DEDICATION

THIS THESIS IS DEDICATED TO THE MEMORY OF MY LATE FATHER, PA TIMOTHY MAKANJUOLA ATOYEBI, AND MY LATE MOTHER MRS FELICIA IBIDUNNI ATOKE ATOYEBI.

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While the storm of getting this doctorate degree lasted, I drew my fortitude from the words of a man of God E. Ajitena:

Journey on a chariot of destiny,

Over the mountains and the valleys,

Facing trials and tribulations,

But with one great consolation;

That, it’s too late to fail.

Noises of distractors persuading,

Counsels of liars diverting,

Pleading towards the downward motion,

But destiny beckoning towards the upward motion;

‘Cause it’s too late to fail.

THE MOST HIGHLY HONOURED IS GOD ALMIGHTY, A PRESENT HELP IN TIMES OF TROUBLE, the one who makes all things beautiful in His own time, who turned mourning into dancing, pain to gain, test to testimony, story to glory, shame to fame and praise. To Him alone I give all the glory.

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ABBREVIATIONS

AAD	Alma-Ata Declaration
ADB	African Development Bank
BI	Bamako Initiative
BHSS	Basic Health Service Scheme
COMPASS	Community Participation for Action in Social Sectors
DFID	Department for International Development
DRF	Drug Revolving Fund
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
KII	Key Informant Interview
LGAs	Local Government Areas
MDGs	Millennium Development Goals
NHA	National Health Accounts
NHP	National Health Policy
NEEDS	National Economic Empowerment and Development Strategy

NEPAD	New Partnership for Africa Development
NGOs	Non-Governmental Organizations
NPHCDA	National Primary Health Care Development Agency
OOPs	Out-of-Pocket Payments
PHC	Primary Health Care
RBM	Roll Back Malaria
SHC	Secondary Health Care
TBAs	Traditional Birth Attendants
THC	Tertiary Health Care
TPHS	Three Phase Health Scenario
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAFF	West Africa Frontier Force
WHC	Ward Health Center
WHS	Ward Health System
WHO	World Health Organization
VHW	Village Health Worker

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ABSTRACT

This thesis is an investigation of the forms and extent of community participation in health care delivery and the extent to which their participation affects the performance of the health care system.

Developments in the health sector in Nigeria three decades after the Declaration of Alma-Ata Conference in Kazakhstan (former Soviet Union), where primary health care was declared a strategy of delivering healthcare services, show that the health care system has deteriorated considerably, resulting in inefficient and ineffective service delivery.

It is possible to explain the failure of the health system to respond to the various efforts of governments directed towards its renewal within the context of the inter-related nature of public health governance and the effectiveness of public health policies. Since major health problems in the country demand attention from the government health care delivery therefore becomes a political issue with the state assuming a central position in its determination. Given the complex nature of health care policy formulation and implementation, the question is, how does the interaction amongst actors in the process affects the effectiveness of primary health care? Further inquiries revolve around the question on the relative strength of the community to participate in the process of health care delivery and how this determines the population's health outcome.

The study adopts both quantitative and qualitative methods in its enquiry and utilizes three data sets (questionnaire administration, focus group surveys and key informant interview) in examining the forms of community participation in selected communities in Lagos State.

The thesis provides empirical evidences of the decline of community participation in the forms and the process of health care delivery. Contrary to the approach of primary health care which emphasizes the participation of community members in the planning of their health care development, findings revealed that, most of what has been described as community participation is rather symbolic, and largely takes a form of incorporation of the community into implementation of health programmes. Rather than be a partner, the community is turned a subject of health care delivery. The reason adduced is that, politics of health legislation, health programmes development and implementation disempowered the communities by making health care an issue of 'who gets what, when, and how' in the country.

The study suggests a system of health governance that incorporates the complex nature of health care delivery in the country. Government should devise ways of reintegrating the notion of community participation into the strategy of health care delivery in the country and ensure that its implementation as much as possible is bereft of politics. The study recommends making 'participatory development' ideology of health care delivery in the country. This is with the view to changing the social order as it affects health care delivery and its implications for citizens' health outcomes. This can be achieved within the context of an enduring ideology.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Sustaining a country's development depends to a very large extent on a vibrant health care sector. This is because the health sector is strategically placed to provide the necessary drive for the good health of the population. The aphorism 'Health is wealth' underscores the importance of health in development.

The wealth of a nation is predicated upon the health of its people, as material resources, productivity and consumption of goods and services will have no meaning if the health of the people is such that it prevents their maximal utilization and activity (French, 1979). Therefore, the improvement of health is of great importance in any development strategy, as good health is perceived as a precondition for sustainable economic and social development (Leisinger, 2004).

The World Health Organization defined health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Hence, pursuing the goal of "health for all" as an objective is an end by itself to the extent that it enables a large number of people to enjoy a state of physical, social and mental well being in addition to the absence of disease and misery (Adeyemi, 1999). Therefore, healthcare, which is a human right, must be available and accessible to every citizen of a country.

However, the situation in Nigeria is a far cry from this state of ideal. The health care delivery system is in crisis as various health indicators in the country present a disheartening picture. Overtime, the health care system in the country has deteriorated resulting in efficient and ineffective service delivery. The overall performance of the health system reflects the dismal situation at the level of primary health care (Nigerian Health Review, 2007). The consequence is the undesirable health condition of the people.

The present state of the health care services can be examined historically within the context of the development of the health care system in the country. The health care system in Nigeria could be traced to the colonial era. Prior to the Second World War, the colonial power was of the view that the colonies must bear the cost of social services and administration on their own. Social services such as health care provisioning were minimal and aimed at serving needs of the colonial personnel and the armed forces. Voluntary agencies provided for the health needs of the mass of the population through a network of missionary hospitals (Ransome-Kuti, 1992). There was a change in this situation with the passage of the Colonial Welfare and Development Act at the end of the Second World War, as resources began to flow from the metropolitan power to the colonies. This resulted in the 1946-56 ten-year plan for development and welfare in Nigeria. Although the planners were colonial officials, however, this was the first attempt to plan for health services development in the country along with other services (Ransome-Kuti, 1992).

Shortly before and immediately after independence, health care became the responsibility of the regional governments and later of the states of the federation. There was a definite attempt on the part of government to assume a leading role in the provision of health services. Almost all the regional governments had a policy whereby all civil servants received free medical service from government institutions, when available. But, no government in any part of the federation had any form of health service, which adequately met the needs of the entire population (Daramola, 1981). The reason was that the health service provided was mainly curative-focused and urban-based. This situation was inherited at independence and it continued until 1975 when the Basic Health Service Scheme (BHSS) was introduced. The major objective of the scheme was to correct the imbalance in the health care system inherited at independence.

The BHSS sought to achieve this objective by increasing the population access to appropriate health services with a focus on prevention and health promotion. The introduction of the BHSS between 1975 and 1983 formed part of the first major attempt of the country at developing its national health system. The BHSS however, failed to achieve its objectives. According to Ransome-Kuti (1985, p.14), "Nowhere in Nigeria were services being provided under the Scheme".

The second attempt began in 1983, when the need for a health policy was identified. The minister of health at the time Dr. Emmanuel Nsan set up a committee to draft a health policy for the country. This event coincided with the development at the international level of the Alma-Ata Declaration (AAD) of

1978 (in former Soviet Union) which emphasized Primary Health Care (PHC) as the key to the attainment of "Health for All". This was to influence the development of Nigeria's first health policy which was enunciated in 1988. A major goal of the National Health Policy (NHP) is the assurance of equity in the distribution of health resources such that individuals, families and communities will have access to effective, affordable and acceptable health care (Osibogun, 1998). The main emphasis was on accessibility, relevant and community-oriented public health programmes and projects.

The policy identified PHC as the cornerstone of the national health system and recommended four main strategies for its implementation; (i) the promotion of community participation in planning management, monitoring and evaluation of the local health system; (ii) the involvement of health related sectors in the planning and management of primary care; (iii) strengthening of functional integration at all levels of the health system; (iv) strengthening of the managerial process for health development at all levels. The policy identified a functionally integrated three-tier structure for the nation's health service: the federal government is to be responsible for: (i) the development of national policies, (ii) the strategies to promote primary health care; and (iii) the provision of tertiary health care. The state government takes care of: (i) technical assistance, logistic support and supervision of the Local Government Areas; (ii) secondary health care in the form of General Hospitals and Training Institutions. The local government is responsible for: (i) community-organized health and related

services; (ii) the provision and maintenance of infrastructure to provide health services; and (iii) the involvement of local communities in support of primary health care (National Health Policy, 1988).

The process of implementation of the new PHC approach in the country started with fifty-two Local Governments Areas at inception and later extended to all local government areas by 1990. The Federal Government, in 1990, directed the states, which had participated fully in developing the Local Government PHC system, to give responsibility for the system to the Local Governments (Ransome-Kuti, 1998). By the end of 1990, access to health services had increased from 30 per cent in 1980 to 67 per cent. However, this trend did not continue as the poor state of health care services shows that the country has not been able to improve on the gains of 1990; rather there has been a downward trend in health development since 1993 (National Health Policy, 2004). The poor responsiveness of health services to users and the inability of the health care systems to meet the health needs of the populace made the government to admit the failure and thus, its response through reforms of the health sector.

1.2 Statement of the Problem

Three decades after the Alma-Ata Declaration (AAD), there has been considerable improvement in global health. For example, in each region (except in the African region) there are countries where mortality rates are now less than one fifth of what they were 30 years ago (WHO, 2008). However, in spite of the

global gains in health, the situation in Nigeria remains critical and disturbing. Since the adoption of PHC as the cornerstone of Nigeria's health policy in 1988 and the devolution of the responsibility of PHC system to the local governments in 1990, much progress has not been recorded. A thorough assessment of the operation of PHC system in the country suggests there are shortcomings. Nigerian National Health Conference held in 2006 observed that, Nigeria still has one of the worst health indices in the world (National Health Conference, 2006).

There is considerable evidence that the country's health care system is in crisis resulting in deteriorating public health delivery. The deterioration is evident in the decline in the most critical health indicators in the country. The life expectancy of 48 years for the average Nigerian is below the African average of 51 years. Infant mortality rate has deteriorated from 85 per 1,000 live births in 1982; 87 in 1990, 93 in 1991, to 100 in 2003. And in 2007, the Federal Ministry of Health (FMOH) reported 110 deaths per 1000 live births. Maternal mortality ratio are estimated at 1100 per 100,000 live births (Soyibo 2005, HNP Summary Profile 2005, WHO 2008). One health facility in the country serves between 6,000-8,000 people (Osibogun, 2009). Furthermore, the overall availability, accessibility, quality and utilization of health services in the country decreased significantly in the past decade. The PHC system has not yielded considerable benefit despite the enormous resources committed to it. PHC facilities serve only about 5-10% of the potential load (WHO, 2002-2007 Country Cooperation Strategy).

The deterioration in health care delivery is traceable to the organization and administration of health care services in the country, which include weak PHC infrastructure, inadequacy of the community or PHC services and the decline in community participation in health care delivery (Asuzu 2004, Omoleke 2005). The International Conference on Primary Health Care and Health System in Africa held in March 2008 in Burkina Faso observed that the limited involvement of communities in the PHC movement is the most significant factor that has inhibited health development in Nigeria (WHO, 2008).

Attempts have been made by the government to address the problems confronting the nation's health care system. The National Primary Health Care Development Agency (NPHCDA) was established in 1992 to help support Primary Health Programmes in the country. Efforts were also directed at revitalizing the PHC system in 1999 with series of steps taken, aimed at reforming the national health system and strengthening the strategies of health care delivery. More recently in 2004, the federal government reviewed and revised the National Health Policy, the health sector was critically reviewed and significant reforms aimed at greater efficiency, effectiveness, cost - effectiveness and equity in the health services were proposed (Nigerian Health Review, 2007). Despite these efforts, the goal of "Health For All" as articulated in the AAD remains elusive for majority of the population in the country.

The foregoing problems highlight the inter-related nature of public health governance and the effectiveness of public health policies. Inability to recognise

this linkage has led to the 'failure-prone' health care delivery system. Efforts at explaining the divergence between policies adopted and services delivered have led to the realization that implementation, even when successful, involves far more than a mechanical translation of goals into routine procedure; it involves fundamental questions about conflict, decision making, and 'who gets what' in a society (Grindle, 1980). As long as major health problems in the country demand attention from the government, so long will health care delivery remain a political issue, while health policy remains crucial to achieve the objective of promoting better health for the people. Therefore, issues in effective public health care delivery will go beyond allocating public resources to basic health services, to how to organize health care delivery, which will involve the individual and the community having power and taking responsibility for their healthcare, in order to produce the health outcomes that will be beneficial to all. How this can be achieved becomes an issue for investigation. Hence, the need for this study.

1.3 Objectives of Study

The most important principle of PHC, as identified at Alma-Ata in 1978 is community's participation (Ransome-Kuti, 1990). The Nigerian government adapted this philosophy and principles as the basis for developing her health care system and a model for delivering health care. This study therefore, seeks to generate empirical evidence about the forms and extent of community participation

in healthcare delivery and the implication for the performance of the country's health care system.

The specific objectives of the study are:

1. To investigate the forms of community participation in local health decision-making and the effect on the performance of local health system;
2. To examine the effect of community financing on the performance of local health system;
3. To examine the implications of political determinant of primary health care formulation and implementation on health care delivery;
4. To contribute to the growing body of knowledge in the area of health care delivery in Nigeria.

1.4 Significance of the Study

In the last three decades, in developing countries, primary health care has been the basis for many health systems reforms. The principles of PHC have been translated to operational systems and implementation strategies. Within this context, many countries have understood PHC as the primary level of care, that is, the point of contact with the community and the population's gateway to the health system (Jurgens, 2004).

The Nigerian government affirms that PHC continues to be the cornerstone of its health development (National Health Policy, 2004). Efforts are currently being directed towards the revitalization of the implementation of PHC as part of

government stewardship role to accomplish the Millennium Development Goals (MDGs). Three of these are health goals: reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases {goals1, 4, 5 and 6, respectively} (WHO, 2007).

The overall policy objective of the NHP is to strengthen the national health system such that it would be able to provide effective, efficient, quality, accessible and affordable services that will improve the health status of Nigerians through the achievement of the health-related MDGs (Revised National Health Policy, 2004). Furthermore, the Seven-point reform agenda of government as it pertains to health care delivery points to the fact that the health sector is in a state of crisis and therefore needs to be given a priority attention. Since alternative approach to integrative method of PHC is yet to be discovered, therefore, the need to investigate the determinants of the effectiveness or otherwise of PHC services becomes imperative.

This study is justified in its purpose of seeking to examine and assess the performance of PHC, with the aim of determining its effectiveness in meeting the basic health demands of the people through community participation. Its findings and recommendations will serve as possible policy options for the policy makers in improving the quality of health care delivery in the country. By its critical examination of the performance of PHC within the context of health governance and health care service delivery, the study will throw up new facts on this phenomenon. Where this is done, a significant contribution to knowledge on public health governance and health care service delivery would have been made.

The heuristic value of the study is that the methodology it employs in its investigation can be used in the study of community participation in other communities across the country. A comparison can thus be made in the process of community participation in health care development.

1.5 Scope of the Study

This work analyses the working of PHC system in Lagos State.

The survey for the study covered four local government areas in the state namely - Badagry, Ikorodu, Shomolu and Surulere.

The empirical investigation in the communities selected from the named local governments areas enabled us to collect data on community participation in health care service delivery. The findings provide the bedrock for the analysis on the forms and extent of community participation and its implications for health care delivery.

1.6 Limitation of the Study

The major limitation of the study is the inability to carry out the empirical investigation in all the communities in Lagos State. This is due to costs, time and the amount of work involved in carrying out research of this nature. However this does not detracts the study from meeting its stated objectives. Through the methodology it employed for the selection of the sampled communities, it is assumed that to a very large extent that, the findings of the study can be generalized to all the communities in Lagos State.

1.7 Research Questions

1. How does the form of community participation in local health decision-making determine the performance of local health system?

2. To what extent does community involvement in health care finance determine the performance of local health system?

3. What are the implications of political determinant of primary health care formulation and implementation for health care delivery?

1.8 Research Hypotheses

Hypothesis 1

H_O: There is no significant relationship between the forms of community participation in health decision-making and the performance of local health system.

H_1: There is significant relationship between the forms of community participation in health decision-making and the performance of local health system.

Hypothesis 2

H_O: There is no significant relationship between community participation in health care financing and the performance of local health system.

H_2: There is significant relationship between community participation in health care financing and the performance of health system.

1.10 Definition of Key Terms

Community Participation – it is a process of involving the community by promoting dialogue with, and empowering, communities to identify their own problems and solve them.

Health Governance – This refers to the mechanisms, which incorporates structures and processes necessary for the working and realization of the goals of public health.

Health Care System – Health care system refers to the institutions, people and resources involved in delivering health care to individuals and communities.

Health System – This include components from the health and other sectors with inter-related activities that contribute to health care services to the extent that action taken within any one component affects the action within the other components and subsequent implications for health outcomes.

Primary Health Care (PHC) - 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 the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Alma-Ata Declaration 1978.

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CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

A comprehensive review of relevant literature is generally believed to be an essential aspect for contributing to knowledge, through research. Literature research in a study of this nature provides a framework for establishing the importance of the study, as well as a benchmark for comparing the results of the study with other findings (Creswell, 1994).

This work reviews and analyses the background to Primary Health Care (PHC) and discusses the definitional issues, and the understanding of its basic approach/strategy of health development. It is widely accepted that community participation in health activities facilitates health and social benefits for participants (WHO, 2000). This literature attempts a review of the concept of community participation, provides some cases of its application to studies which show the range of approaches and understanding of the concept. This is with the view to identifying the gap in knowledge, which this study intends to fill.

2.2 Background to Primary Health Care (PHC) Development

There is a broad consensus that the development of PHC is critical to the success of the provision of health care services (Van Balen 2004, Hall and Taylor 2003, Sanders 2003). Before the adoption of PHC approach in 1978, health care services

worldwide were often inaccessible, unaffordable, inequitably distributed and inappropriate in their emphases and approaches. Historically, health services in both developed and developing countries have been concentrated in urban centres and were curative in nature. For many of the developing countries, their health care systems emerged from colonial medical services that emphasized high-cost technology, urban-based and curative care. At independence in the 1950s and 1960s, they inherited health care systems modelled after those of the industrialized nations (Magnussen, Ehiri and Jolly 2004).

Public health programmes of international development agencies during this period were also largely targeted at eradicating specific diseases. Each disease eradication programmes operated autonomously, with its own administration and budget, and very little integration into the larger health system. Short-term interventions did not address the need of poor populations' overall disease burden. International health agencies and experts by 1970s began to examine alternative approaches to health improvement in developing countries (Cueto, 2004). These agencies started the advocacy for the integration of health services (Banerji, 2003). It was further stated that health service delivery needed to be considered as part of the whole social and economic development of a nation and that any improvement in services needed to take into account the whole question of national structures, priorities and goals (Rifkin and Walt, 1986). Attention shifted to the bottom-up approach of health care system. This approach emphasized prevention and managed health problems in their social contexts rather than the

alternative top-down approach which failed to address the issue of equity and how to improve global health (Magnussen, Ehiri and Jolly 2004).

A joint WHO-UNICEF Report (1975) further identified the shortcomings of traditional vertical programmes that concentrated in specific diseases and emphasized the use of modern technologies while little attention was paid to community participation in health care. The need for an integrated health care system that would target the citizens led to the adoption of PHC care as a strategy for health care delivery in Alma-Ata in 1978. PHC became a core concept for World Health Organization as a result of the Declaration of Alma-Ata in 1978, giving rise to World Health Organization's goal of 'Health For All' (WHO, 2003).

PHC approach arose in response to a mismatch in the allocation of resources for health improvements and health needs. In this situation disadvantaged sections of the population, often the majority, as well as rural dwellers suffered poor health and yet received little health care or the benefits of other health-promoting measures. The more prosperous sections of the population, often the minority and urban based, enjoyed better health, receive the benefits of a wide range of health-related facilities and have at their disposal a relatively developed health care services, including expensive hospitals. The strategy of health care adopted at Alma-Ata in 1978 was to address this problem (WHO, 1981).

The Alma-Ata Declaration (AAD) was inspired by the changes and experiments in health care, which in turn was a result of the struggles and attempts at social transformation by societies in the Third World. It was a synthesis of various concepts of healthcare services adopted by countries such as China, Tanzania, Sudan, Venezuela, former Soviet Union, Papua New Guinea in the 1960s and 1970s (Magnussen, Ehiri and Jolly 2004, Hall and Taylor 2003, Litsios 2002, Hein 2000). The AAD on PHC gave primacy to people and subordinated technological considerations to the prevailing cultural, social, economic and epidemiological conditions (Banerji, 2002). The Conference adopted PHC as the means for providing a comprehensive, universal, equitable and affordable health care service for all countries. The sixth principle of the declaration states that:

> 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 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 (Alma-Ata Declaration 1978).

PHC in this context includes both primary medical care and activities tackling determinants of ill health (Gillam, 2008). The strategy in effect required that the people of the community will assumed the role of planning and implementing their health system. But this can be achievable with appropriate local technology,

and resources at the disposal of the community. This approach implies a reordering of priorities that should transcend all levels and sectors concerned with the promotion of health (WHO, 1981). It involves a paradigmatic shift in the way health care services are delivered. Decisions on health matters have to come from the 'bottom-up' as against 'top-down' approach. For effective implementation of this strategy, the community needs to be empowered. In most developing countries, the local communities are not empowered and as a result have not been able to impact on health decisions as PHC envisioned.

> Primary health care envisaged universal coverage of basic services such as education on methods of preventing and controlling prevailing health problems; promotion of food security and proper nutrition; adequate safe water supply and basic sanitation; maternal and child health, including family planning; vaccination; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs…The community, through its leaders, was to be involved in the planning and implementation of its own healthcare services through community Primary Health Committees (Hall and Taylor, 2003 p.19).

