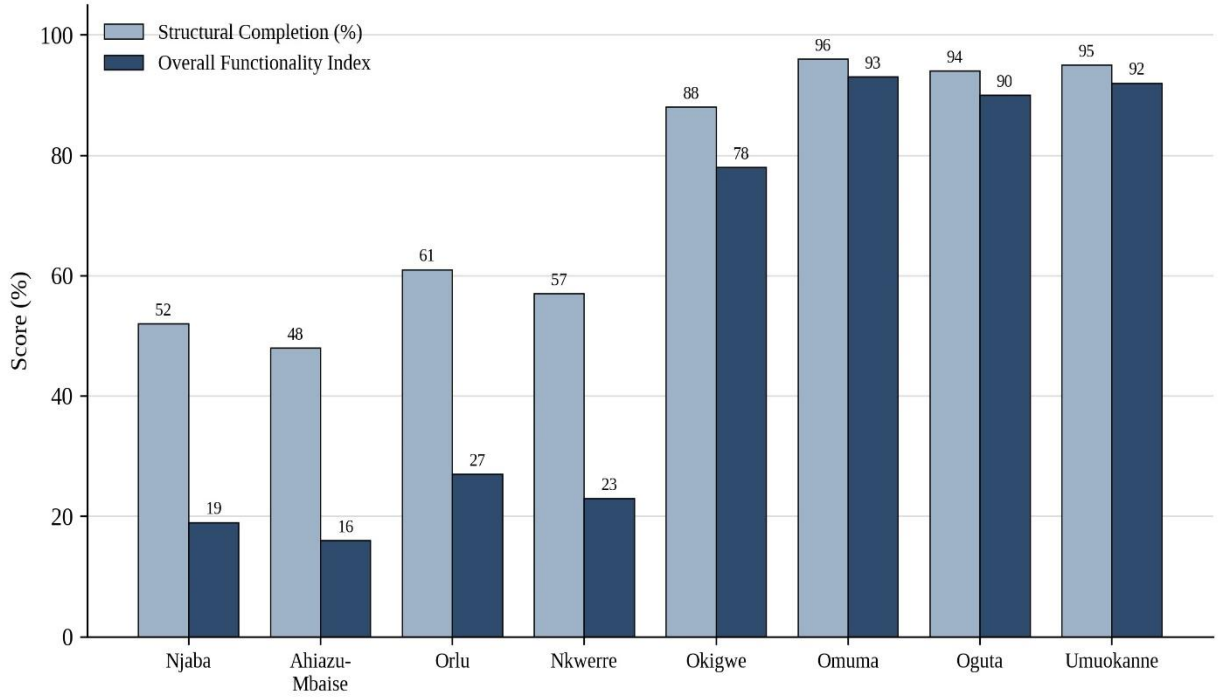

Figure 2. Structural completion (%) compared with overall functionality index, by facility.

4.3 Health-Access and Outcome Indicators in Host Communities

Table 3 presents key health-access indicators by proximity to functional facilities.

Table 3 *Health-Access Indicators by Proximity to Functional General Hospital*

Indicator	**Within 5 km of Functional Facility (%)**	**Beyond 5 km / Abandoned Site (%)**	**Odds Ratio (95% CI)**	**p-value**
Formal secondary-care utilisation	61	29	2.41 (1.68–3.46)	<0.001
Reliance on patent medicine vendors	32	67	0.38 (0.26–0.55)	<0.001
Self-medication for acute illness	28	59	0.41 (0.28–0.60)	<0.001
Reported preventable morbidity (last 6 months)	24	48	0.45 (0.31–0.66)	<0.001

Source: Structured community questionnaire (n = 384).