With its all encompassing strategy of health care delivery, PHC is, understanding and improving the range of social, political and economic factors which ultimately influence the improvement of health status (Rifkin and Walt, 1986).

While there is a great deal of agreement about the principles underlying PHC, there exists many problems, political, planning and management, involved in putting the approach into effect (Vaughan & Watt, 1984).

PHC as an approach explicitly outlines a strategy that addresses the underlying social, economic and political causes of poor health (Sanders, 2003). In emphasizing the socio-political implications of PHC as a strategy of health care improvement, Tejada de Rivero (2003) maintains that health is a social phenomenon whose determinants cannot be neatly separated from other social and economic determinants, health is a complex social and political process that requires political decision-making not only at the sectoral level but also by the state. The range of social determinants of health according to Keleher (2001) incorporates inter-related circumstances of poverty, wealth and income distribution, psycho-social deprivations, discrimination such as sexism and racism, powerlessness, factors related to gender, age, race and ethnicity, socio-ecological environments, literacy and health service utilization. Specifically, as conceived in the AAD, such a strategy must promote a more equitable distribution of resources. The realization of the principles of AAD on health would therefore require the action of many other social and economic sectors as well as in community structures and processes. In sharing this view, Werner (2003) stresses that 'Health For All' as enunciated by the declaration will require structural change in the direction of greater socio-economic equity. He argues that, by stressing the need for a comprehensive strategy that not only provides basic health services for all, but also addresses the pervasive underlying social, economic and political causes for poor health, the AAD links health to a strongly participatory strategy that has since become known as 'people-centered development'. The implication is that the

people especially at the community level would take control of the planning and management of their own health for a better health outcome.

2.2.1 Community Participation in Health Care Delivery

Many perspectives have been advanced for adopting community participation in health activities as a strategy for health development (Grysbok, Yinger, Dios, Worley and Fikree 2006, Jurgens 2004, Zakus 1998, Sepehri and Pettigrew 1996, Bjaras, Haglund and Rifkin 1991). PHC as an approach was developed for providing health care services, which involve community-based preventive, promotive and curative activities. It is designed to extend health benefits equitably and to involve local communities in 'grassroots' participation (Stone, 1986). In other words, it is the community approach to community health. Community participation is thus recognized as crucial for the attainment of 'Health For All'. The AAD stresses that in order to plan and implement PHC effectively, strong participation of the people affected is essential. As outlined at section VII (5) of the Alma-Ata Declaration:

> PHC 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 (Alma-Ata Declaration 1978).

PHC is the component of health services that addresses most of the health problems arising in a community (Gofin & Gofin, 2005). As a strategy, it calls for the active involvement of community members in the various stages of

programme development, implementation, and evaluation (Wayland & Crowder, 2002). The community members take active part not only in the planning of health programme in their community but also in the implementation of such. Participation of community members in the planning of their health care development is then taken to be an essential requirement of the approach of PHC.

Though the term ‘participation’ occupies a central feature in PHC delivery, its meaning requires that it should be made more comprehensible as it has been observed that ‘participation’ is not a one-dimensional concept, and is often poorly operationalised, or ambiguously used in health systems (Jurgens, 2004, p.11).

The term participation according to Rifkin, Muller and Bichmann (1988, p. 933) has a wide range of meanings; firstly, participation must be active. The implication of this is that mere receiving of services does not constitute participation. Secondly, participation involves choice, the right and the responsibility of people to make choices and therefore, explicitly or implicitly, to have power over decisions which affect their lives. Thirdly, choice must have the possibility of being effective that is, mechanisms are in place or can be created to allow the choice to be implemented.

On participation, Jurgens (2004, p.11) emphasizes that:

> (i) It must involve; genuine and voluntary partnership; (ii) between different stakeholders from communities, health services and other sectors; (iii) and is based on shared involvement in contribution to ownership of, control over, responsibility for and benefit from agreed values, goals, plans, resources and actions around health.

Participation in health, according to Mubyazi and Hutton (2003), can range dramatically from relatively passive involvement in predetermined activities to full control of organizations and health related affairs. Jurgens (2004) also argues that, besides variations in definition, participation also varies in its outcome. The degree of (community) participation can vary from a low degree of involvement (people are being informed but not consulted) to the highest degree of community participation where communities have control and the power to decide on goals and means.

Although the concept of 'community participation' is popular, its meanings and usage continue to generate controversy. Olico-Okui (undated) expresses the view that in spite of the broad consensus for community participation and its purposes, the concept, however, continues to defy any single definition or interpretation. No universally accepted definition of community participation exists in health literature and this adds to the confusion surrounding the concept (Taylor, 2004). According to Crowley (2001), community participation means having input into structures of decisions making and planning. Zakus and Lysack (1998) conceive it as a process whereby community members collectively assess their health needs and problems and organize to develop strategies for implementing, maintaining and monitoring solutions to those problems. Community participation is a process that increases a community's capacity to identify and solve problems (Gryboski, et al., 2006), while Rifkin (1985) sees it as a strategy and process to help individuals develop their full potentials and capacities. To Ransome-Kuti (1985) community participation means that the citizens control the process of

transformation whereby they mobilize and act to improve the quality of their lives. It is also a process of involving the community by promoting dialogue with, and empowering, countries to identify their own problems and solve them (WHO, 2003). It is clear from these definitions that community participation involves people giving their own ideas and influencing decision-making.

The importance of community involvement in health care delivery has also been explored. Sepehri and Pettigrew (1996) argue that: (i) community involvement in health is a basic right, which all people should be able to enjoy; (ii) community involvement in health can be a means of making more resources available by drawing upon local knowledge and resources; (iii) community involvement in health can make health services more cost-effective by extending their coverage and lowering their overall cost; (iv) community involvement gives the community the right to ensure that services are acceptable and respond to the priorities of the community as opposed to medical needs as defined by the health authorities; and (v) community involvement breaks the knot of dependence that characterizes much health development work and makes local people aware that they could become active participants in development in general.

Emphasizing the importance of community involvement in health care planning and implementation, Ekunwe (1996, p. 52) identifies three distinct phases in the process of achieving community participation. The first phase is where the expert plans and implements a programme and merely invites the community to ‘rubber

stamp' the project. In this case the community becomes the passive recipient of plans formulated by professionals. The second phase is one in which the professionals identify what they consider to be the health needs of the community and invite members of community to plan and implement projects aimed at meeting these needs. Community impact is only felt at the implementation stage of the process. The third phase is the one in which the community identifies a health need and approaches the professionals for technical advice and support in formulating and implementing solution(s) to the needs. Ekunwe thus argues that the identification of a health need may occur independently (felt health need) or may be the result of health education by the professional who thus help the community to convert a real health need to a felt health need. However, these so called phases in reality are different approaches which may bring out different understanding of community participation. Hence, the justification of Morgan's (2001, p. 222) view that:

> the proliferation of meanings attached to the phrase 'community participation in health' (also called 'popular participation', 'social participation' and 'community involvement') has allowed it to be analyzed as a political symbol capable of being simultaneously by a variety of actors to advance conflicting goals, precisely because it means different things to different people.

In revisiting community participation, David et. al cited in World Health Report (2003, p.25) highlight three main difficulties with the conceptualization and evaluation of community participation. These are (i) the great variety of health indicators using community participation as a strategy, (ii) the complexity of

community participation and (iii) what community participation itself is understood to mean. They recommend the need to develop community structures that take into account the needs, resources, social structures and values of the community.

Community participation has evolved to include a variety of methods and approaches, some focusing on activities, others on processes (Gryboski et al. 2006). While acknowledging that there are different interpretations, terms and processes used to understand community or citizens participation which makes it difficult to establish a clear and commonly shared concept of community participation in health planning, Murray (2004, p. 2) is of the view that, the level of participants' influence or control of decision-making, actions and outcomes is often key to the descriptions of community participation.

Rifkin (1986, p. 246) proposes three important questions in participation, 'why participation', 'who participates', and 'how do people participate'. A review of the concept reveals further that there are several possible answers to the 'who', 'why', 'what' and 'how' questions on community participation (Murthy, 2003). A systematic investigation of the processes of participation will enable an understanding of who participates, why they participate, how they participate and what benefits accrue from participation.

Rifkin (1986) observes that different interpretation of community participation has resulted in different forms of practice, and there is no agreement about which form is correct. Perhaps this can be explained within the context of participation. To Sepehri and Pettigrew (1996), community participation could be approached by examining the 'dimensions' and 'contexts' of participation. The dimension of participation will include the kind of participation that is taking place, the sets of individuals in the participatory process, the various features of the unfolding process, and the purpose of participation. The context of participation focuses on historical, environmental and socioeconomic parameters under which participation takes place.

Rifkin (1986, p.241) advances three approaches to community participation. These approaches describe how planners and agencies develop community participation in health programmes. The approaches rest upon, firstly, the way in which planners define 'health' and, secondly, how planners think the community should respond to that definition. The first is the medical approach which defines health as the absence of disease. Community participation is defined as activities undertaken by groups of people following the directions of medical professionals in order to reduce individual illness and improve general environment. The second, the health service approach defines health as 'the physical, mental and social well being of the individual'. It defines community participation as the mobilization of community people to take an active part in the delivery of health services. The third is the community development approach. It defines health as a

human condition which is a result of social, economic and political development, and community participation as community members being actively involved in decisions about how to improve that condition.

Rifkin's third approach, which views health as a human condition relates to the critical issue about the empowerment of the people necessary for participating in decisions that affect their development. Ninalowo (2007 p. 6) observes that:

> The concern with human condition across cultures and different types of social formation or polity, is predicated on the assumption of the ethical principal that amelioration of social life and conditions of living for the generality of the citizenry is desirable.

Crucial to the attainment of development are a healthy and productive people while a healthy population is an important indicator of development. Developments in health are easily among the best known human development indicators (Alubo, 2001). However, there is a sense in which the peoples' effective participation in decisions on issues that affect them will bring about development. "The primary health care values to achieve health for all require health systems that put people at the centre of health care. What people consider desirable ways of living as individuals and what they expect for their societies - i.e. what people value - constitute the parameters for governing health sector" (World Health Report, 2008). Taylor (2004) has also expressed the notion about community participation as an ideological orientation. It rests on the assumptions that health inequalities between the rich and poor, both between and within

societies, are unacceptable, as is the unequal distribution of the benefits of development. As Ninalowo (2007, p. 6), further notes:

> Development may be understood to be the state or process of emancipation of a given populace from deprivation of basic needs and political subjugation or oppression. It is in that sense that, development may be properly conceived of as moments of popular empowerment. For development properly speaking, implies freedom from hindrances to actualization of the very essence of humanity. That is freedom from penury, ignorance, political powerlessness, cultural marginalization, poor health and so on.

Therefore, while participation is to achieve better access for people to health improvement initiatives, it is also about giving people some control over the means to improve their health, thereby increasing their power in relation to bureaucracies and health professionals (Taylor, 2004). Health in this context is not only the 'well being of the individual', but it is also a human condition. This condition does not improve radically by providing more services or mobilizing the community to provide more health resources, but by having the community taking control and responsibility for decisions about how to mobilize, utilize and distribute services and resources (Reidy and Kitching, 1986). In line with this, Gardiner (1994, p. 10) also observes that:

> Past experience has shown community participation to be highest where there is community consciousness of its rights and responsibilities with regard to development. The existence of an organizational structure for action, a history of successful community action and the identification of health as a priority need have been demonstrated to be the hallmarks of potential for community action in health. It is to be anticipated therefore that the process will increase the level of community participation in health as part of the development process.

The recognition and acceptance that health is not only an outcome of development but contributes significantly to economic growth, social stability and individual life chances has made health part of many larger more comprehensive policy initiatives (Kickbusch, 2005).

This brings to the fore the role of the state and its relationship to individuals and groups within the society. Although the contestation on the centrality of the state to contemporary political life remains, however, it has been argued that:

> …whether depicted as an overbearing apparatus of patriarchal oppression or as the very condition of social and political freedom, as an 'ideal collective capitalist' or a fetter on the self-regulating capacity of the market, few commentators would disagree that the concept of the state is fundamental to social, political and economic analysis" (Hay & Lister, 2006, p. 1).

It is safe to admit that the central role of the state still reflects in the political dynamics of contemporary societies. The state and its institutions remain viable actors in making and implementing policies (Peters & Pierre, 2006). More importantly for policy formulation and implementation, the state occupies a central position because it is the stage where interacting process of policy-making takes place. Peter and Pierre (2006, p. 219) extend the argument that "in spite of its changing role the state to a great extent retains its central position in selecting and legitimating policy goals…"

The purposes and objectives of government and the content of policies are the political actions and programmes designed to pursue the values and goals of the society. Public policies in this sense become the instruments through which the government achieves its objectives. Its visible manifestation is the strategy taken

by government to solve public problems (Palumbo, 1988). The values of government are reflected in its policies. The extent to which the policies are implemented will determine the realization of governmental objectives.

2.2.2 The Policy Process and Its Dimensions

Understanding how the objectives of any particular policy can be achieved requires the knowledge of its development and how the process works. The policy process refers to specific steps taken by government to solve problems, make decisions, allocate resources or values, implement policies and, in general, to do things expected of them by their constituents. Agenda setting, legislation, programme implementation and evaluation are all stages in the decisions that translate to government policies (Milstead, 1999). This process "involves a complicated interaction among government institutions, actors and the particular characteristics of substantive policy areas" (Thompson, 1981, p. IX). This means that the process of policy-making is characterized by activities that involve various actors and interests within the policy arena.

More importantly in the understanding of the policy process is the contextual dimensions which may be socio, economic, and political. Analyzing the context and dimensions of any particular policy provides the explanation of a divergence between its formulation and implementation. Because policies are formulated and implemented in an environment of social complexity and intense political

competition, understanding the political context becomes imperative for a critical analysis of the success or failure of policies.

Policy, according to Bambra, Fox and Scott-Samuel (2005, p.191) is formulated within certain preset political parameters, which define what is, and what is not, possible or acceptable.

Furlong (1999) underscores the importance of the political context of the policy process by reviewing the works of Bobrow and Dryzek (1987), Bosso (1992), deLeon (1988-89), Ingram and White (1988-89), May (1991), and Schneider and Ingram (1993). These works emphasized the need to analyze the political context in which policies get on the agenda, alternatives are formulated, and policies are put into effect. Ingram and White cited in Furlong (1999, p. 57) observe that "politics can influence both design process and design outcome in a number of ways. It can constrain problem definition and the range of alternative solutions available for consideration…" hence, the reason why Sharkansky (1992, p. 519) argues that:

> politics can be found at all stages of the policy process. Elected officials, the professional employees of government, and the activities of parties and interest groups compete over the definition of social and economic problems.

Lindblom (1986, p.4) thus posits that "a policy is sometimes the outcome of a political compromise among policy makers, none of whom had in mind quite the problem to which the agreed policy is the solution". It is in this sense that Walt (1994) describes public policy making as a political process and not simply an

analytical problem-solving process, but a process of negotiation, bargaining, and the accommodation of many different interests which reflect the ideology of the government in power.

Sharkansky (1992, pp. 516-518) identifies several kinds of politics that may reduce the quality of public policies; 'populism', 'partisanship', 'patronage', 'ideology' 'professional and technical predisposition' 'bureaucratic politics' and 'self-interest'. All these elements in the main impact on the basic process of policy-making and determine to a significant extent the success or failure of policies.

Our study of the influence of politics on policy-making cannot be adequate without a discussion on the notion of 'power' which is central to all political inquiry. In analyzing the centrality of power in political science, Lasswell and Kaplan as cited in Onuoha (1988, p. 86) hold that the 'concept of power is perhaps the most fundamental in the whole of political science; the political process is the shaping, distribution and exercise of power (in a wider sense, of all the deference values, or of influence in general)". Relating power, policy making and policy implementation, they state that:

> A decision is a policy involving severe sanctions (deprivations)… Power is participation in making of decisions… It is the threat of sanctions which differentiate power from influence in general. Power is a special case of the exercise of influence; it is the process of affecting policies of others with the help of (actual or threatened) severe deprivation for non-conformity with the policies intended (Lasswell and Kaplan as cited in Onuoha, 1988, p.86-87).

The objective reality of policy-making is that power is involved. "The realization of most societal goals, even in situations in which the actor's commitment and knowledge are considerable, requires the application of power" (Etzioni, 1968). This is borne out of the plurality of actors, goals and a scarcity of resources. Under this situation, the process of taking decisions will invariably involve conflicts or consensus, and either way, decisions reached would still reflect the relative power of the various actors. This is the reason why Bell (1970, p. 397) submits that, "decisions are a matter of power, and the crucial questions in any society are: who holds power, and how is power held?" This tends to make Shively's (1987, p. 90) observations that "good analysis will not only assess the objective merits of a policy but also take into account the power constraints under which the policy must work" accurate.

The reality of policies in many developing countries is that a huge gap often exists between policies and their implementation. Policy implementation is a dynamic process involving directed change that results in the accomplishment of policy goals (Wilken, 1999). But as Quade cited in Wilken (1999, p. 189) observes, "During implementation there is almost always something that does not go according to plan". In other words there is often a widening gap between intentions and results i.e. policy objective, outcomes and impacts. To that extent policy objectives are hardly achieved and the impacts of policy or programmes are not felt by the target beneficiaries.

Various reasons are adduced for this divergence between policy formulation and implementation. Grindle (1980) advances that a wide variety of factors, from the availability of sufficient resources to the structure of intergovernmental relations, the commitment of lower level officials to reporting mechanisms within the bureaucracy, the political leverage of opponents of the policy to accidents of timing, luck and seemingly unrelated events can and do frequently intervene between the statement of policy goals and their actual achievement in the society. Such factors account for the often imperfect correspondence between policies adopted and services actually delivered (Van Meter & Van Horn, 1975).

Walt (1994) however, argues that, rather than seeing implementation as a stage in the sequential transmission of policy from formulation to implementation, it should be seen as a much more interactive process, and just as policy formulation may be characterized by negotiation and conflict. He concludes that "policy-making is interactive with formulation and implementation two elements in a continuous loop and both as political as the other" (Walt 1994, p.156). The pervasiveness of politics in the policy process may make some policy problems intractable thereby increasing the gap between policy objectives and its impact.

In reality, health policy is part of a broader public policy agenda, whose practical aspects are inextricably linked with power and politics (Bambra, Fox and Scott-Samuel, 2005). The process of its formulation and implementation takes place

within an environment of politics. In this sense, health policy is conceived as a product of political interaction.

However, bringing a health care problem to the attention of government can be a tremendous first step in getting relief Milstead (1999). Government response and programmes put in place for target groups are all part of the process of addressing specific problems. But as Milstead (1999) rightly observes, government's response is often political. That is the decision about who gets what, when, and how are made within the framework of power and influence, negotiation, and bargaining.

Health policy is an important vehicle for influencing the health of individuals, families, and communities. Most health care policy initiatives are designed to address one or more of three concerns; cost, access, and quality (Smart, 1999). The 1978 Alma-Ata Declaration on the role and contents of PHC within the overall health system indicates that it constitutes the fundamental strategy for delivering public health (Nigerian Health Review, 2007). The World Health Organization is making increased emphasis on the role of health system and attention is focusing on the importance of policy-making in achieving effective health systems (Hanney, Gonzalez-Block, Buxton and Kogan, 2003). It has been recognized that without strong policies and leadership, health systems do not gravitate towards PHC values or efficiency respond to evolving health challenges (WHO, 2008).

PHC policies in particular are formulated to address the basic health problems of the people through access, cost effectiveness and appropriate technology. However, the knowledge of the major actors in PHC development, their relative power to influence health care decisions and how the process works is required for the understanding of how these objectives can be achieved.

PHC policies are formulated and implemented by a combination of legislators, bureaucrats, specialized agencies, professional experts and special interest groups. The political dynamics of interaction between these actors can and do influence health care formulation and implementation. The political dynamics can and often manifest in various conflicts. The system of health administration in Nigeria, for instance, involves the three levels of government; federal, state and local government authorities. These levels of administration also have relationships with a variety of interests in the health sector such as the private sector, pharmaceutical companies, non-governmental organizations, international organizations and donor agencies, health professional associations and community groups. It has been shown that the relationships between the various groups were often characterized by conflict (Nigerian Health Review, 2007). This situation has obvious implications for the effectiveness of all levels of the health system, but the implications tend to be the most serious at the level of PHC because it is the lowest level of administering the system. Its ability to respond to conflicts and politics at higher levels will therefore tend to be seriously constrained (Nigerian Health Review, 2007). This underscores the point that

powers of some of the actors and interests in health care decision-making are enormous, not only do they dominate the whole process and often times influence policy decisions, but also their actions determine the effectiveness of the policy. In a situation where the powerful and influential actors failed to maintain a balance in the equation, the less privileged people mostly found at the local level are continually disempowered.

2.2.3 Community Participation Processes: Case Study Samples

Efforts at developing a framework through which community participation in any health care specific program can be measured have resulted in the work of Rifkin, Muller and Bichmann (1988). Following analysis of more than 100 case studies, Rifkin et al. (1988) designed methodology outlining indicators for participation in health care programmes. They identified five dimensions (needs assessment, leadership, organization, resource mobilization and management) influencing participation which could be incorporated into an analytical framework known as the pentagram model. For each of the indicators, a continuum with wide participation (community people plan, implement and evaluate the programme using professionals as resources) is developed at one end. At the other end, is the narrow participation (professionals take all decisions, there is no participation). The continuum is then divided into a series of points and a mark is placed at the point which most closely described participation in the health program being assessed. When a mark has been placed on the continuum, these marks are then connected in a spoke configuration that brings them together at the base where

participation is the narrowest. By placing the appropriate mark on each continuum and connecting the marks, the degree of breadth of participation to describe a baseline which provides for a comparative assessment at a later time or by other assessors can be shown. These indicators could be used for measuring participation and to compare differences in participation (1) at a different time in the same program, (2) by different assessor of the same program and (3) by different participants in the same program (Rifkin, Muller and Bichmann, 1988, P. 934).

In order to assess the value of this model (pentagram model), Bjaras, Haglund and Rifkin (1991) used the method to analyze the community development process in a community intervention programme aimed at preventing accidents by involving local community citizens and groups in Sollentuna municipality in Sweden. An assessment of the participation process was made for 2 years and 4 years respectively. A number of data sources which included participants' observations and structured interviews with selected persons from both the health sector and the community were used in the study of change in Sollentuna Accident Prevention Programme (SAPP) in the two periods. Bjaras et al. (1991) were able to describe the breadth of participation with the five indicators of the pentagram model, which were intended to describe changes in participation from one period to another. They concluded that the method was of value for describing and understanding the participation process and was also found to be relevant in an accident prevention program in an industrialized country. The study however, recognized some weaknesses in the pentagram model. The model according to

Bjaras et al. (1991) may neglect some indicators in favour of others, and again, the two assessments in the case of SAPP may have to be made by the same group of people. But despite the limitations, the method was found to be a valuable educational tool when used as a process indicator for the program, and important for understanding change.

Eyre and Gauld (2003) using the pentagram model, explored the broader concept of community participation in health services development and examined which aspects were reflected in a practical setting. They applied the pentagram model of Rifkin et al (1988) with the five dimensions of participation to probe whether a trust model in a small community of Lawrence in New Zealand was facilitating community participation. Study participants were purposively sampled, in accordance with their richness of experience in the establishment and/or ongoing involvement with running the trust. Interview data were used for ranking the five indicators of participation. The Lawrence study found strong levels of participation within the parameters of Rifkin's definition and measurement framework. The study suggests that a community health trust, at least in the case of Lawrence, can promote community participation. Eyre and Gauld (2003) however recognized the shortcomings in utilizing the pentagram framework and with the Lawrence study, they observed that the measurement process is inherently subjective, furthermore, the findings reflect only the views of those most involved in the Lawrence trust. The framework does not focus on those who

do not participate and potentially under-investigates the citizen's or client's role in community participation.

The study of Jacobs and Price (2003) demonstrates that even where community health projects are externally funded, the success of implementation still requires substantial community involvement. Jacobs and Price used the pentagram analytical framework for measuring the level of community participation in their study of two communities- Maung Russay and Kirivong operational health districts in Cambodia. The aim of their study was to identify the most appropriate actors and strategy for initiating community participation in-time bound externally funded health projects. The study used a number of research methods which included personal observation, structured interviews with committee members and cross-sectional surveys. Using Rifkin et al (1988) pentagram framework, Jacobs and Price (2003) were able to map the contrasting levels of community participation in Maung Russay and Kirivong. Their study however, discovered that establishing effective community participation in externally funded health projects with relatively short implementation time-frames required engagement with existing community-based organizations and agencies. A major recommendation from their study is that participatory research should be utilized at the outset of community-based health interventions to identify (and subsequently develop the capacity of) an appropriate local organization to lead community participation initiatives.

In order to make a multidimensional assessment of community participation in Roll Back Malaria (RBM) initiative in five countries namely; Burkina Faso, Ghana, Nigeria, Tanzania and Uganda, Chilaka (2005) also made use of the pentagram model (also known as the spidergram model). The five countries in the study were randomly selected with a view to exploring community participation in different regions and settings in Africa. The scores and ratings were allotted to the various assessment parameters for each country based on evidence adduced from the extracts in the RBM country profiles and reports of programme activities by the countries themselves. The study reiterates the enormous potential for health development inherent in greater community participation. Although the study posits that community participation is not yet a very significant factor of influence in the RBM programme, it is nonetheless a veritable strategy for health development.

While they acknowledged the fact that community participation is one of the major aspects in the re-orientation of PHC in Cameroon, Ngum, Medi, Fang, Ekema and Linonge (2003) discovered that community participation was not oriented towards community empowerment. In order to discover factors that influence community involvement, commitment and participation within a conventional dialogue structure setting for community participation, Ngum et al. (2003) conducted a fact-finding survey on Knowledge, Attitudes and Practices (KAP) with respect to community participation in Tiko Health District in Cameroon. The study used semi-structured questionnaires to collect data on the

knowledge, attitudes and practices as well as suggestions towards improving community participation in the Tiko districts. The Rifkin et al. (1988) scale was also used to assess the level of community participation. Ngum et al. (2003) discovered that community participation in Tiko Health District in the year 2001-2002 was low due to the fact that the main actors did not know the meaning and goal of community participation. Their study recommends improvement in knowledge of community participation for a positive influence on community participation.

Many other studies have also tried to see the impact of community involvement in health decision-making. Gryboski, Yinger, Dios, Worley and Fikree, (2006) provide some evidence that community ownership of a health programme derives from a strong participatory process and, at the same time, promotes the full integration of the programme and its positive health benefits in the community. Gryboski et al. (2006) examined a range of approaches that community-level health programs have taken to implement participatory methods, and the evidence of such outcomes as impact and sustainability. They used India, Nepal, Peru and Senegal as case studies with each case study scored according to the Community Participation Program Development Continuum, a subjective determination of whether a project was low, moderate, high, or very high in the three areas of Equity/Inclusiveness, Management and Process, and Outcome Evaluation. They found that community participation was strong across all the case studies for programme planning, management and decision-making; and community

members were key to programme implementation, although community participation was low in the design or analysis of programme evaluation. However, Gryboski et al. (2006) recognizing the limitations of their study suggested that research still needs to be undertaken to better define and analyze the community participation process. Such research should include among others; better understanding of how community participation leads incrementally to changes in health outcomes, effective combinations of **quantitative and qualitative methods** that can yield important sources of information about programme effectiveness and suggest connections between process and outcomes. Gryboski et al. also suggested the need for more studies of cost-effectiveness and sustainability to understand the appropriate inputs needed for health improvements, and the timeframe needed to realize and sustain the outcomes.

Sepehri and Pettigrew (1996) report the research carried out in two villages in Nepal. The research was undertaken to compare and contrast the scope and extent of community participation in the delivery of primary health in a community-run and-financed health post (Ghandruk) and a state-run and-financed one (Sikles). Questionnaire-guided interviews with participant observation were used to elicit a range of information from sampled households in each village. In addition, personal interviews were also conducted with various other individuals involved in the delivery and organization of health care services. Although, the assumption was that benefits are greater under a community-financed health centre, since community-financing, as a tangible demonstration of community participation will

increase utilization. They found, contrary to this assumption, that no significant difference could be detected in the extent of the two communities' participation in the delivery and utilization of health services. They also discovered that the pattern and extent of community participation in health activities, was largely influenced by the physical, social and cultural environment. Their research however did not provide a detailed examination of the possible impacts of these socioeconomic and cultural factors.

Also writing on community participation for effective action and resource mobilization for health care delivery, Osibogun (1998) discovers in his study of Ala/Idowa (two small rural communities in Odogbolu Local government area of Nigeria) effective community cooperation in the area of health care financing. Members of the community were brought together to form a health society which runs a local Insurance health scheme to take care of the financial health needs of the community. The health society was registered with the state government which makes it possible for it to consider other forms of collaboration amongst its members.

While it is widely acknowledged that community participation is required for effective performance of health programmes and projects, Mahmood, Moss and Karmaliani (2003) discovered that there are organizational and socio political factors operating at the community level that also need to be understood. They discovered in their study of a district in Karachi in Pakistan that there are a

number of local factors influencing health system development among which are; politicization of community facility, inability of voluntary groups to cooperate in work, conflict over control of the development of a front-line hospital and local staff versus hierarchy. They also identified that organized interests at the community level determine the fate of any health system in Karachi. Their study of Karachi's community and health services provided evidence of how health services were shaped by the influence of local organizational and sociopolitical factors. Mahmood et al. (2003) therefore suggested further studies for a deeper understanding of these issues.

In the studies of the pattern of community participation in health activities, most of the scholars failed to investigate the influence of social, cultural, economic and political context of participation. As the proponents of the pentagram analytical model had suggested, it is the developmental processes of health care that need further exploration and research strengthening capabilities within countries. Further work needs to be done at the local level so that it is culturally, historically, ecologically, socially, and economically relevant to what these processes are and how they work (Rifkin & Walt, 1986).

Gillam (2008) has also observed that a community focused operational research agenda has been neglected in favour of research on individual interventions and he suggested an evaluation of new ways of organizing primary health care services in specific settings. This can be done when an investigations on the

operation of the health care systems is carried out within specific settings, taking into consideration its political, economic and socio-cultural environments.

Again most of these studies focused their investigation of community participation on specific programs operation within the community, and even while doing this ignored the contextual elements of participation. The studies failed to explore the social and political structures within which the programs operate. The present study addressed this limitation by going beyond analysis of community participation in specific programs to an investigation of how the community participates in the planning of the local health care system which is responsible for the provision of health care services at the community level. A study of this nature that investigates the extent of community participation in health care delivery will go beyond the dimension of participation to include the context of participation.

2.3 Health Care System Development in Nigeria

The health services of Nigeria evolved through a series of historical developments including a succession of policies and plans introduced by various administrations (Sorungbe 1990). Health policies in Nigeria have been enunciated in various forms, either in national development plans or as government decisions on specific health problem.

2.3.1 The Colonial Health Care System

The evolution of Nigeria's public health service began with the Ten-year Colonial Administration Plan from 1946 to 1956, when treatment was required for soldiers

of the West African Frontier Force (WAFF) and the Colonial administration's staff. The colonial medical service developed to provide free medical treatment to the army and the colonial service officers. The extension of the services to the general populace was incidental. It was a result of the integration of the army into the colonial government, treatment was extended to the local civil servants and their relatives and eventually, to the local population living close to government stations.

The objective of colonial medical service was to provide health service for: a) the nucleus of colonial officers and administrators including members of their family, b) the armed forces and the police, c) the members of the civil service particularly the senior civil servants. As Daramola (1981) rightly observes, the health service was never intended for the generality of Nigerians.

Social services such as health, provided by the colonial administration were minimal and aimed at serving the needs of their personnel and the armed forces (Ransome-Kuti 1992). Sir Hugh Clifford was quite explicit about this in a dispatch to his colleague in Sierra Leone, he stated that 'his medical Establishment (was) maintained almost exclusively for the benefit of the European population (Crowther, 1968).

The health care provided by the colonial administration was very limited. Some ideas of the limitations of the medical services in British West Africa were provided by the number of beds available in Government Hospitals. In 1936,

Nigeria had only 3,503 for Africans, and Gold Coast only 995. In Nigeria and Gold Coast, the number of doctors in government services, European and African was 190 (Crowther, 1968). Even then, many of these doctors and a considerable part of the funds were devoted to the medical needs of the European community.
The British placed greater emphasis on controlling fecal contamination of food and water. Hospitals were built principally for the benefit of colonial administrators and settler; and rural clinics were usually the residual efforts of missionaries' activities. From time to time, a few Africans elites were invited to use the colonial facilities established for non-settlers, such matters as health, education, mass immunizations, screening of populations for disease, and nutrition played only a small part in colonial policies (World Bank, 1994).

Throughout the colonial period, the religious missions played a major role in modern health care in Nigeria. According to Ogundeji (2002) the early Catholic and Protestant missionaries exerted great influence on the development of medical care in Nigeria. Mission-based facilities were concentrated in certain areas, depending on the religious and other activities of the missions. The Roman Catholic hospitals in particular were concentrated in the southeastern and midwestern areas. By 1954, almost all the hospitals in the midwestern part of the country were operated by Roman Catholic missions. The next largest sponsors of mission hospitals were, the Sudan United Missions, which concentrated on middle belt areas, and the Sudan Interior Missions, whose activities was restricted to the Islamic north.

There were other mission establishment with interest in medical work such as Church Missionary Society (CMS) founded by Dr. Van Cooten, the Methodist Mission led by Rev. Thomas Birch Freeman, the Baptist Mission led by Rev. Thomas Bowen, the Presbyterian Mission which was founded by Rev. Hope Masterton Waddel, the United Missionary Society led by Dr. Andrew Stirret, the Qua Iboe Mission led by Dr. Samuel Bill and the Seventh Day Adventist Mission.

The missions also played an important role in medical training and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe, for many of the first generation of Western-educated Nigerian doctors.

These networks of mission hospitals and voluntary agencies provided for the health needs of the mass of the population (Ransome-Kuti, 1992).

The end of the World War II came with the passage of the Colonial Welfare and Development Act. There was an inflow of resources from the metropolies to the colonies, and partly in response to nationalist agitation, the colonial government extended modern health and education facilities to some of the Nigerian population. This later resulted in the ten-year 1946-56 plan for development and welfare, covering all aspects of government activities in the country (Sorungbe, 1990). While it was observed that the planners were colonial officials, however,

the plan was acknowledged to be the first attempt in health development services in the country.

The 1946 health plan established the Ministry of Health to coordinate health services throughout the country, including those provided by the government, by private companies, and by the missions. The plan also budgeted funds for hospitals and clinics, most of which were concentrated in the main cities; little fund was allocated for rural health centers. There was a strong imbalance between the appropriation of facilities to Southern and Northern areas. With this plan, the first faculty of Medicine and University hospital in the country were established viz University College Ibadan which was founded in 1948. A number of nursing schools were also established. By 1960, there were sixty-five (65) government nursing or midwifery training schools.

Ityavyar cited in (Alubo 2001) notes that medical care under colonialism was patently curative and located in the urban centers, close to the target population. Services were elitist and relied on doctors and nurses rather than on aids or auxiliaries, and also on the home country for drugs, equipment and other supplies. National resources for health were primarily deployed to benefit the urban elite by means of an overwhelming emphasis on curative care provided through hospitals in towns and cities. The rural masses that constituted about 70 percent of the population depended on voluntary agencies or traditional forms of care. Thus resources for health flowed essentially in one direction towards the elite, best

educated and the most affluent in society (Ransome-Kuti 1992). However, the problem of health remained right to the time of independence.

2.3.2 Evolution and Development of Primary Health Care (PHC) System

General Yakubu Gowon, in 1975, announced the introduction of Basic Health Service Scheme (BHSS) as part of the Third National Development Plan (1975-1980). The Plan recognized the need for the federal government to make a greater and more effective impact on health during the Third Plan (Daramola, 1981). This was the first attempt to put a PHC service in place in the country.

There was a deliberate attempt to draw up a comprehensive National Health Policy focusing on such issues as health manpower development, the provision of comprehensive health care services based on the basic health service scheme, disease control, and efficient utilization of health resources, medical research, health planning and management. PHC through the BHSS was designed to correct the persistent problems of the Nigerian health care system, namely curative bias and the skewed distribution of facilities in favour of urban areas (Alubo, 1993).

The aims of the scheme were to:

(a) increase the proportion of the outcome population receiving healthcare from 25 to 60 percent,

(b) correct the imbalances in the location and distribution of health institutions and between preventive and curative medicine,

(c) provide the infrastructure for all preventive Primary Health Care (PHC) programmes (such as control of communicable disease, family health, environmental health, nutrition and others) and to,

(d) establish a health care system best adapted to the local conditions and to the level of health technology.

The plan for the implementation of BHSS was basically to,

(a) establish a basic health unit in every Local Government Area of about 150,000 population consisting of; 1 comprehensive health centre which will serve as the headquarters of the services, 4 primary health centres each to serve about 20,000 population, 20 health clinics each to serve about 2,000 population, 5 mobile clinics to link the comprehensive health centre and primary health centres with the health clinics.

(b) provide the health manpower required to man the services; 19 Schools of Health Technology, one in each state, were established to train three categories of community Health workers (the Supervisors, Assistants and Aides).

The Community Health Officers who are the most senior category of health workers were to be trained in the teaching hospitals (Ogundeji, 2002).

The British Ministry of Health assisted the Federal Ministry of Health to draw up a list of equipment for the three types of health facilities (Health Clinics, Primary Health Centres, and Comprehensive Health Centres) which were supplied to those built in various states between 1979 and 1983 (Ransome –Kuti, 1990).

According to Alubo (1993):

> Basic Health Service Scheme was by conception, grass roots-oriented, the local government areas – most of which are rural, were its fulcrum. The scheme was designed to lead to community participation, to complement other aspects of rural development, and to lead ultimately to self-reliance. As part of this goal of participation, each community was directed to select two of its members for training as village medical assistants, after which they would return and work in the community (Alubo, 1993, p. 234).

During the implementation of the scheme, the principles of PHC were not applied. The community did not in any way participate (Ransome-Kuti, 1990). There were other problems with the implementation of the scheme as Ransome-Kuti (1990 p.xv) further observes:

> The School of Health Technology did not equip the trainees with the skills to set up PHC system. To do this, they required a practice area in which the skills to be acquired were being practiced. Hence the trainees were trained to provide mainly curative services. The health facilities to which they were posted were converted to mini-hospitals. The aides, in particular never ventured out into the community but were used as messengers in the clinics, and the assistants behaved like 'doctors' diagnosing and treating patients and doing 'wards round'. Their contact with the community was minimal. Enormous quantities of sophisticated equipment were purchased contrary to the principles of self-reliance and appropriate technology. Dental chairs, theatre equipment, and X-ray machines were supplied to health centres but could not be used either because they were beyond the skills available in the area or there was a lack of basic elements of the infrastructure such as electricity and water….

It is apparent that the BHSS did not achieve its stated objectives. Some factors militated against the achievement of these objectives; politicization, leading to fractionalization of the Basic Health Units with various components of the units located in different LGAs of a state, instead of all the units being sited in one LGA. Twenty-five (25) health facilities were to be constructed in one Local Government Area. The buildings would be shared among different communities, not on the basis of need but on the basis of influence and politics, and would therefore be scattered throughout the states in a disorderly manner (Ogundeji 2002). The lack of community participation, the refusal of new cadre of staff trained to work but refused to work in the rural areas and their focus on provision of clinic-based curative services instead of community-based preventive and promotive activities were also features of the failure of the scheme.

According to Ransome-Kuti (1992, p. 11)

> the health care provided by local government for the rural mass totally neglected level of administration, reflecting the lack of concern for the rural majority which had characterized all administrations both during the colonial and post-colonial era.

By the end of 1983, with an expenditure of about N200 Million incurred, most of the facilities under BHSS remained uncompleted all over the country (Ransome-Kuti, 1998). At the end of the plan and up till 1985, no PHC service as envisaged by the BHSS plan or proposed in any form existed anywhere in the country. Furthermore, Alubo (1993, p. 234) observes that, in spite of the rhetoric about correcting curative imbalance, the major thrust of the scheme was ironically on

medical care rather than health care. Aspects such as food, nutrition, water supply, and community participation were hardly included in the implementation. BHSS's implementation therefore reflects the reduction of health problems to medical problems. As regard access, the scheme made no allowance for rapid increases in the population; consequently, a shrinking percentage of the population had access to medical care.

However, in spite of the problems associated with the implementation of BHSS and its failure to achieve its objectives, BHSS continued to be the thrust of health development during the Fourth National Development Plan-period 1980-1984.

It is to be noted therefore, that health care system in the country up till the end of the BHSS period centred mainly on curative rather than promotive and preventive aspects of health care delivery. It was more of medical services rather than health care services, bureaucratically controlled rather than community-oriented.

The process of community oriented approach focuses on the population health needs as determined by them and not by the health officials alone. Community themselves are seen as part of the decisions that inform the nature of health care delivery. Conceived this way, health decision making commences from the bottom-up through the community people, and not to be seen as the sole responsibility of health bureaucrats.

With the global declaration in 1978 of PHC as the key to the attainment of Health for All and its reaffirmation by the African Health Ministers in 1985, the Three-

Phase Health Development Scenario (TPHS) was adopted as a strategy for strengthening national health systems in the country (NPHCDA, 2001).

The Three-Phase Health Scenario recommended three-tier levels for health care delivery with PHC forming the primary level and central focus. This influenced the development of Nigeria's maiden health policy, which was developed between 1985 and 1986 and launched in 1988. This became the second attempt to provide a national health care system for the country.

Sorungbe (1990, p. 2), notes that the country's health services before the adoption of the national health policy showed major defects and had consequences for the health of the population. He identifies the followings to be the major problems:

i) The coverage was inadequate. It was estimated that no more than 30 percent of the population has access to modern health care services. Rural communities and the urban poor were not well served.

ii) The orientation of the service was incorporated with disproportionate high investment in curative services to the detriment of preventive services.

iii) The management often showed major weaknesses resulting in waste and inefficiency, as shown by failure to meet targets and goals. Voluntary organizations and other agencies providing health care with various inputs were poorly coordinated.

iv) The involvement of the community was minimal at critical points in the decision-making process. Because communities were not well informed on matters affecting their health, they were often unable to make rational choices.

v) Other defects include lack of basic health statistics, poor financial resource allocation to health services, especially in priority areas, and defective basic infrastructure and logistic support.

The National Health Policy was formulated in the context of Nigeria's national goals and philosophy which were clearly enunciated in the Second National Development Plan (1970-74), which described the five national objectives to make Nigeria:

(a) A free and democratic society;

(b) A just and egalitarian society;

(c) A united, strong and self-reliant nation;

(d) A great and dynamic economy;

(e) A land of bright and full opportunities for all citizens (Sorungbe, 1990).

The overall goal of the policy is the attainment of enhanced standards of health by all Nigerians in order to promote a healthy and productive life (African Development Bank, 2002). A health system based on PHC was adopted as the means of achieving the goal.

PHC incorporates seven essential features as shown in the table below.