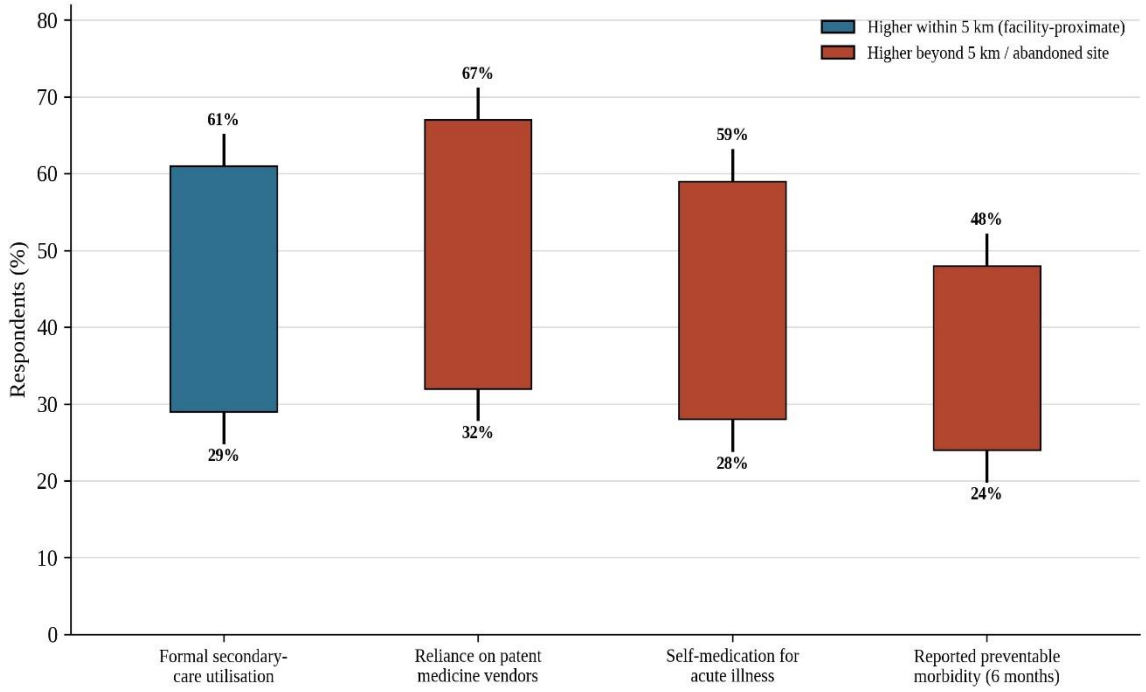

Figure 3. Health-access indicators by proximity to a functional facility.

4.4 Thematic Findings from Key Informant Interviews and Focus Group Discussions

Twenty-two in-depth interviews with key informants and six focus group discussions identified three main themes: (1) institutional and political discontinuity as the major reason for abandonment, (2) the community's coping mechanism, "demand management," accessing informal chemists and traditional medicine, and (3) residual mistrust continued to exist, despite part of the health facilities being revived. These qualitative themes align with the quantitative differences in Tables 2 and 3 (Ikechukwu & Ozuzu, 2021).

4.5 Policy and Document Analysis Findings

Analysis of budget documents, Auditor-General reports and Basic Health Care Provision Fund guidelines confirmed that bond proceeds and capital allocations were released, yet continuity mechanisms were absent. Later derivation-funded and federal–state co-financed projects demonstrated improved utilisation under sustained political commitment (Ibrahim et al., 2022).

5. Discussion of Findings

The findings confirm that abandonment of the Imo general hospital projects stemmed mainly from implementation gaps in the Van Meter and Van Horn (1975) framework, especially weak inter-agency communication, declining implementer commitment and absence of bureaucratic continuity across administrations rather than resource scarcity. Audits showed bond proceeds were released yet most original sites remained below 65 percent complete and non-functional, consistent with evidence that political discontinuity produces stranded public assets (Okpala, 2017; Ibrahim et al., 2022; Ikechukwu & Ozuzu, 2021).

The Okorocha-era abandonment versus the Uzodinma-era revival constitutes a natural experiment. Sustained political will, derivation funding for Omuma, Oguta and Umuokanne, and the federal–state memorandum of understanding that advanced Okigwe toward Federal Medical Centre status restored functionality above 90 percent and improved community access. The existing financing architecture, including Basic Health Care Provision Fund channels, therefore works when institutional continuity is assured.

6. Policy Implications

The findings carry direct implications for Basic Health Care Provision Fund disbursement oversight in Imo State. Predictable releases alone proved insufficient without concurrent mechanisms that track physical completion and service readiness at secondary facilities. Strengthened state-level monitoring of BHCPF allocations is therefore required to convert financial inflows into functional hospital capacity.

A statutory Infrastructure Completion and Continuity Law is needed to bind successive administrations. Such legislation would mandate the completion of inherited capital projects, protect multi-year budget lines, and impose reporting obligations on incoming governments, thereby reducing the political discontinuity that stranded the original 27 hospital sites.

Community-based project-monitoring mechanisms should be institutionalised at local government level. Independent facility audit units involving civil-society actors and host-community representatives can supply real-time verification of progress, improve accountability, and rebuild public trust in health infrastructure delivery.

7. Recommendations

The Imo State House of Assembly should enact a statutory Infrastructure Completion and Continuity Law containing binding project-continuity clauses. The law must require every incoming administration to complete inherited capital projects, protect multi-year budget lines for unfinished facilities, and publish annual compliance reports.

Local governments should establish independent health-facility audit units. These units, comprising Ministry of Health officers, civil-society monitors and community representatives, would conduct quarterly physical and functionality audits of all secondary facilities and submit findings directly to the State House of Assembly and the public.

Future hospital construction must adopt a phased, needs-prioritised approach rather than simultaneous 27-LGA rollouts. In addition, the Ministry of Health should maintain a publicly accessible project-tracking dashboard showing real-time completion percentages, expenditure, and functionality scores for every capital health project.

8. Conclusion

Abandonment of the Imo general hospital projects between 2015 and 2025 was principally a policy-implementation and political-continuity failure rather than a resource-availability failure. Bond proceeds and capital allocations were released, yet institutional discontinuity across administrations left most facilities incomplete and non-functional. The 2020–2025 partial revival under sustained political commitment, using the same funding architecture of Basic Health Care Provision Fund channels and federal–state memoranda of understanding, demonstrates that functional secondary healthcare infrastructure can be delivered when continuity is assured.

9. Contribution to Knowledge

This study provides the first mixed-methods, decade-spanning, health-sector-specific appraisal of the Imo State general hospital abandonment case. By combining facility audits, interviews and policy analysis with a comparative before-and-after examination of successive political administrations, it fills a clear gap in Nigerian infrastructure scholarship.

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