Table 2.1 Seven Features of Primary Health Care (PHC)

No	Features of PHC	Quotation from Alma-Ata Declaration
1.	An element of the Health System	Primary health care… It forms an integral part both of the country's health system… It is the first level of contact of individuals, the family and community with the national health system….
2.	Focus on Priorities	…essential health care….
3.	Scientific Basis	…based on scientifically sound....
4.	Culture Sensitivity	…socially acceptable methods and technology
5.	Equity	…made universally accessible to individuals and families in the community…
6.	Community Participation	…through their full participation…
7.	Sustainability and self-reliance	….at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination.

Adapted from Nigerian Health Review (2007)

Since health development contributes to and results from socio-economic development, the sectors shall be mutually supportive and together contribute to the ultimate goals of the nation. Hence, development shall be seen not solely in humanitarian terms but as an essential component of social and economic development as well as being an instrument of social justice and national security (Sorungbe, 1990, p. 4).

The policy identified PHC as the cornerstone of the national health system and recommended four main strategies for its implementation.

(a) The promotion of community participation.

(b) The involvement of health-related sectors in the planning and management of the services.

(c) Strengthening of functional integration at all levels of the health system, and ;

(d) Strengthening of the managerial process for health development.

The policy prescribed a functionally integrated three-tier structure for the nation's health service.

The Federal government is to be responsible for:

(a) the development of national policies;

(b) the strategies to promote primary health care; and

(c) the provision of tertiary care.

The State Government is to be responsible for:

(a) technical assistance, logistic support and supervision of the Local Government Areas.

(b) secondary care in the form of General Hospitals and;

(c) training institutions especially for levels below that of the doctor, including primary health care workers.

The Local Government is to be responsible for:

(a) the development and maintenance of primary care;

(b) the training of community-based health workers such as the village health workers and the traditional birth attendants.

Each of the 774 LGAs in the country is responsible for operating the health facilities within its area, including the provision of basic out-patient, community health, hygiene and sanitation services. The State Ministry of Health coordinates activities and provides technical support. Health service delivery in each LGA is the responsibility of the Health and Social Welfare Counselor (ADB, 2002). Within this system of health governance and in relations to provision of PHC, the local government assumes the larger responsibility.

For the first time in the country, planning for health services implementation was done using the bottom-up approach. The national health policy was to guide the articulation of PHC strategy and the plan of action or its implementation.

2.3.3 Implementation of the PHC System

The implementation of the PHC started with fifty-two local governments. In order to meet the national health policy goal of 'Health for All by the year 2000', the emphasis of the PHC programme from 1986 to 90 was to develop health system infrastructure necessary for PHC that will ensure adequate coverage of the population with effective health services that meet the essential needs of individuals, families, and communities with their active involvement and participation at all levels.

Two levels of care were identified in the LGA: the village, the ward/district and the LGA headquarters. At the village level were the health centers. The process of implementation began from the bottom, by developing village health services.

Village communities are mobilized to discuss and agree on their health problems, and the strategies and activities to tackle them.

With technical assistance from the federal, state and local governments, villages were encouraged to form village health committees. These committees selected individual and traditional birth attendants for training as village health workers to provide the integrated preventive, curative and midwifery services at the village level.

The service provided by the village health team is supervised by community health workers based in the community and the health centers. The village health committee has full authority over the village heath services. Problems that cannot be solved at the village level are referred to the Health Center.

The local government is to provide, a health center in every ward/district manned by the team of community health workers. The services provided at the health center are under the authority of the ward/district health committee consisting of the chairmen of all the village health committees in the ward. The health center is the highest level of health care facility under the jurisdiction of the local government and in the nation’s PHC system. Problems that cannot be solved will be referred to the secondary health care system- the General Hospital, under the jurisdiction of the state government.

The state is to provide at least, a general hospital in every local government to serve as the apex of the local government health care system. Each local government health committee must select one of its village health committee chairmen to represent it on the management committee of the General Hospital.

Problems that cannot be solved at the level of the General Hospital will be referred to the Tertiary system under the jurisdiction of the federal government.

The federal government is to provide a tertiary facility in each state to serve as the apex of the health system in the state. In order to complete the management system designed for the National Health Service that ensures its ownership by the community, a village health committee chairman on the Board of the Teaching Hospital in the state.

The model Local Government Area (LGA) approach was used in the implementation of the programme. This means selecting some LGAs in which all the necessary steps in setting up the system and building their infrastructure will be taken so that promotive, protective, preventive, restorative, and rehabilitative services can be delivered to every citizen as required.

In 1986, 52 model LGAs were selected on the basis that technical support will be given by identified institutions. Twelve were to be supported by the Departments of Community Health of University Teaching Hospitals where community health officers are trained, 20 by the State Ministry of Health, and 20 by the Schools of Health Technology, (the state institutions in which PHC workers are trained).

The model local government areas had to undertake a number of steps in data collection, planning and strengthening of their management system in order to qualify for the federal grant of 500,000 Naira to begin the development of their PHC system (Ransome-Kuti, 1999).

These LGAs are to be used as practice areas for students. 32 other LGAs were chosen in 1987 on the basis of implementation of WHO's Women-in-Health programme.

In 1988, Bamako Initiative (BI) was introduced as a strategy to strengthen PHC in the country. BI was adopted in 1987 by African health ministers as a strategy for accelerating PHC implementation and ensuring access to essential health services to the majority of the population. The initiative placed emphasis on (i) the promotion and implementation of a minimum package of services; (ii) access to drugs at affordable cost; (iii) cost-sharing between government and users and, (iv) effective participation of the community in the local management of the health system (WHO, 2003).

The Bamako Initiative was adopted in 4 Local Government Areas as pilot. It was later extended to 6 Local Government Areas and to another 6 in 1991. The initiative continued in other Local Government Areas until it rose to 52 in 1995. DFID supported 17 Local Government Areas to implement Bamako Initiative (BI) between 1995 and 1999. All the Local Government Areas in the country joined in the implementation of the Bamako Initiative in 1998 (The Road, 2002).

Also in the same year, 26 more LGAs were selected in the implementation of the development of PHC system, the criteria chosen being to have been declared disadvantaged LGAs by virtue of topography (deserts, rivers, and mountains), size, or population density.

Another set of LGAs (so called 'willing LGAs', which term signifies their stated willingness to join the programme even though the full financial support of the federal could not be guaranteed) received 275,000 Naira each. On that basis, 128 LGAs joined in the implementation (Ransome-Kuti, 1999).

In 1989, some existing LGAs were divided which brought the total number of LGAs to 450, of which approximately 70 percent were included in the national PHC programme, either as model LGAs or as 'willing' LGAs (Sorungbe, 1990).
In 1990, the Federal Military Government directed states, which had participated fully in developing the LG PHC system to give responsibility for the system to the local governments.

The era of PHC as enunciated in the policy witnessed some obstacles in its implementation. According to Ogundeji (2002), as soon as the Fourth National Development Plan took off around 1985, the parameters on which resource expectations were based changed dramatically following the downturn in the world oil market. Foreign exchange earnings from crude oil fell from about US

$24 billion in 1981 to only about US $6 billion in 1985. An economic reform, the Structural Adjustment Programme (SAP) was put in place in September 1985 with a view to removing several areas of administrative control and adopting a free market oriented economy that would encourage private enterprise and the more efficient use of resources. SAP had a negative impact on the health sector resulting in decline in funding, quality of care and service utilization as a result of introduction of cost recovery policies. SAP led to cuts in spending on health and social services. The prescription of SAP namely, devaluation of the currency and the privatization of services especially in the social sector led to declining in standard of living and had negative impact on the quality and utilization of health services (NPHCDA, 2001).

The Review Team of World Health Organization that visited the country in 1992 noted that community mobilization would greatly be assisted if the boundaries of the health district are the same as the electoral ward which elects a councilor to the LGA (NPHCDA, 2006).

It was in the light of this observation that the National Primary Health Care Development Agency (NPHCDA) introduced the Ward Health System in 2001 by adopting the political wards as the operational units for the implementation of the PHC programme.

The goal of the Ward Health System (WHS) is to improve and ensure sustainable health services with full and active participation of people at the grass-roots level.

The Ward Health Services (WHS) provides PHC services to a political ward, constituency from where a councilor is elected into a local government council. It has a referral Ward Health Center (WHC) which provides integrated services to cover all PHC components as its apex health facility.

The National Academy of Science (2008) however observed that despite the subsequent establishment of the Ward Health System (WHS) which was primarily to promote active community participation, there still exists lack of community involvement in planning and implementation. Services are not based on health needs of the community. Delivery of services are also poor due to inadequate and dilapidated physical infrastructure, basic equipments, drugs and supplies and poor information system for evidence based planning and management of primary health care.

The Federal government tried to address these problems by constructing models of PHC centres. 381 model PHC centres were constructed between 2000 and 2005. Additional 293 were built between 2005 and 2007.

The new model PHC centre is to serve as apex health facility and referral centre within the ward. It is to coordinate and supervise all the health services within the ward, both at the facility and community level (NPHCDA, 2006).

The Table below shows the distribution of new federal model PHC centres by Zones.

Table 2.2: Distribution of the New Federal Model of PHC Centres (2001 - 2006) by Zones

Zone	No. Awarded	No. Completed
South East	85	49
South West	100	65
South South	78	49
North East	94	57
North West	126	79
North Central	90	60
National Total	573	359

Source: Nigerian Health Review (2007)

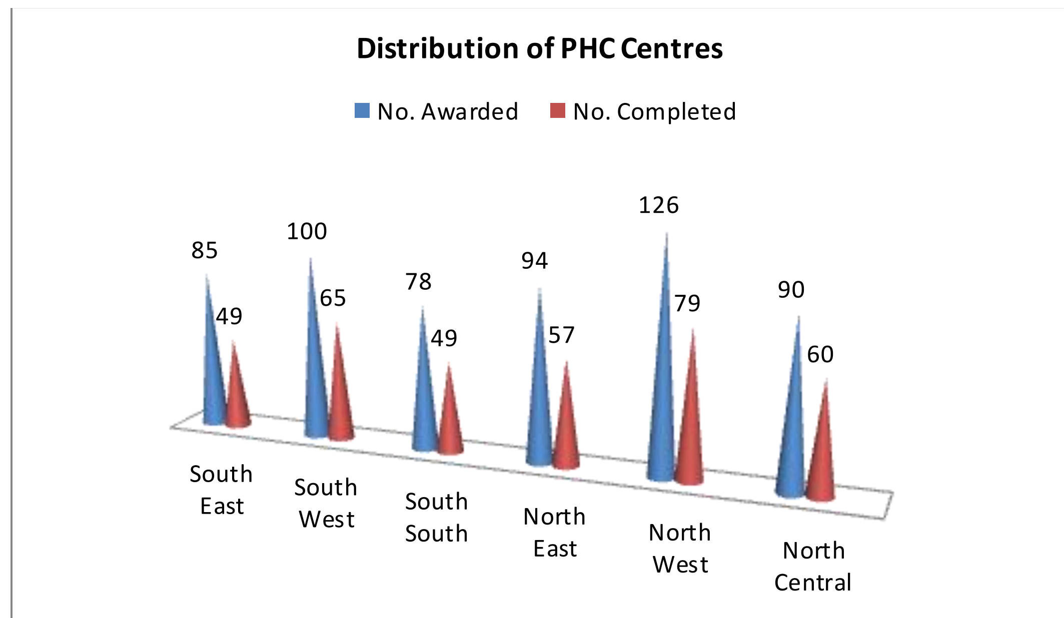

Figure 2.2 Distribution of the New Federal Model of PHC Centres (2001 - 2006) by Zones

It can be seen from the above table that, the federal government between years 2001 and 2006 was able to construct in the South-East 49 model PHC centres out of 85 numbers awarded. In the South-West 65 were constructed out of 100 awarded, and in the South-South, 49 PHC centres were constructed out of 78. In the North-East, 57 numbers of PHC were constructed out of 94. The government was able to construct 79 PHC centres out of 126 awarded in the North-West. In the North-Central, out of 90 PHC centres awarded, 60 numbers were constructed. In all the regions, the total numbers of PHC centres constructed were 359 out of the total numbers of 573 awarded. There was no region where the federal government was able to meet the target number of the PHC centres awarded for construction.

In a bid to strengthen the PHC, the Senate has also passed the National Health Bill. The bill aims to establish a framework for the regulation, development and management of the National Health System and underpins PHC as the entry point into the national health system (Nigerianmuse.com 2008).

At present, a National Health Reforms Agenda is being implemented by the present administration to carry forward the health strategies of the National Economic Empowerment and Development Strategy (NEEDS), New Partnership for Africa Development (NEPAD) and the Millennium Development Goals (MDGs).

The table below shows the current health indicators of the country.

Table 2.3 Nigeria's Health Indicators

Indicators	Both sex	Source and year
Life Expectancy	44 years	NPC 2007
Crude Birth Rate	43 per 1000 live births	NPC 2007
Crude Mortality Rate	14.7%	NPC 2007
Under-5 Mortality Rate	201/1000 live births	National Bureau of Statistics, 2007
Maternal Mortality ratio	800/100,000 live births	National Bureau of Statistics, 2007
HIV/AIDS prevalence rate	3.9%	NACA, 2007
%Safe water access	72% Urban/49% Rural	2006 estimates

Source: Human Resources for Health Country Profile - Nigeria (2008).

The major contributors to the disease burden of the country are Malaria, Tuberculosis (TB) and HIV/AIDS. Malaria is a major health and developmental problem in Nigeria, with a prevalence of 919 per 100,100 populations.

The country has the highest TB burdens in Africa and is fourth out of 22 TB high burden countries that contribute 80% to the estimated 3 million annual deaths from tuberculosis. The prevalence of TB in the country is 536/100 000 with an annual incidence of 283/100 000 and an estimated 105 000 deaths annually. Nigeria's current prevalence rate translates to an estimated 3.9 million people living with HIV and AIDS, the second highest prevalence in the world (Nigerian Health Review, 2007).

The crisis in the country's health sector is attributed to factors which include weak PHC infrastructures, inadequacy of the community or PHC services and the decline in the community participation in health care delivery.

2.4 Theoretical Framework

Frameworks of analysis for the emergence, formulation and implementation of public health strategies and policies exist. They are modes of analysis which focus on decision-making processes, but while some take a macro-view, others adopt a micro-view. Macro theories are concerned with power in political system, and can be differentiated by consensus or conflict as a theme. The micro theories of policy-making focus on the mechanisms and administrative routine of policy making (Walt 1994). However, both macro and micro theories provide separate ways in which public policy can be viewed and analyzed. These models are useful for an examination of how public health strategies and policies have emerged and developed within the policy process.

One way of explaining public health policy is to see it as a product of interaction within and between different political institutions (Baggott, 2000). Public policy is authoritatively determined and implemented by these institutions. An institutional approach focuses on the processes of agenda setting, policy formulation and policy implementation, and the ways in which these processes are influenced by relationships and procedures within and between institutions. The institutionalist focus means that the analysis of policy-making involves taking account of the way in which the configuration of interests and ideas within an institutional context shapes and determines the conduct of policy-making (Parsons, 1995). Informal arrangements such as policy networks can also come within the realm of institutional politics. These networks encompass pressure

groups, government agencies and other participants having an interest in a specific policy area (Baggott, 2000). Traditionally, the institutional approach in political science did not devote much attention to the linkages between the structures of government institutions and the content of public policy. Instead, institutional studies usually described specific government institutions in terms of their structures, organization, duties, and functions without systematically inquiring about the impact of institutional characteristics on policy outputs (Dye, 1987).

Dye (1987) however argues that, despite the narrow focus of early institutional studies in political science, the institutional approach is not necessarily an unproductive one. Government institutions are really structured patterns of behavior of individuals and groups. These stable patterns of individual and group behaviour may affect the content of public policy. Institutions may be so structured as to facilitate certain policy outcomes. They may give advantage to certain interests in society and withhold advantage from other interests. Certain individuals and groups may enjoy greater access to government power under one set of structural characteristics than under another set. Hays 2002 cited in Schmidt (2006, p. 98), avers that:

> ...institutionalism emphasizes the extent to which political conduct is shaped by the institutional landscape in which it occurs, the importance of the historical legacies bequeathed from the past to the present and the range of diversity of actors' strategic orientation to the institutional contexts in which they find themselves.

The impact of institutional arrangements cannot be ignored in understanding the process of policy formulation or how problems are defined (Parsons, 1995). Understanding the basic institutional and value structures in which policies are made gives meaning to the efforts at explaining why policies sometimes do not achieve their desired objectives. The structure of government institutions may therefore have important policy consequences. However, the institutional approach alone may not sufficiently aid our knowledge and understanding of the role of individuals and groups in public policy formulation and implementation and, as they affect both. The question of who influences policy is as important as investigating the role of institutions in policy process.

A commonly held view of democracy is that there are many ways in which people can participate in the policy process and so influence governments to promote the policies they want (Walt, 1994). The pluralists would argue that within liberal democracies political equality and individualism are protected by the fundamental political rights to vote and to free speech. Also that access to government is guaranteed through electoral choice, lobbying and other forms of pressure group activity and the mass media. The pluralist policy process would expect that policy output will be in the collective public interest because they have achieved majority support, and the government is the unbiased arbiter between many competing interests (Walt, 1994, p. 36). The elitist perspective challenges this view by arguing that power is in the hands of a few, and policy is decided by a small group of elites within or outside government. Elite model of the policy

process holds that power is concentrated in the hands of a few groups and individuals. Decision-making according to this model is a process which works to the advantage of the elite (Parsons, 1995).

Elitism as a theory of social power is most associated in its earliest form with the work of Robert Michels (1911, 1962), Vilfredo Pareto (1935), and Gaetano Mosca (1896, 1939). Their common thesis is that the “concentration of social power in a small set of controlling elites was inevitable in all societies….” (Evans, 2006, p. 41). One of the classical elite theorists Mosca argues that the history of politics has been characterized by elite domination – in all societies… two classes of people appear- a class that rules and a class that is ruled. The first class, always the less numerous, performs all political functions, monopolizes power and enjoys the advantages that power brings, whereas the second, the more numerous class, is directed and controlled by the first” (Mosca, 1939).

The conceptual scheme which Mosca and Pareto have handed down comprises some common notion that in every society there is, and must be, a minority which rules over the rest of the society. This minority known as the ‘political class’ or ‘governing elite’, composed of those who occupy the posts of political command and, more vaguely, those who can directly influence political decisions (Bottomore, 1964, p. 12). The classical elite theory therefore challenges the key premises of most western liberal assumptions about politics, the organization of government and the relationship between the state and civil society (Evans, 2006).

The classical elitists' ideas form the basis upon which later elite approaches were to be formulated. Later studies have followed the classical elitists closely in their concern with problems of political power in the society. Many elite theories suggest that policy decision is dominated by particular social classes within the society. Mills (1956, p. 3 - 4) advances that:

> the power elite is composed of men whose positions enable them to transcend the ordinary environments of ordinary men and women; they are in positions to make decisions having major consequences. Whether they do or not make such decisions is less important than the fact that they do occupy such pivotal positions: their failure to act, their failure to make decisions, is itself an act that is often of greater consequence than the decisions they do make. For they are in command of the major hierarchies and organizations of modern society

Lasswell (1936) in his contribution to elite approach took the view that:

> The study of politics is the study of influence and the influential… the influential are those who get the most of what there is to get…. Those who get the most are elite, the rest are mass (Lasswell in Parsons, 1995, p. 249).

The elitists therefore see power as concentrated in the hands of unrepresentative groups working in collaboration to confine the agenda and limit the area of public participation. In this regard, elite theorists have advocated two points; firstly, that not all people, particularly those with the greatest needs, participate in policy making, because there is a bias in favour of some and against others. Secondly, that there is this side of power reflected in constriction or containment of decision making achieved through manipulating the dominant community values, myths, and political institutions and procedures (Kamuzora, 2006, p. 65).

Despite the appeal of elite theory as a tool of political analysis, major flaws have been observed in its articulation. The pluralist critique of elitism rests on the view that these elites are not cohesive; that is they fail to act in concert. Thus, elites are seen as fragmented rather than integrated since each is involved primarily with his/her own relatively narrow concerns and constituencies (Evans, 2006). The formation of ruling elite requires not only control over important resources but also the establishment of unity and cohesiveness among its members. Again, Evans (2006, p. 57) contends that:

> when contrasted with other theories of the state, elite theory tends to be preoccupied with the nature and role of privileged elites in decision-making centres and pay less attention to developing a broader understanding of the relationship between the state and civil society….

However, despite the limitations, elite theory continues to provide an important insight into the analysis of politics. Elitism still provides an important focus for the work of political scientists because both the ownership and control of wealth and the monopoly of political power still reside in the hands of the few (Evans, 2006). As Varma (1975, p. 179) rightly observes, "politics cannot be studied properly without identifying the ruling class, or the governing and non-governing elites, and measuring their respective roles".

This study eclectically adopts the two theories using them as frameworks of analysis for a deeper understanding of the inter-related nature of health

governance and the effectiveness of public policy. Health policy in general and PHC in particular are formulated and executed within institutions. The need to investigate the diverse institutional arrangement for PHC policy becomes imperative. How does the division of responsibility among federal, state, local governments and other health- related agencies affect PHC implementation? For instance, the NPHCDA was established to interpret and support policies, provide guidelines and coordinate the implementation of PHC. Some of these functions have been eroded or taken over by other units of the Federal Ministry of Health (International Conference on PHC, 2008). Furthermore, the role of local authority in PHC delivery is of great importance as the PHC is the first contact of the people with the nation's health care system. Specifically, the delegation of primary care to local governments was intended to bring decision-making and services closer to where people lived and worked, thereby permitting the delivery of health care to be adapted and fine-tuned for local needs (Nigerian Health Review, 2007). The extent to which local governments adequately perform these functions determines the effectiveness of PHC in meeting the basic health problems of the people. The local government has been described as the weakest and the poorest tier of government and lacks the capacity for effective service delivery. This is borne out of the constrained imposed on local governments' position and authority within the country's inter governmental arrangement.

Policy-making can be viewed as involving the "authoritative allocation of values" and when interpreted broadly can include people making the policy as

government ministries as officials, as local health service managers or as representatives of a professional body (Hanney et al. 2003). Understanding the influence and power of these actors in particular for PHC policy determines the extent to which the policy meets the objective of solving the basic health care services in the country. In other words it is possible to explain the development of PHC and its operation in terms of the influence and power of some of these groups and, then examine the implication for health care service delivery. That PHC is a broad empowering approach to health care with its core principles geared towards improving the health of the population is not in contention. However, Morgan 1989 as cited in (Brodwin, 1997, p. 72) argues that although PHC rhetoric may have a strong egalitarian and progressive bent, actual PHC projects, once they are implemented, usually buttress the established political order. Vaughan and Walt (1984) in the same manner argue that PHC approach is essentially political; the way it is implemented in each country will reflect the political priorities and systems of that country. Although participation is the central feature of PHC, the World Health Organization (WHO) (2002) has observed that, even if community participation is embodied in the country's legal and administrative system, its effective implementation depends on many factors and so may not automatically result in a successful involvement of the community. Participation, especially in the context of community is intricately linked to question of democracy, power and control of health services.

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CHAPTER THREE

METHODOLOGY OF STUDY

3.1 Introduction

Methodology refers to the choices made in executing a research (Silverman, 2001). It is the means by which we reflect upon the methods appropriate to realize fully our potential to acquire knowledge of that which exists. It thus relates to the choice of analytical strategy and research design - which is the logical sequence that connects the empirical data to a study's initial research questions and, ultimately to its conclusions (Yin, 2002).

Social research methods can be categorized into two - the quantitative and qualitative research methods.

Quantitative research is based on statistical comparisons of the characteristics of the numerical measurement representing cases being studied (Manheim, Rich, Willnat and Brians, 2008, p. 429). The essence of quantitative research is the study of relationships between variables. For the quantitative researcher, reality is conceptualized as variables which are measured, and the primary objectives are to find how the variables are distributed, and especially how they are related to each other, and why (Punch, 2003, p.2).

The qualitative method is a research strategy designed to gather qualitative information, usually in narrative form, in order to describe or understand people in their natural setting (Manheim et al. 2008).

In an attempt to have an in-depth understanding of the phenomenon being studied, the method used in this research is both the quantitative and qualitative (a combined method study). “A combined method study is one in which the researcher uses multiple methods of data collection and analysis” (Creswell, 1994, p.174). This approach is known as triangulation, a term used by Denzin (1978) to argue for the combination of methodologies in the study of the same phenomenon. The concept of triangulation was based on the assumption that any bias inherent in particular data sources, investigation, and method would be neutralized when used in conjunction with other data sources, investigation, and methods (Denzin and Lincoln 2003). Denzin and Lincoln (2000) have also identified four types of triangulation:(i) data triangulation, which involves the use of a variety of data sources in a study, (ii) theory triangulation, this is where a researcher uses multiple perspectives to interpret set of data, (iii) investigator triangulation, this involves the use of several different researchers and (iv) methodological triangulation, which is the use of multiple methods to study a single phenomenon.

This study used the data and methodological triangulations in its investigation of the phenomenon under study. Through the multiple sources of data and multiple methods of data collection, the study was able to triangulate the findings of the qualitative with the quantitative. Also, the field interviews were used to validate our secondary data especially from the literature.

3.2 Study Area

The study area is Lagos. The state was created on May 27th, 1967 by virtue of the state (Creation and Transitional Provisions) Decree No. 47 of 1967 which restructured Nigeria into a federation of twelve states. However, Lagos as a trading port has a recorded history dating back to the Portuguese explorers of the 16th century. The state is composed of old Federal Territory of Lagos which remains the financial hub and was the Federal Capital of Nigeria (up to December 12, 1991), and the old Colony Province of the defunct Western Region of Nigeria comprising Badagry, Ikeja, Ikorodu and Epe Divisions.

Situated in the southwestern corner of the country, this elongated state spans the Guinea coast of the Atlantic Ocean for over 180km., from the Republic of Benin on the west to its boundary with Ogun state in the east. It extends approximately from latitude $6^0$2'North to $6^0$4'North and from longitude $2^0$45'East to $4^0$20'East. Of its total area of 3,577sq.km., about 787sq.km., or 22 per cent is water. Although Lagos state has been unaffected by subsequent state creation exercises in the country since the late 1970s, its local government structure, along with those of other states in the Federation, has been reorganized several times. These reorganizations have resulted in the establishment of following numbers of local government areas over time: eight in 1976; twenty-three in 1982; revert to eight in 1983; fifteen in 1991; and twenty in 1996. Presently, the state comprises 20 Local Government Areas (LGAs) and 37 Local Council Development Areas (LCDAs) (2009, OnlineNigeria.com).

3.2.2 Study Sites

The study sites comprised of Shomolu, Badagry, Surulere and Ikorodu Local Governments Areas.

Shomolu

Shomolu Local Government Area was formerly known as Mushin East Local Government Area, when it was carved out of the defunct Mushin Town Council in 1976.

Shomolu is located at the East Senatorial District of Lagos State. It is bounded by 3 Local Governments- Yaba Local Government Development Area, Bariga Local Council Development Area, part of Akoka, Bashua, Obanikoro, Pedro Village, Onike, Ikorodu Road, and Mushin Local Government.

The Shomolu Local Government Area is essentially inhabited by the Yoruba, prominent among them are the Ijebu, the Egba, Awori and Ilaje. However, other ethnic groups from East and Northern parts of the country are equally large in number in the Local Government.

Akoka the community in which the qualitative study was carried out is cosmopolitan in nature and is essentially inhabited by the Yoruba, Awori and the Ilaje. It is also inhabited by other ethnic groups from the eastern and northern parts of the country. Akoka is headed by a traditional ruler known as Baale.

Akoka is made up of one ward. The only available health center provides health services to Bajulaiye, Okesuna, Alase, Orile –Shomolu, Alade communities in Shomolu Local Government Area. Akoka has a number of both private and government owned academic institutions. These institutions however, have their

own health centres which cater for the needs of their members. Majority of the inhabitants of Akoka are civil servants. Quite a number of the populations in Akoka are self-employed in the informal sector.

Badagry

Badagry was traditionally known as 'Gbagle'. Badagry is a coasted town and a Local government Area (LGA) in Lagos State, Nigeria. It is situated between Metropolitan Lagos, and boundary between Benin at Seme.

Badagry was founded in the early 15th century on a lagoon off the Gulf of Guinea. Its protected harbor made the town to become a key port in the export of slaves to the Americas. From the 1840s, following the suppression of the slave trade, Badagry declined significantly, but became a major site of Christian mission work. In 1863, the town was annexed by the United Kingdom and incorporated into the Lagos Colony. In 1901, it became a part of Nigeria.

Badagry subsists largely on fishing and agriculture, and maintains a small museum of slavery.

Ilado community, a site of our qualitative study in Badagry comprises of one ward. Ilado is headed by a traditional ruler known as Baale.

There is a health centre which provides health services to other communities such as Aradagun, Imeke, Igbanko, Ago-Ajo, Obale, Iworo, Esepe-Mushin as well as riverrine communites - Ikotun, Maba, Okogbo, Ojogun, Dadi, Luwi, Ago-Ilaje. Ilado is essentially Awori community. Other ethnic groups of Nigeria also reside there. The major occupation of the inhabitants of Ilado is farming and mat weaving.

Surulere

Surulere is a Local Government Area (LGA) in Lagos, Nigeria. Surulere is a residential and commercial area. It is a cosmopolitan area located in the Lagos mainland in Lagos state with an area of 23 $km^{2.}$ It harbours the Lagos National Stadium which was built in 1972.

Ijeshatedo the site of our qualitative study has a functioning health center which provides services to communities in Itire-Ikate and Lawanson. Ijeshatedo is cosmopolitan in nature and is composed of almost all major ethnic groups in Nigeria. Ijeshatedo comprises of civil servants as well as a number of people engage in private business activities.

Ikorodu

Ikorodu is a Local Government Area (LGA) in Lagos State, Nigeria. Located along the Lagos lagoon, it shares a boundary with Ogun State.

Ikorodu was founded by Yoruba who settled in the area. The name Ikorodu is a form of 'Oko Odu' which means 'Odu farm'. During the 19th century, Ikorodu was an important trading post for the Remo Kingdom, it achieved this by being situated along the trade route between Lagos and Ibadan.

Igbogbo/Baiyeku is the site for the qualitative study in Ikorodu Local Government Area. Baiyeku has one health centre at Igbogbo and a children centre at Ewu-Elepe. The major occupation of the indigenes are farming and fishing. Baiyeku share boundaries with Orita and Ofin. The extension of lagoon to these communities provides a means of water transportation system to Ajah in Ibeju-Lekki Area of Lagos State (wikipedia free encyclopedia. mhtl).

3.3 Study Design

This study made use of both quantitative and qualitative research methods. The survey method of data collections was used. The survey has long been a central strategy in social research (Punch, 2003). Surveys include cross-sectional and longitudinal studies using questionnaires or structured interviews for data collection with the intent of generalizing from a sample to a population (Babbie, 1990, p. 118).

Basically, there are two broad types of data differentiated on the basis of their source; (i) the primary source and (ii) the secondary source. Data for this study came from both sources.

Primary Sources

For primary source of data, the study made use of various instruments of behavioural research methods of data collection viz, Questionnaire, Key Informant Interview (KII) and Focus Group Discussion (FGD).

Secondary Sources

The secondary data for the study were gathered from library and internet sources, which include books, journals articles and periodicals. Government publications from Ministry of Health and other health related agencies also served as resources for the study.

3.3.1 Quantitative Method

Quantitative method in this study involves the capturing of the range of activities in the relationship between community participation and the quality of health care in numerical terms.

3.3.2 Study Population

The study population comprised adults from age 20 years and above. It is assumed that at this age an individual is old enough to be aware of the activities in his/her community and will be able to contribute to community development. Since the study specifically targeted community participation in health care delivery, as such, sampled communities were selected from four Local Governments viz; Badagry, Surulere, Ikorodu and Shomolu in Lagos state. Using the Lagos State division and categorization of local governments into two zones (North and South) (Central Office of Statistics, Lagos, 2006), the four local Governments Areas were selected randomly from the two divisions Badagry and Surulere Local Governments Areas were selected from Zone 1 (South), while Ikorodu and Shomolu Local Governments Areas were selected from Zone 2 (North). Factors taken into consideration in the selection are the rural-urban variations as PHC must take cognizance of unequal development in the rural-urban centres. According to Moore (1984, p. 6), rural-urban variations are characterized by the following; ecology and landscape, size and density of human population, patterns of economic activity, economic function and characteristic patterns of human interaction.

3.3.3 Sample Size

It is common practice in social research to work with samples rather than the entire population, particularly when the population under consideration is very large, such as country, a region or an urban area (Blaikie, 2003).

A 'sample' means a smaller subset drawn from some larger group (Punch, 2003). Sampling is any procedure for selecting units of observation from a population and is used to make statement about the whole population (Selltiz, Jahoda, Deutsch and Cook, 1959, Babbie 2004).

Justification for sample size is based on various assumptions: (i) the time frame for the research, (ii) the financial implication of a very large sample size and (iii) the representativeness of the sample.

The study used a sample size of 1500, distributed amongst the four local governments. The sample size for each local government was based on proportional representation, since the population size of the local governments vary.

Population of the sampled local governments;

Badagry, 332,685,

Surulere, 1,183,886,

Shomolu, 949,730, and

Ikorodu, 558,422.

(Source: Central Office of Statistics, Lagos 2006).

The populations of all the four local governments were added to give the total population of 3,024,723. This was divided by the population of each local government, and the result multiplied by 1500 to get the number of questionnaires administered per local government. Thus, selected sample size for each local government was proportional to the population size of the local government. A total number of 587 questionnaires were administered in Surulere local government, 470 in Shomolu local government, 277 in Ikorodu local government and 166 in Badagry.

3.3.4 Sampling Method

The study used the multistage sampling method. The principles underlying multi-stage sampling is to start by sampling a population which is more general than the final one. At the second stage, on the basis of the first sample, a new population is considered, one which is less general than the first one, and a new sample is subsequently determined. The procedure continues until the population to be investigated is reached and a final sample is drawn. At each stage, sampling is done in a random way, using simple random sampling, interval or systematic sampling or stratified random sampling (Bless and Higson-Smith, 1995).

For this study, four local governments were selected randomly. In each of the sampled local governments, communities where primary health care centre(s) are located were also selected purposively for sampling. This is because location of PHC centre determines accessibility and usage. Other communities within the local governments were selected using simple random method. A total number of

22 communities were sampled. Streets were used to form a cluster in the sampled communities. Residential buildings were selected from the cluster using the principle of systematic sampling-which involves the selection of the *nth* subject or item from serially listed population subjects or units: where **n** is any number usually determined by dividing the population by the required sample size (Asika, 1991).

3.3.5 Pilot Study

A pilot study is a pretest that is conducted by doing a survey on a small sample of respondents similar to those who will be in the larger sample. It is the study in miniature and gives the researcher an opportunity to identify potential problems and to modify the research instruments before embarking on the main study. The pilot study enables the researcher to crosscheck; the accessibility of the sample group, the likely response rate and whether or not the data collection tool provides the depth, range and quality of information required (Hancock, 2002, p. 15).

A pre–test of the questionnaire was carried out to determine the validity of the constructed questions, question clarity and internal reliability. The feedback from the initial respondents selected for the pre-test provided the opportunity to reconstruct questions considered ambiguous and difficult to understand by the respondents.

3.3.6 Questionnaire Administration

Pre-coded structured questionnaires were administered face-to-face to members of the household selected for interview in the communities (Appendix I). The questions centered on services provided at the PHC centres in the communities, community involvement in the identification of health needs. Questions were also asked about the peoples' knowledge of the community's representatives' participation in the planning and management of the community health system.

Procedure:

Lists of communities in the selected local government were obtained from the Department of Agriculture in each local government. Questionnaires were administered in communities where primary health care centre(s) are located. Questionnaires were also administered in other communities which were randomly selected within the same local government. Since combination of streets constitutes a community, streets were used to form a cluster in a sampled community. The number of questionnaire administered in each community was determined by the total number of questionnaire allocated to each local government.

The principal researcher and the research assistants identified the number of residential buildings in a cluster. It is from the cluster that the buildings were picked using the principle of systematic sampling where every *nth* building is drawn from the cluster; in this case the interval size ranges between two and four depending on the number of buildings in a cluster. On getting to the building, the research assistant compiled the list of households in the selected building. In a

plural household building, the households to be interviewed were picked using the simple random method and questionnaire administered to the selected households. In a single household, questionnaire was administered to the occupant of the building. In a situation where the selected household was empty, the subsequent household was picked. This procedure was employed for all communities in the four local governments studied.

3.3.7 Qualitative Study

The study used the Pentagram Framework of Rifkin, Muller and Bichmann (1988) described in the literature to make an assessment of the process of community participation in the communities. Rifkin et al (1988) identified five indicators of participation; Needs Assessment, Leadership, Organization, Resource Mobilization and Management. These indicators take as their starting point that health improves through community participation and that broad participation builds on a wide range of activities and involvement of different community groups (Rifkin et al. (1988). This qualitative method allowed us to assess and describe community participation process in the communities. Focus Group Discussion (FGD) and Key Informant Interview (KII) were used as instruments of data collection (see Appendices II and III).

Procedure:

3.3.8 Focus Group Discussion (FGD)

The Focus Group Discussions (FGDs) were organized for members of Community Development Committee, Health Coalition and Community Health Promoters in each of the local governments. The choice of group interview was determined by the fact that by creating multiple lines of communication, the group interview offers participants a safe environment where they can share ideas, beliefs, and attitudes in the company of people from the same socioeconomic, ethnic, and gender backgrounds (Madriz, 2003).

A total of four FGD sessions were held in Ilado, Akoka, Ijeshatedo and Igbogbo-Baiyeku communities. Members of Community Development Committee, Health Coalition and Community Health Promoters in these communities were purposively selected for interviews. The selection was based on their rich experience in working with the health facilities in their communities. Each group consisted of between 8-12 participants (with at least 2 females) who had lived in the community for at least 10 years. Preliminary field trips were made to each of the four communities to seek dates of interviews with selected contacts. There were follow-up telephone calls to ensure that members of the focus groups were ready for the scheduled interviews.

Each interview took place at a location determined by the participants for sake of convenience; interviews lasted between an hour and half. Permission was sought

by the principal researcher from respondents to audio-tape the interviews, and this was granted. The FGD sessions were conducted with the aid of a discussion guide (see Appendix II). The responses were audio-taped, transcribed and then analyzed.

3.3.9 Key Informant Interview (KII)

Key Informant interviews were conducted with health officials working in selected PHC centre. One key informant per community was selected. Questions asked centred on the services provided at the health facility, adequacy of facility in meeting community health problems, community health financing and the involvement of community people and their representatives in health care development in the community. Interview guide was constructed for the key informant discussion (see Appendix III). Both the quantitative and the qualitative investigation were carried out between May and October, 2008.

3.4 Method of Data Analysis

Data analysis is a process of successively summarizing and distilling data in order to reach substantive conclusion (Punch 2003, p.45). The data are presented firstly by statistics that provide general information about the sample (frequency and percentage tables). The emergent data was also computer-processed using the Statistical Package for Social Science (SPSS version 10.0).

Chi-square-a test of significance for associations between nominal-level variables was first calculated for the variables. Bivariate analysis was also used to determine the empirical relationship between the variables (Babbie, 2007).

A Bivariate Correlation is a correlation between two variables (Field, 2000). It involves either establishing similarities or differences between the characteristics of categories of objects, events or people, or describing patterns or connections between such characteristics (Blaikie 2004).

The data collected through the qualitative method were analyzed under the five indicators (needs assessment, resource mobilization, organization, management and leadership) of participation of Rifkin et al. (1988). Ranking was performed for each of the community using Rifkin et al. indicators and ranking categories based on the information collected. The findings of the qualitative study were used to validate the quantitative analysis. On the basis of this conclusions were drawn.

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CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This section presents data on the demographic background and responses to questions which gauged perceptions of people on the following issues; Needs Assessment, Resource Mobilization, Organization, Management and performance of healthcare system in the communities. Responses are presented in frequency counts and percentages distributions and in column-chart graphics as shown below.

Tables 4.1 – 4.6 present information on the socio-demographic characteristics of the respondents which to a large extent determined how they perceived the questions asked and their responses to those questions.

Tables 4.7 – 4.24 present information on the perceptions of the people on various aspects and the process of community participation in the communities where the survey was carried out. The chapter also presents analyses of the results of the quantitative and qualitative studies. The analyses form the basis of the discussions in the next chapter.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Table 4.1 (Age of Respondents)

Age	Frequency	Percentage
20-29	114	7.6
30-34	772	51.5
35-39	176	11.7
40-44	213	14.2
45-49	90	6.0
50&Above	117	7.8
No response	16	1.1
Total	1498	100.0

Source: Field Survey 2008

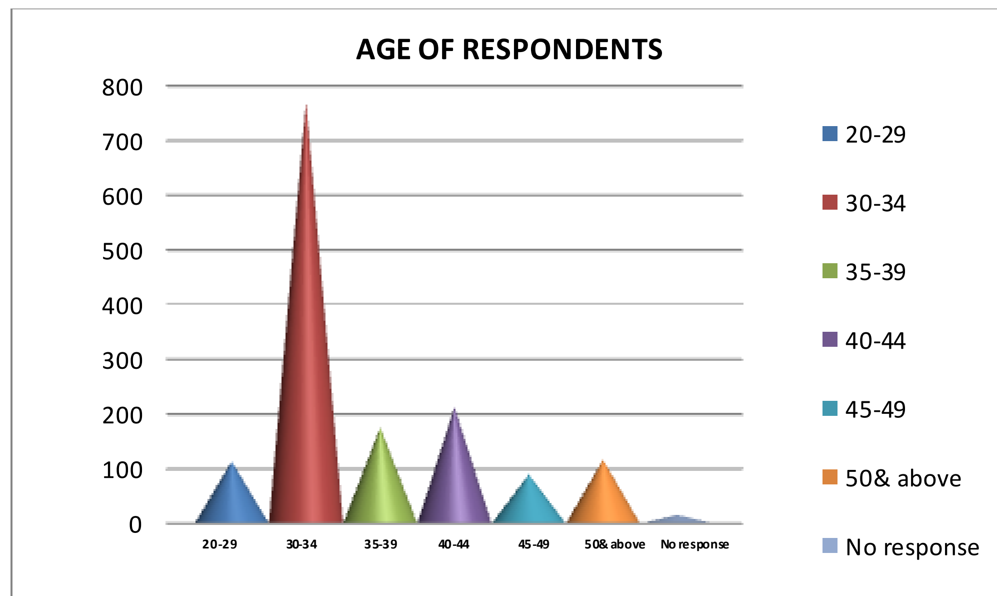


Figure 4.1 Age of Respondents

The respondents in the study varied in socio-demographic characteristics. The ages varied between 20 and 50 years & above. The respondents were already adults at the time the survey was carried out. The implication of this is that, the

respondents cannot be unaware of the activities in their communities and are able to participate in those communities' activities, including health care delivery.

Table 4.2 (Sex of Respondents)

Sex	Frequency	Percentage
Male	635	42.4
Female	807	53.9
No response	56	3.7
Total	1498	100.0

Source: Field Survey 2008

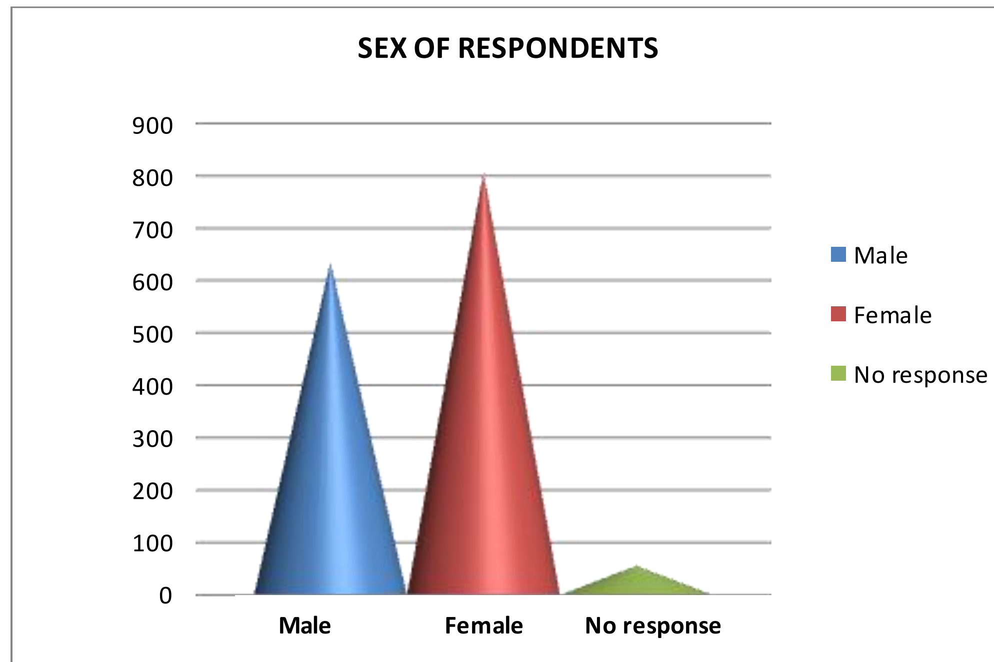


Figure 4.2 Sex of Respondents

The data showed that the respondents in the survey comprised of both male and female in the communities, although there are more female 807 (53.9%) than

male 635 (42.4%). However, this is an indication that both sexes in the communities participated in the investigation.

Table 4.3 (Marital Status of Respondents)

Marital Status	Frequency	Percentage
Married	1234	82.4
Single	132	8.8
Separated	44	2.9
Divorced	19	1.3
Widowed	59	3.9
No response	10	0.7
Total	1498	100.0

Source: Field Survey 2008

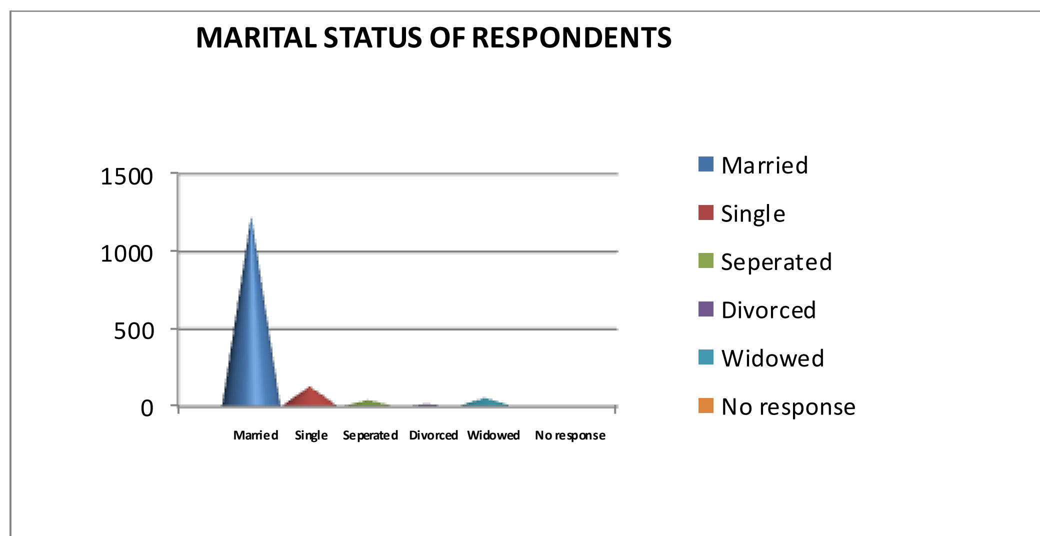


Figure 4.3 Marital Status of Respondents

The data showed that 1,234 (82.4%) of the respondents were married. This is instructive as respondents are adults and it was largely assumed that some of them would be married at the time the survey was carried out in the communities. It is

therefore assumed that family health, including family planning and other common health issues in the communities will not be strange to them.

Table 4.4 (Number of Children)

No. of Children	Frequency	Percentage
None	138	9.2
1-3	715	47.7
4-6	493	32.9
7and above	150	10.0
No response	2	0.1
Total	1498	100.0

Source: Field Survey 2008

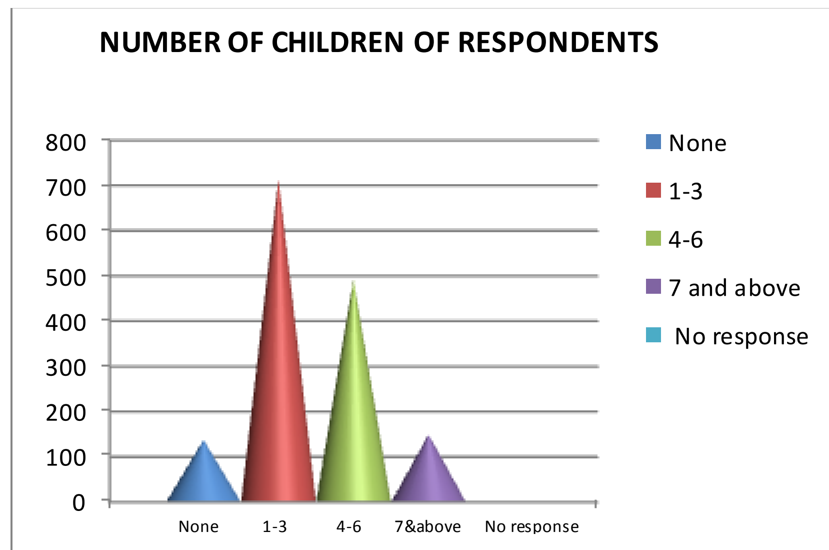


Figure 4.4 Number of Children of Respondents

According to the data in Table 4.4, about (90.6%) of the respondents said they have children although the numbers of children vary between 1 and 7. It is therefore assumed that the respondents will have knowledge on issues of child

health, maternal health (including reproductive health), adult health and family planning amongst others in the community health care services.

Table 4.5 (Educational Status of the Respondents)

Educational Status	Frequency	Percentage
None	260	17.4
Primary Sch.	432	28.8
Secondary Sch.	550	36.7
Higher Educ.	225	15.0
No response	31	2.1
Total	1498	100.0

Source: Field Survey 2008

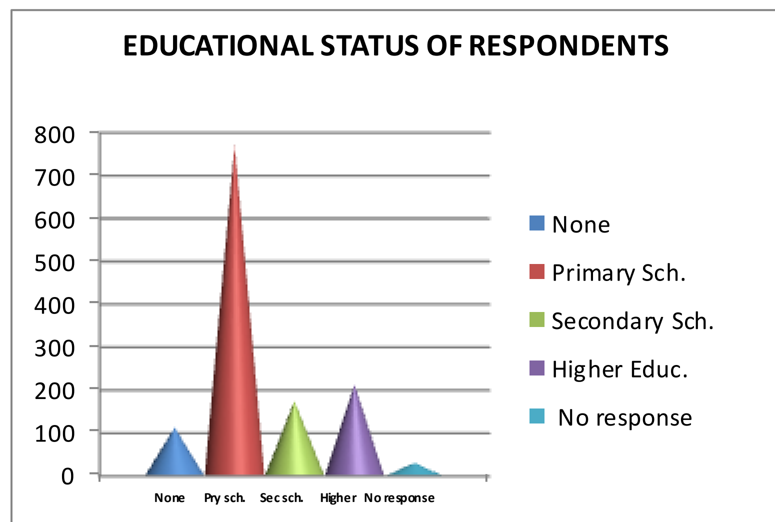


Figure 4.5 Educational Status of Respondents

The data showed that about (70%) of the respondents are educated, although their level of education varied (primary school, 28.8%, secondary school, 36.7% and higher education, 15%). This is an indication that majority of the respondents are

literate and able to understand the issues being investigated in the study and were able to respond to the questions asked in the questionnaires.

Table 4.6 (Occupation of the Respondents)

Occupation	Frequency	Percentage
Manager	507	34.0
Exec.Officer	58	3.9
Educationist	92	6.1
Health worker	39	2.6
Clerical asst.	37	2.5
Trader	385	25.7
Artisan	265	17.7
Others	43	2.9
No response	70	4.7
Total	1498	100.0

Source: Field Survey 2008

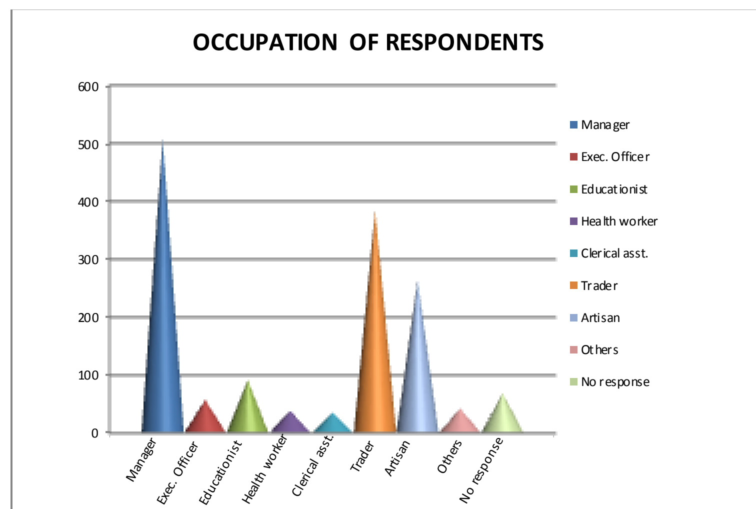


Figure 4.6 Occupation of Respondents

The respondents are engaged in one occupation or another. This is expected as their levels of education varied, although sizeable majority (43.4%) belongs to the group of traders and artisans in the communities as Table 4.6 indicated.

Majority of the respondents as indicated above belongs to the informal sector. The implication of this will include impoverishment of the people if more of healthcare financing in the communities is borne through Out-of-Pocket (OOP) payment or user fee.

NEEDS ASSESSMENT

Table 4. 7 (Health Centres/Clinics in the Communities).

No. of Health Centre	Frequency	Percentage
One	805	53.7
Two	616	41.1
Three	23	1.5
Four	3	.2
Five and above	4	.3
No response	47	3.1
Total	1498	100.0

Source: Field Survey 2008

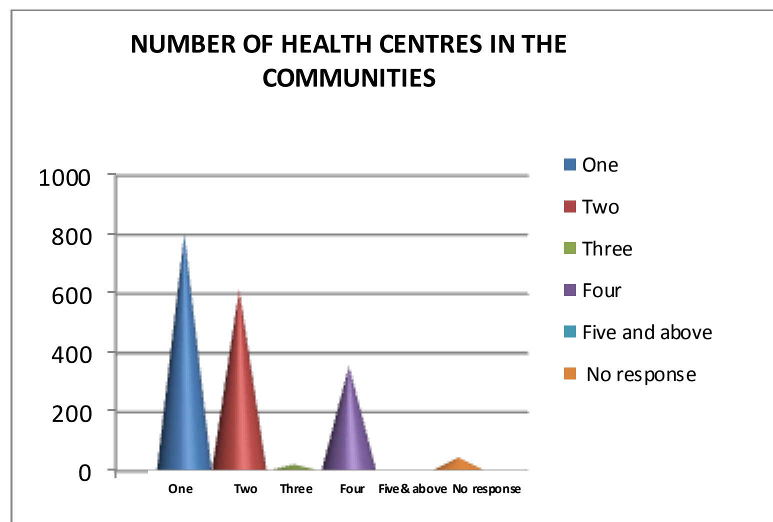


Figure 4.7 Number of Health Centres in the Communities

Data from the survey revealed that most of the communities have between one and two health centres which serve many other communities in the same area.

The implication of this is that health services may not reach most of the people in the communities due to the limited health facilities available in the communities and this may also affect community involvement in health care decision.

Table 4.8 (Use of Health Facilities)

Usage of facility	Frequency	Percentage
Every time	349	23.3
Once in a while	745	49.7
Don't use at all	327	21.8
No response	77	5.1
Total	1498	100.0

Source: Field Survey 2008

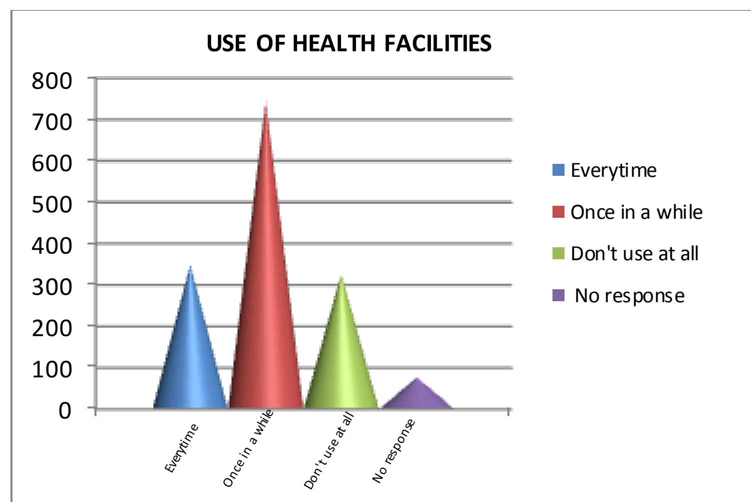


Figure 4.8 Use of Health Facilities

From the Table 4.8, some 349 (23.3%) of the respondents use the facilities always, 745 (49.7%) use the facilities once in a while, 327(21.8%) do not use them at all. This may also have implications for community participation as

availability and use of health facilities determines extent of participation. If people in the communities recognize that health facilities are available, and are good and within their reach, they are likely to make use of such facilities. Frequent usage will give the people in the communities opportunity to assess the adequacy and quality of health services been provided.

Table 4.9 (Health Services Determinants)

Health Services Determinants	Frequency	Percentage
The Government	701	46.8
The Community	107	7.1
Government and Community	347	23.2
Others	50	3.3
No response	293	19.6
Total	1498	100.0

Source: Field Survey 2008

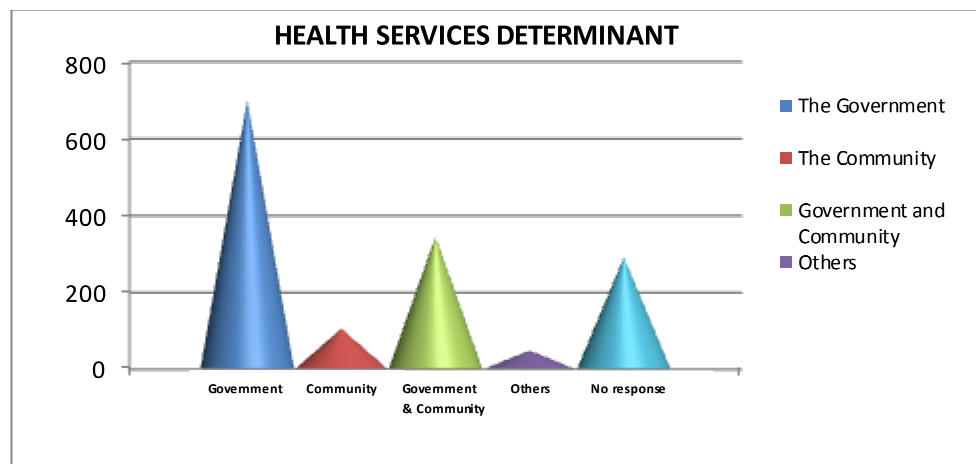


Figure 4.9 Health Services Determinants

The data showed that the government to a large extent determines the type of health services provided in the communities. A total number of 701 respondents (46.8%) were of the opinion that the government determines the provision of

health services, although, 347 respondents, (23.2%) claimed it is the responsibility of both government and the communities. It is clear that majority are of the view that the type of health services provided in the communities is determined by the government.

RESOURCE MOBILISATION

Table 4.10 (Health Care Financing in the Communities)

Health Care Financing	Frequency	Percentage
Government	821	54.8
Community	108	7.2
Community based organization	80	5.3
Government &Community	150	10.0
Government &Community based organization	48	3.2
Government,Community & Community based Organization	59	3.9
No response	232	15.5
Total	1498	100.0

Source: Field Survey 2008

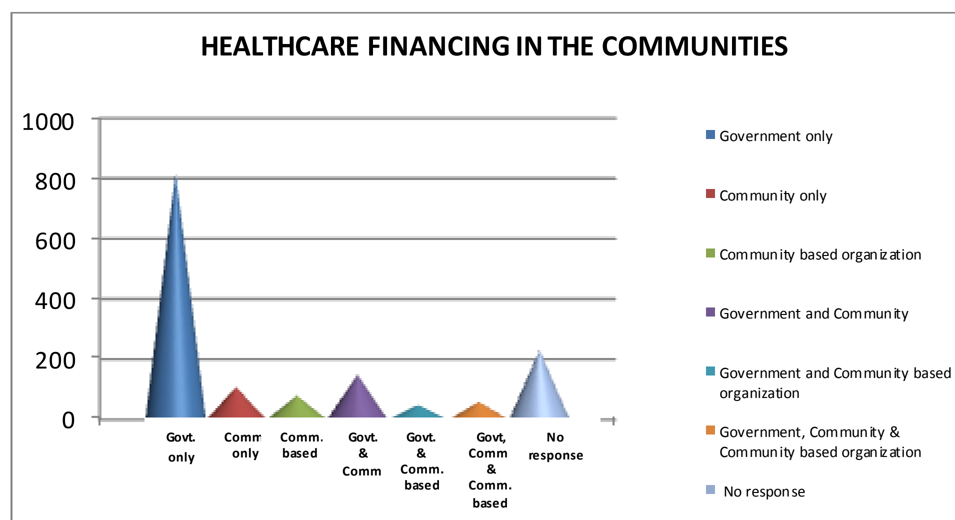


Figure 4.10 Health Care Financing in the Communities

The extent of community's involvement in health care delivery is evident when the issue of who determines the type of health care services is juxtaposed with the issue of health care financing in the communities. The strategy of PHC incorporates the concept of self-reliance, where communities shall be encouraged to finance health care directly, or find community solutions to health problems through the contribution of labour and materials. From the data, 821 (54.8%) of the respondents said that the government is the main financier of health care in the communities, while only 150 (10%) of the respondents said that the government and the community are responsible for health care financing.

Table 4.11 (Communities Supports to Health Projects)

Health Project Support	Frequency	Percentage
Manpower	520	34.7
Materials	150	10.0
Financial Contribution	173	11.5
All of the above	240	16.0
None of the above	201	13.4
No response	214	14.3
Total	1498	100.0

Source: Field Survey 2008

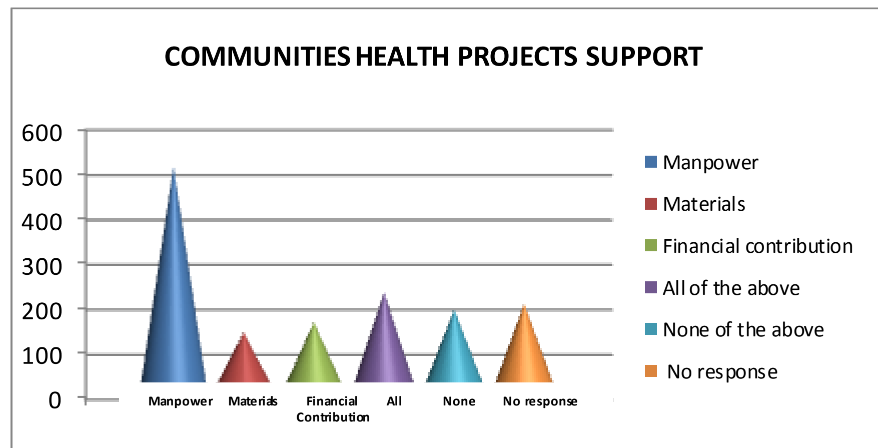


Figure 4.11Communities Health Projects Supports

The limited role of the communities in health care finance is also evident in their efforts in implementing and sustaining a health programme or project in the communities. One of the ways the communities participate is by providing necessary materials for health projects. 34.7% respondents said the communities participate in the implementation of health programmes and projects by providing materials for the projects. 10% of the respondents said the communities participate by providing manpower for the projects. This form of participation suggests that the people in the communities participate at the implementation stage of projects located in the communities. It is suffice to say that the people of the communities were not part of the conception of the projects but still give supports in terms of providing materials and man power. Communities' impact is only felt at the implementation stage. This is a minimal participation on the part of the people in the communities especially as the people only give supports at the tail end of the decision process.

The data from the survey revealed that community people do not necessarily contribute money towards health projects. Only 11.5% said they make financial contribution towards implementation of health project(s) in the communities. This seems not to be far from the fact that 70.2% of the respondents said they never contributed money towards any health project in the communities as indicated in Table 4.12.

Table 4.12 (Communities Financial Contribution towards Health Projects)

Financial Contribution to Health project	Frequency	Percentage
Yes	227	15.2
No	1051	70.2
No response	220	14.7
Total	1498	100.0

Source: Field Survey 2008

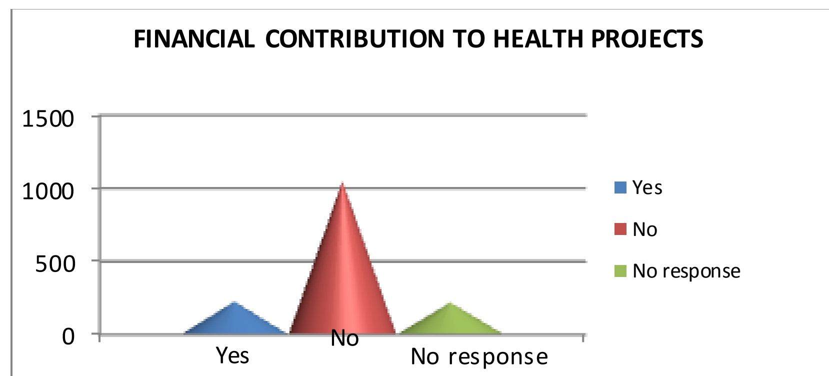


Figure 4.12 Financial Contribution to Health Projects

The responsibility of health care financing primarily lies with the government with support from the communities. According to our survey, 1,051 respondents about 70.2% said they never contributed money towards any health project in the communities. Only 227 respondents (15.2%) said they did. The reasons for this may not be unconnected with the fact that community people are not involved in the identification of health needs of the communities and therefore, do not see themselves as co-owners of health care facilities and programmes/projects in the

communities. This has implication for community participation in health care service delivery.

Table 4.13 (Respondents and Payment for Health Services)

Payment for services at the health facility	Frequency	Percentage
Yes	362	24.2
No	1035	69.1
No response	101	6.7
Total	1498	100.0

Source: Field Survey 2008

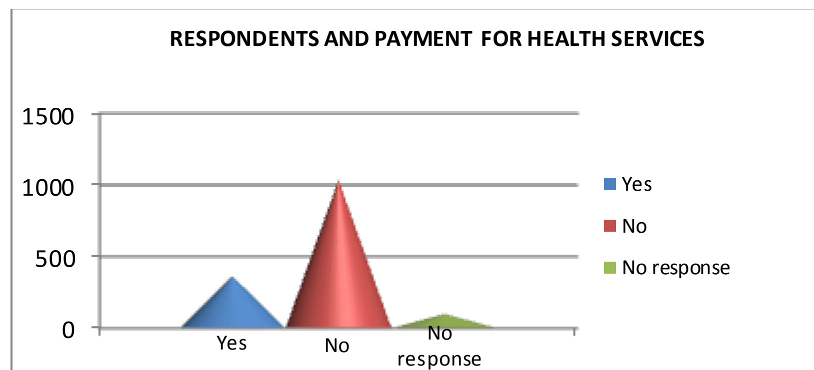


Figure 4.13 Respondents and Payments for Health Services

Table 4.13 shows that the majority of the respondents 1035 (69.1%) claimed they do not pay for health services at the facilities, while 362 (24.2%) of the respondents claimed they make payments for health services rendered at the facilities. This is an indication that some of the health services required by the communities are not available at the facilities. Private hospitals and clinics make up for the inadequacies of the public health facilities in the communities.

ORGANIZATION

Table 4.14 (Development Committee)

Development Committee	Frequency	Percentage
Yes	1091	72.8
No	313	20.9
No response	94	6.3
Total	1498	100.0

Source: Field Survey 2008

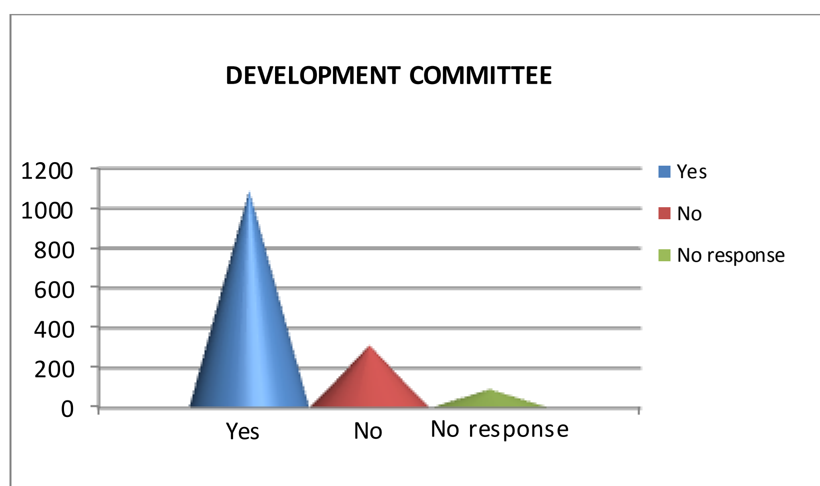


Figure 4.14 Development Committees

PHC strategy recommends a structure at the community level to represent the community people in the planning and management of the local health system. The committees' role is to ensure that their facilities are in good shape and the equipment and drugs are not pilfered. From Table 4.14 above, majority of the respondents 1,091 (72.8%) said that Development Committees existed in all the communities. But as the next Table indicates, the people of the communities

varied in their opinion of how the committees work with health officials to run the health centres.

Table 4.15 (Committees Participation and the Operation of Health Facilities)

Committee and the running of health centre	Frequency	Percentage
Yes	324	21.6
No	739	49.3
Don't know	356	23.8
No response	79	5.3
Total	1498	100.0

Source: Field Survey 2008

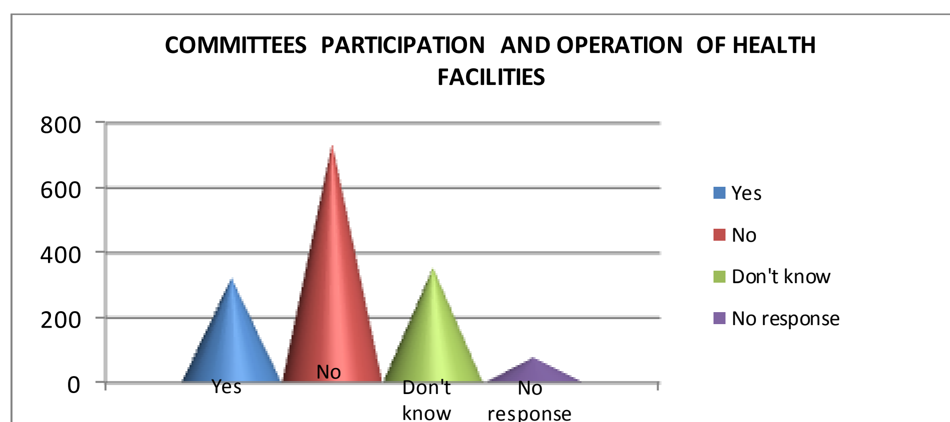


Figure 4.15 Committees Participation and the Operation of Health Facilities

Community peoples' knowledge of whether the committees participate in the operations of the health centres also varies. 739 (49.3%) of the respondents said the committees do not take part in the running of the health centres, while 324 (21.6%) claimed they do. 356 (23.8%) of the respondents could not say whether the committees take part or not. This is an indication that the community people though are aware of the existence of the committees, but do not really know how the committees work with the health professionals.

Table 4.16 (Frequency of Committee's Meetings with Health Officials)

Committee's meeting with health officials	Frequency	Percentage
Once a week	292	19.5
Every two weeks	307	20.5
Once a month	429	28.6
Every three months	51	3.4
Every six months	47	3.1
No response	372	24.8
Total	1498	100.0

Source: Field Survey 2008

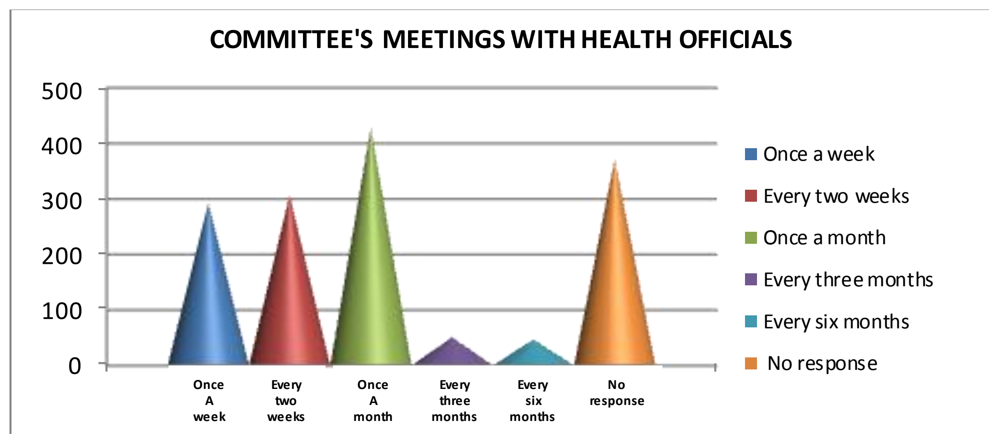


Figure 4.16 Committee's meetings with Health Officials

Respondents' knowledge of the frequency of the committees' meeting with health officials varies, however, community members know that their representatives do meet with health officials. 429 (28.6%) of the respondents claimed that the committees meet with health officials once in a month, 307 (20.5%) of respondents said they meet twice in a month, while 292 (19.5%) of them claimed that they meet weekly with health officials to discuss health matters. 51 (3.4%) of the respondents said they meet with health officials every three months while 47

(3.1%) said they meet every six months. Development Committees' meeting with Health Officials in the communities is one form of participation in health development no doubt. From our field survey, it is apparent that community people are aware of meetings between Development Committees and Health Officials in the communities, however, their knowledge of the frequency of the meetings varies.

MANAGEMENT

Table 4.17 (Communities Representatives' Participation on Health Matters)

Community Participation & Health Development	Frequency	Percentage
Meetings with health officials on health Matters	274	18.3
Bringing health matters to the attention of health officials	378	25.2
Mobilization of community members to fund health projects	229	15.3
All of the above	304	20.3
No response	313	20.9
Total	1498	100.0

Source: Field Survey 2008

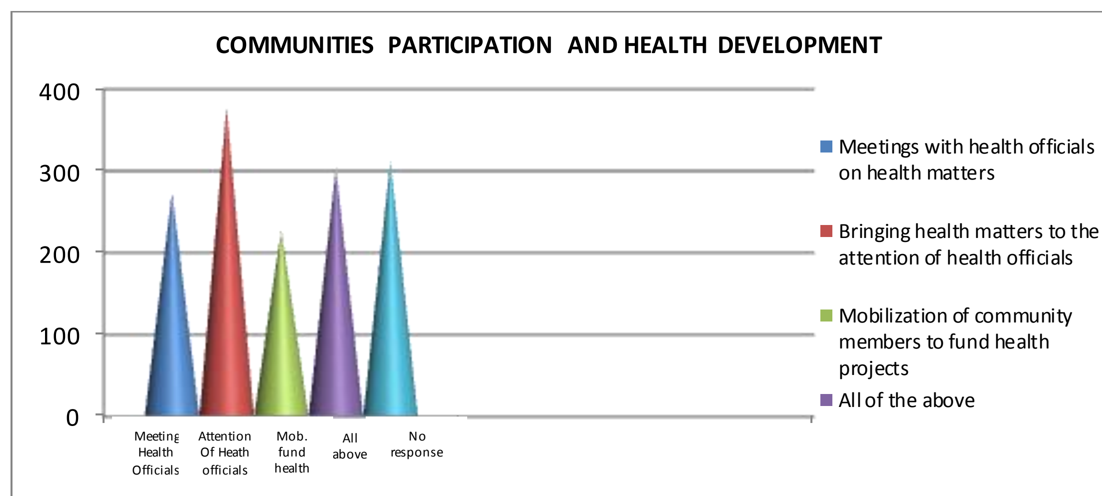


Figure 4.17 Communities Participation and Health Development

The community people were of the opinion that their representatives participate in the community's health care development in different ways. Our survey reveals that people of the communities have different perceptions of community participation. To some of the respondents, attending meetings translates to participation, while some other people see the ability of their representatives to mobilize community people for health action as participation. Specifically from Table 4.17, 274 (18.3%) respondents said their representatives participate by attending meetings with health officials to decide on health matters of the communities. 378 (25.2%) respondents said they participate by bringing important health matters to the attention of health officials, while 229 (15.3%) respondents said their representatives participate by mobilizing community members to fund health projects.

Table 4.18 (Communities Participation in the Implementation of Health Project/Programmes)

Community Participation in Health Programmes	Frequency	Percentage
Provision of manpower	453	30.2
Provision of materials	504	33.6
Financial contributions	92	6.1
All of the above	190	12.7
No response	259	17.3
Total	1498	100.0

Source: Field Survey 2008

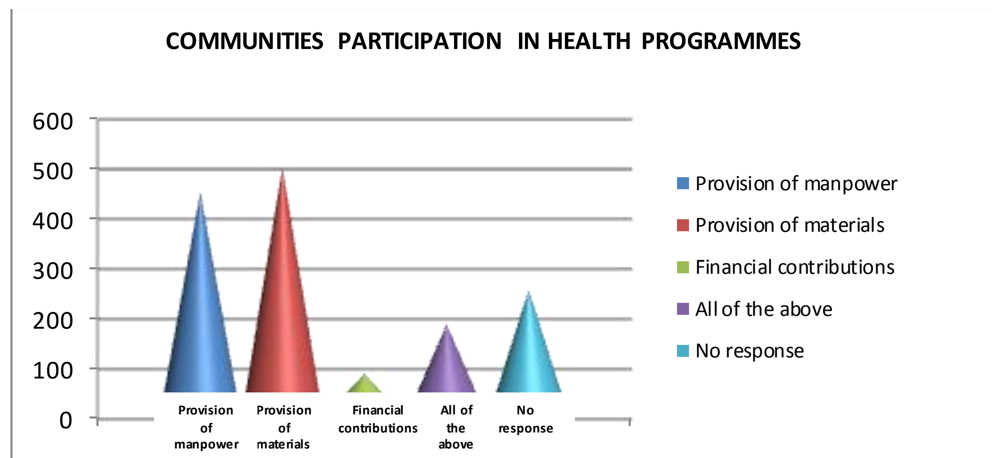


Figure 4.18 Communities Participation in Health Programmes

It is evident from Table 4.18 above that community people participate in the implementation of health projects/programmes in their communities by providing needed manpower (30.2%), materials (33.6%) and making financial contributions (6.1%) towards such projects and programmes. Though, this is done in different degrees as Table 4.18 revealed.

Table 4.19 (Communities and Continuity of Health Projects)

Continuity of Health Projects	Frequency	Percentage
Participation in implementation	735	49.1
Community monitoring	300	20.0
Financial contributions	59	3.9
All of the above	144	9.6
No response	260	17.4
Total	1498	100.0

Source: Field Survey 2008

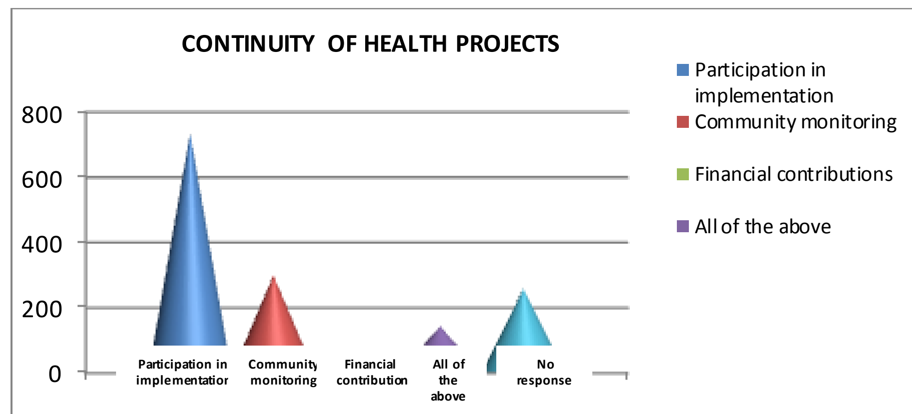


Figure 4.19 Continuity of Health Project

Table 4.19 also revealed that the community ensured the continuity of health projects in their communities by participating in the implementation of such projects, monitor and make financial contribution towards the projects. From the Table above, 735 (49.1%) respondents participated in the implementation of projects, 300 (20.0%) respondents monitored the projects to keep such projects running while 59 (3.9%) respondents will make financial contributions towards the projects. 144 (9.6%) respondents claimed they participate, monitor and make financial contributions towards projects in the communities to keep them running.

LEADERSHIP

Table 4.20 (Leadership Representation of Groups within the Communities)

Community Groups representation in the Committee	Frequency	Percentage
Yes	907	60.5
No	349	23.3
Don't know	190	12.7
No response	52	3.5
Total	1498	100.0

Source: Field Survey 2008

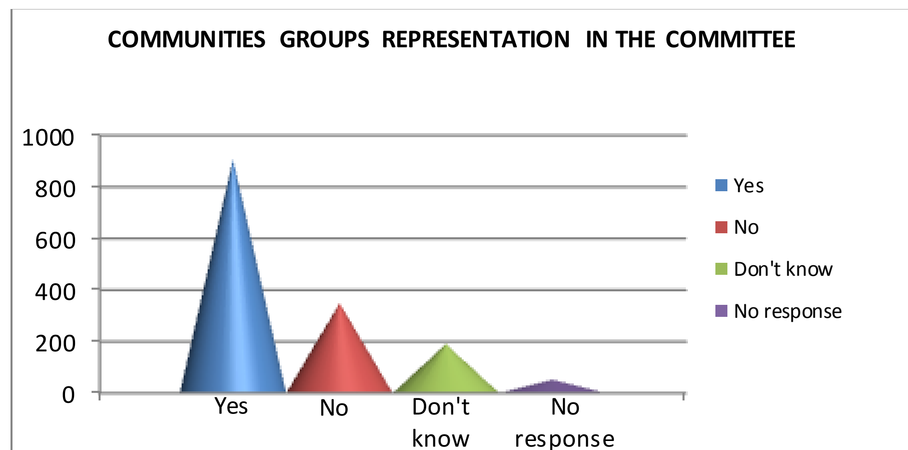


Figure 4.20 Communities Groups Representation in the Committee

From Table 4.20, 907 (60.5%) respondents said the leadership represents various groups within the community. This may explain the reason why the community people rated high the quality of their leadership in the community. To this extent it is expected that various health matters will receive adequate attention.

Table 4.21 (Communities' Leadership and Groups' Health Matters)

Leadership representation on groups' health matters	Frequency	Percentage
Ensuring different groups are represented on the committee	482	32.2
Ensuring various health matters receive health officials attention	192	12.8
Both	565	37.7
No response	259	17.3
Total	1498	100.0

Source: Field Survey 2008

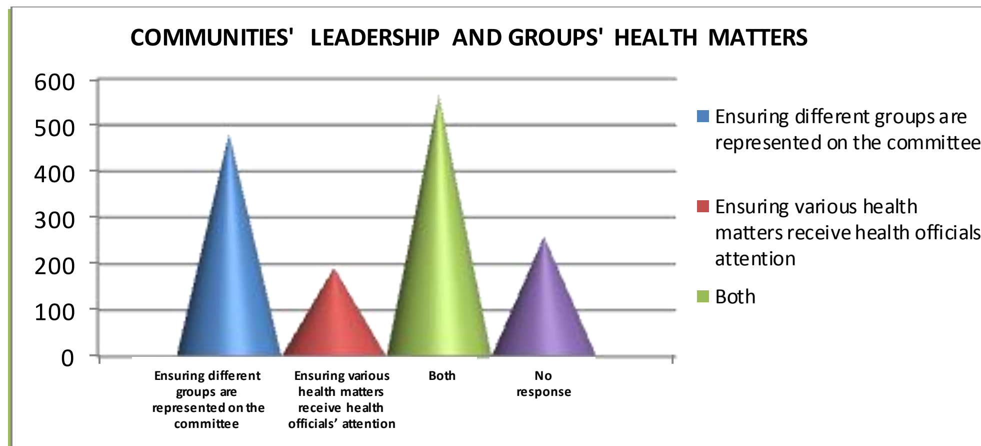


Figure 4.21 Communities' Leadership and Group's Health matters

The knowledge of the respondents' on how the leadership of the communities ensures that various groups' health matters received attention varies. About 192 (12.8%) of the respondents claimed that the leadership ensures that various groups' health matters received attention by bringing such health matters to the attention of health officials. 482 (32.2%) of the respondents said ensuring that

various groups' health matters received attention is done by adequate groups' representation on the committee.

Table 4.22 (Most Common Health Problems in the Communities)

Common Health Problem(s)	Frequency	Percentage
Malaria	906	60.5
Measles	43	2.9
High Blood Pressure	36	2.4
Cough	277	18.5
HIV/AIDS	141	9.4
Body pains	24	1.6
Cholera	19	1.3
Diabetes	4	0.3
Diarrhea	4	0.3
No response	44	2.9
Total	1498	100.0

Source: Field Survey 2008

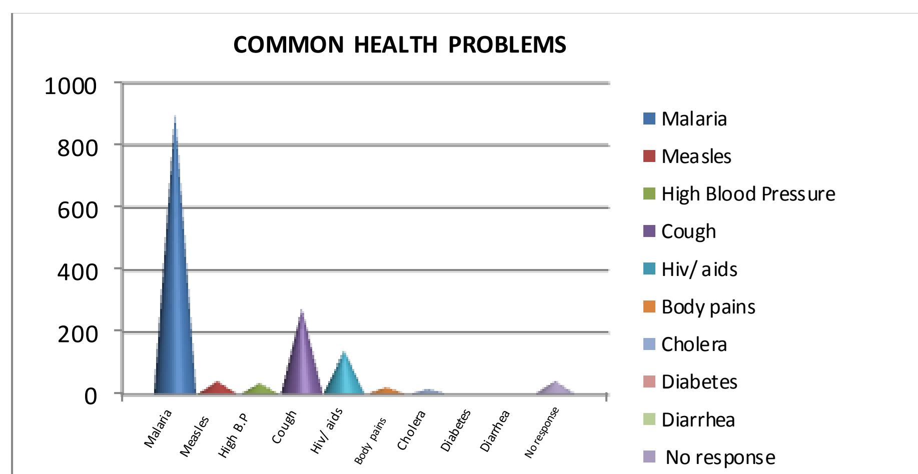


Figure 4.22 Common Health Problems in the Communities

Malaria is relatively high prevalence health problem in the communities. According to Table 4.22 majority of the respondents 906 (60.5%) claimed Malaria is the most common ailment in the communities.

Table 4.23 (Causes of Communities' Health problems)

Reasons why community Suffers from the health problems	Frequency	Percentage
Poor access to water	372	24.8
Poor quality of water	856	57.1
Insufficient knowledge on Prevention of disease	71	4.7
Poor access to health facility	21	1.4
Poor quality of health facility	31	2.1
High cost of treatment	51	3.4
Others	53	3.5
No response	43	2.9
Total	1498	100.0

Source: Field Survey 2008

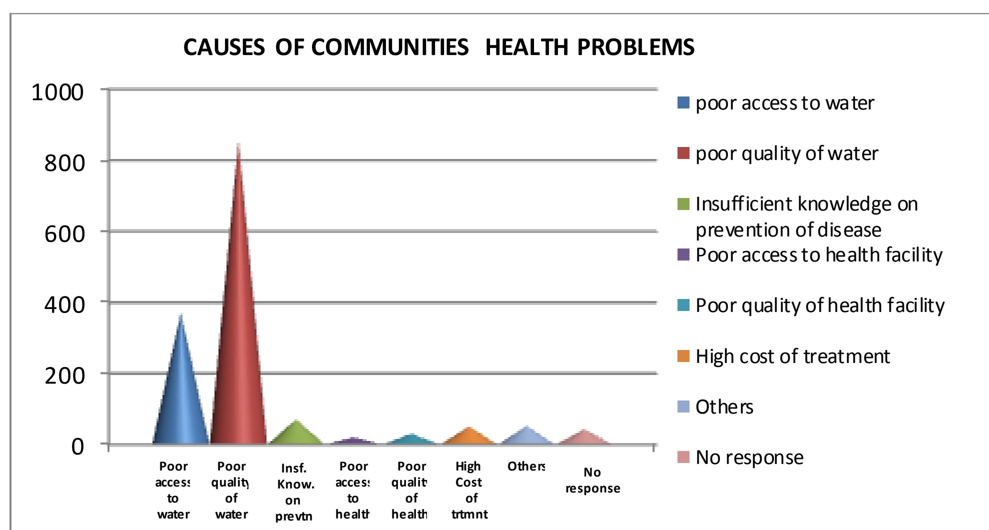


Figure 4.23 Causes of Health Problems

The respondents in Table 4.23 attributed health problems to many causes, this include lack of access to water and poor quality of water, poor health facilities and high cost of treatment as well as insufficient knowledge about the treatment of the ailment. The social determinant of ill-health in the communities is evident

as a high percentage 81.9% of the respondents attributed the cause of the many of illness in the communities mainly to poor access to water and poor quality of water and sanitation.

Table 4.24 (Quality of Healthcare in the Communities)

Community's views on the quality of healthcare	**Frequency**	**Percentage**
Very good	146	9.7
Good	234	15.6
Fair	1007	67.2
Poor	108	7.2
Very poor	3	0.2
Total	1498	100.0

Source: Field Survey 2008

Figure 4.24 Quality of Healthcare

From Table 4.24, 146 (9.7%) respondents claimed the health care service is very good. 234 (15.6%) of the respondents said it is good, while 108 (7.2%) described it as poor. However, most of the respondents 1007 (67.2%) said the quality of health care services in all the communities is fair. This is an indication that the present health care system does not produce optimal satisfaction to the people of the communities and also depicts the state of the healthcare delivery services which is not meeting the basic health care demands of the people. This is suggestive of the need for health care service improvement that will address health problems of the population.

The Pentagram Dimension and the Communities' Rankings

Using Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs), a series of questions were developed (Appendix II and III) to elicit information from members of community organizations and key informants in the health sector. Information gathered was organized around certain categories using the five process indicators viz (needs assessment, resource mobilization, organization, management and leadership) developed by Rifkin et al. (1988). Relative ranks were assigned to each of the five process indicators in the communities (see Table 4.26). The study was able to draw a breadth of community participation process in health care decision-making in the four communities; Akoka, Ilado, Ijeshatedo and Igbogbo/Baiyeku.

Indicators:

(i) Needs Assessment (NA)

(ii) Resources Mobilization (RM)

(iii) Organization (O)

(iv) Management (M)

(v) Leadership (L)

Rank categories:

1= narrow community participation,

2= restricted/small community participation,

3= mean, fair community participation,

4= open, good community participation,

5= wide, excellent community participation (Rifkin et al. 1988).

4.25 Health Care Services Available at the PHC Centres in the Communities

Igbogbo/Baiyeku	Ijeshatedo	Ilado	Akoka
(1)Family planning (2)Children health including immunization (3)Ante-natal clinic (4)Health education (5)Outreach programmes	(1)Family planning (2) Health education (3) Immmunization (4) Ante-natal clinic (5)Out-reach programmes	(1)Family-Child welfare services Including immunization (2)Maternal health delivery (3)Nutrition (4) Family planning (5)Out-patient Delivery services (6)Out-reach programmes	(1)Family planning (2)Ante-natal clinic (3)Child welfares services including immunization (4)General-outpatient services (5)Out-reach programmes (6) Health education

Source: Field Survey 2008

Evidently, from the qualitative data, the communities under study; Ilado, Ijeshatedo, Igbogbo/Baiyeku and Akoka participate, in varying degrees, in the planning and management of their local health care system.

Community organizations exist in the four communities. Community Development Association, Health Coalition Groups, Community Health Promoters, Community Development Committees. Though these organizations participate in identifying the health needs of the community, their participation is mostly evident in the outreach service provided by all the health facilities visited in the communities.

Outreach service involves visits by health officials and community organizations to areas that are far from the health centre. Outreach services may focus on individual preventive measures such as immunization and oral rehydration therapy, or community-wide health promotion, such as education on child nutrition or adult diet and exercise. These services depend substantially on community support and mechanisms for identifying, training, and supporting village or community health workers (Gillam, 2008). In spite of the fact that community organizations take part in this activity, as the qualitative analysis revealed, health services are still largely determined by the medical/health professionals.

The KIIs provided evidences of health professionals' dominance of health services determination. Just as our quantitative analysis revealed, that 46.8% of respondents said the government determined the type of health services provided.

Communities are considered mere recipients of government health care delivery services.

As regards health care financing, the responsibility of mobilizing resources for that falls on the community organizations. While community organizations strive to contribute financially to health care development in the communities, community members were of the view that health care financing should be borne by the government. In the four communities studied, community people make little financial contribution to health projects and programmes. The contributions are mainly in forms of providing manpower and materials and not necessarily making financial contribution.

In Ilado, communities make voluntary donation in terms of materials towards health projects and maintaining the primary health care centre in the communities. In Akoka, community members claimed voluntary contribution and donation are made once in a while towards health development. In Igbogbo/Baiyeku, Community Development Committee said they have contributed recently to health development by donating a plot of land at 'Ewu Elepe' to build children's centre, and two plots of land at 'Selewu' for the construction of health centre. In Ijeshatedo, community members claimed that they contribute only once in a while to maintain health facilities in their community. Activities of non-governmental and international donor agencies for health care support were evident in all the communities.

There is a link between community organizations, how they are organized, and how they function in the management of the local health system. This is important because community organizations are suppose to take part in the decision-making process. In all the communities studied, community organizations evolved out of the community and not externally imposed. For example in Igbogbo/Baiyeku, about 50 CDAs meet once in a month at the Town Hall to discuss issues in the community. Community Health Committee's representatives are selected from the wards - (Ewu Elepe, Orita, Ibeshe, Ofin, Igbogbo) that make up the community. CDAs and Health Coalition Groups in Ilado and Ijeshatedo are drawn from within the communities. In Akoka community, CDAs and Community Health Promoters come from within the community. These groups participate in varying degrees in community health care management. In spite of the strong community activities, health officials plan and manage health services. It is interesting to note that, these community organizations meet regularly with health officials to discuss important health issues of the communities, yet, they are excluded from core decision-making process.

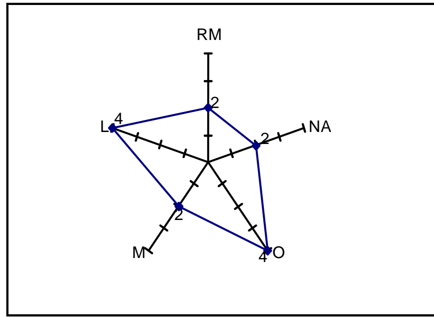
Leadership in our analysis signifies the representativeness of community organizations. This does not only determine the acceptability of community organizations amongst the people of the community, but also determines the extent to which community organizations can influence local decision-making in health care since they are seen as the representatives of the people. Community organizations in Ilado and Ijeshatedo communities although recognized by the

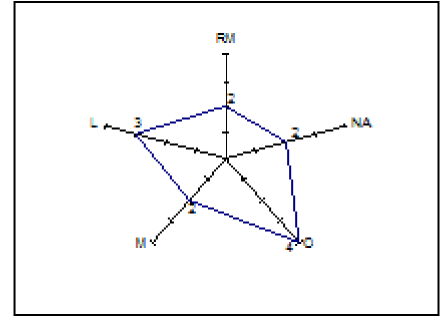
health professionals do not enjoy much support from the communities, because from the accounts of the CDA members, the people of the communities are always suspicious of their activities. Igbogbo/Baiyeku and Akoka community organizations – the CDAs and Community Health Committees are representatives of the communities and they enjoy support from the communities.

Emerging from the qualitative analysis also is the fact that community members identified malaria as the most common health problem in the communities and attributed the cause and the prevalence to dirty environment and lack of access to water. This finding also validates the quantitative data where 60.5% of the respondents made this claim. Identification of the high prevalence of malaria and the causes attributed to water supply and sanitation in the communities is indicative of the limited achievements of the country's current efforts at combating it. It is also suggestive of the need for a different strategy from the existing one which presently seems not to be working.

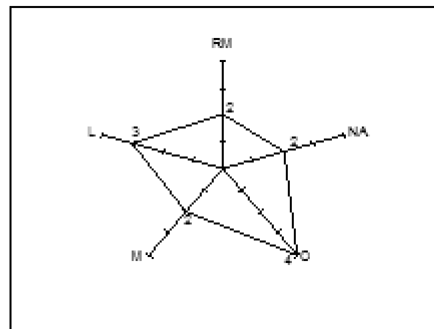
Table 4.26 Rankings for the four Communities.

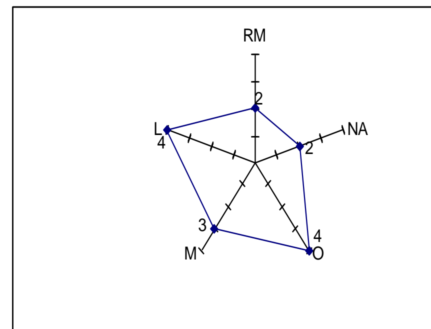
	Akoka	Igbogbo-Baiyeku	Ijeshatedo	Ilado
Needs Assessment (NA)	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by the health professionals.	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by the health professionals.	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by health professionals.	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by health professionals.
Resource Mobilization (RM)	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.
Organization (O)	4= (open, good community participation) community organizations evolve from within the community.	4= (open, good community participation) community organizations evolve from within the community.	4= (open, good community participation) community organizations evolve from within the community.	4= (open, good community participation) community organizations evolve from within the community.
Management (M)	3= (mean, fair community participation) community organizations discuss health issues with health officials but do not take part in health care planning and management.	2= (restricted, small community participation) community organizations do not participate in health care planning and management.	2= (restricted, small community participation) community organizations do not participate in health care planning and management.	2= (restricted, small community participation) community organizations do not participate in health care planning and management.
Leadership (L)	4= (open, good community participation) community organizations active and representative of community. Enjoy support from the community.	4= (open, good community participation) community organizations active and representative of community. Enjoy support from the community.	3= (mean, fair community participation) community organizations are recognized by health professionals but do not enjoy much support from the community.	3= (mean, fair community participation) community organizations are recognized by the health professional but do not enjoy much support from the community.





Diag. 1 Igbogbo/Baiyeku Community   Diag. 2 Ijeshatedo Community





Diag. 3 Ilado Community   Diag. 4 Akoka Community

Figure 4.25 - The Pentagram showing levels of Participation in Igbogbo/Baiyeku, Ijeshatedo, Ilado and Akoka Communities.

The diagrams above show how wide or narrow participation is on a continuum of each of the five indicators which influence participation in each of the communities.

TEST OF HYPOTHESES

Hypothesis 1

H_O: There is no significant relationship between the forms of community participation in health decision-making and the performance of local health care system.

H_1: There is significant relationship between the forms of community participation in health decision-making and the performance of local health care system.

In order to test the above hypothesis, Chi-square, Cross Tab and Pearson correlation statistics were used. Cross tabs' statistics and measures of association are computed for two-way tables only. If a row, a column, and a layer factor (control variable) are specified, the Crosstabs procedure forms one of associated statistics and measures for each value of the layer factor (or a combination of values for two or more control variables).

The results of the testing of hypothesis I are presented in table 4.27 - 4.32 below:

Table 4.27 Crosstab of Health Care Performance and Usage of Health Facility

Crosstabs

Usage of health facility	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
Every time	31 8.9%	50 14.3%	233 66.8%	33 9.5%	2 .6%	349 100.0%
Once in a while	74 9.9%	117 15.7%	506 67.9%	48 6.4%		745 100.0%
I don't use it at all	27 8.3%	57 17.4%	221 67.6%	21 6.4%	1 .3%	327 100.0%
Total	132 9.3%	224 15.8%	960 67.6%	102 7.2%	3 .2%	1421 100.0%

$r = 0.26, p = 0.03$

$\chi^2 = 29.073, df = 8, p = 0.03$

We can deduce from Table 4.27 that a significant relationship exists between use of health facilities and the quality of health care services. From the Table r is calculated at 0.26 or about 26% relationship between usage of health facilities and the performance of the health care system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis is therefore accepted that is, there is significant relationship between the forms of community participation in health decision-making and the performance of local health care system. It is presumed largely that usage of health facilities by community members signifies participation as this will give them the opportunity to assess the performance of the health system in terms of the services delivered.

Table 4.28 Crosstab of Health Care System Performance and Health Service Determinants.

Crosstabs

Health service determinants	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
The government	66 9.4%	108 15.4%	471 67.2%	56 8.0%		701 100.0%
The community	11 10.3%	14 13.1%	73 68.2%	9 8.4%		107 100.0%
The government & the community	30 8.6%	56 16.1%	236 68.0%	23 6.6%	2 .6%	347 100.0%
Others	2 4.0%	8 16.0%	34 68.0%	6 12.0%		50 100.0%
Total	109 9.0%	186 15.4%	814 67.6%	94 7.8%	2 .2%	1205 100.0%

$r = 0.21, p = 0.05$

$\chi^2 = 39.063, df = 12, p = 0.05$

Table 4.28 above shows that, a significant relationship exists between who determines the type of health care services and the performance of the health care system. From the Table above r is calculated at 0.21 or about 21% relationship between who determine type of health care service to be provided and the performance of the health care system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis is accepted, that is, there is significant relationship between the forms of community participation in health decision-making and the performance of local health care system. This is suggestive of the fact health care system will respond positively to the health needs of the community if community people are able to identify such needs.

Table 4.29 Crosstab of Health Care System Performance and Development Committee.

Crosstabs

Development Committee	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
Yes	102 9.3%	163 14.9%	752 68.9%	71 6.5%	3 .3%	1091 100.0%
No	32 10.2%	59 18.8%	195 62.3%	27 8.6%		313 100.0%
Total	134 9.5%	222 15.8%	947 67.5%	98 7.0%	3 .2%	1404 100.0%

$r = 0.23, p = 0.03$

$\chi^2 = 46.554, df = 4, p = 0.02$

From Table 4.29 above, it can be stated that a significant relationship exists between the existence of Development Committee and the performance of health care system. The existence of Development Committee is indicative of a structure through which dialogue (communication) takes place between community members and health professionals. From the Table above r is calculated at 0.02 or about 2%. This is significant at 95% Confidence Interval (r<0.05). The alternative hypothesis which states that there is significant relationship between the forms of community participation in health decision-making and the performance of local health care system is therefore accepted.

Table 4.30 Crosstab of Health Care System Performance and Committee's Meetings with Health Officials.

Crosstabs

Committee's meeting with health officials	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
Once a week	30 10.3%	47 16.1%	192 67.2%	21 65.8%	2 .7%	292 100.0%
Every two weeks	37 12.1%	45 14.7%	204 66.4%	21 6.8%		307 100.0%
Once a month	42 9.8%	66 15.4%	296 69.0%	24 5.6%	1 .2%	429 100.0%
Every three months	4 7.8%	9 17.6%	32 62.7%	6 11.8%		51 100.0%
Every six months	4 8.5%	5 10.6%	37 78.7%	1 2.1%		47 `100.0%
Total	117 10.4%	172 15.3%	761 67.6%	73 6.5%	3 .3%	1126 100.0%

$r = 0.11$, $p = 0.03$

$\chi^2 = 51.270$, $df = 16$, $p = 0.04$

Table 4.30 above shows a significant relationship between the intervals of committee's meeting with health officials and the performance of health care system. From the Table above r is calculated at 0.11 or about 11% relationship between who determines type of health care service to be provided in the community and the performance of the healthcare system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis is therefore accepted, that is, there is significant relationship between the forms of community participation in health decision-making and the performance of local health care system.

Table 4.31 Crosstab of Health Care System Performance and Different Ways of Participation by Community Representatives.

Crosstabs

Different ways of participation by community representatives	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
Meetings with health officials to decide on health matters	34 12.4%	39 14.2%	187 68.2%	13 4.7%	1 4%	274 100%
Bringing health matters to the attention of health officials	29 7.7%	68 18.0%	256 67.7%	25 6.6%		378 100%
By mobilizing community members	26 11.4%	36 15.7%	148 64.6%	19 8.3%		229 100%
All of the above	31 10.2%	42 13.8%	206 67.8%	23 7.6%	2 .7%	304 100%
Total	120 10.1%	185 15.6%	797 67.3%	80 6.8%	3 .3%	1185 100%

r = 0.30. p = 0.03

$\chi^2 = 53.025$, df = 12, p = 0.04

We can infer from Table 4.31 above that a significant relationship exists between the ways the community representatives participate and the quality of health care services. From Table above r is calculated at 0.30 or about 30% relationship between the ways representatives participate and the performance of the health care system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis which states that there is significant relationship between the forms of community participation in health decision-making and the performance of local health care system is therefore accepted.

Table 4.32 Crosstab of Health Care System Performance and Community Leadership and Groups' Health Matters.

Crosstabs

Community leadership and various groups' health matters	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
Groups are represented on the committee	47 9.8%	64 13.3%	342 71.0%	27 5.6%	2 .4%	482 100.0%
Groups' health matters receive attention	20 10.4%	23 12.0%	135 70.3%	14 7.3%		192 100.0%
Both	57 10.1%	99 17.5%	366 64.8%	42 7.4%	1 .2%	565 100.0%
Total	124 10.0%	186 15.0%	843 68.0%	83 6.7%	3 .2%	`1239 100.0%

$r = 0.22, p = 0.04$

$\chi^2 = 58.792, df = 8, p = 0.04$

From Table 4.32 above r is calculated at 0.22 or about 22%. This shows a significant relationship between leadership various ways of ensuring that various groups' health matters received attention and the performance of health care system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis is accepted that is, there is significant relationship between the forms of community participation in health decision-making and the performance of local health care system. It is assumed that the ability of the leadership of the committee to incorporate various groups' interests and ensuring that their health matters received adequate attention will determine the extent to which the health system responds to the various health matters and consequently its performance.

Hypothesis 2

H_O: There is no significant relationship between community participation in health care financing and the performance of local health care system.

H_2: There is significant relationship between community participation in health care financing and the performance of health care system.

The results of the testing of the above hypothesis are presented in table 4.33 - 4.34

Table 4.33 Crosstab of Health Care System Performance and Health Care Financing in the Community.

Crosstabs

Healthcare financing in the community	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
Government only	76 9.3%	133 16.2%	548 66.7%	63 7.7%	1 .1%	821 100.0%
The community only	11 10.2%	19 17.6%	68 63.0%	10 9.3%		108 100.0%
Community based organization	3 3.8%	11 13.8%	58 72.5%	8 10.0%		80 100.0%
By the government & community	15 10.0%	22 14.7%	100 66.7%	11 7.3%	2 1.3%	150 100.0%
The govt. & community based organization	6 12.5%	9 18.8%	31 64.6%	2 4.2%		48 `100.0%
Govt. community & community based organization.	5 8.5%	6 10.2%	46 78.0%	2 3.4%		59 100.0%
Total	116 9.2%	200 15.8%	851 67.2%	96 7.6%	3 .2%	1266 100.0%

$r = 0.05$, $p = 0.01$

$\chi^2 = 59.136$, $df = 20$, $p = 0.01$

We can deduce from Table 4.33 above that a significant relationship exists between the ways healthcare is financed in the community and the performance of healthcare system. From the Table above r is calculated at 0.05 or about 5% relationship between the ways health care is financed and the performance of health care system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis is therefore accepted that is, there is significant relationship between community participation in health care financing and the performance of health care system.

Table 4.34 Crosstab of Health Care System Performance and Community Ways of Supporting Health Project.

Crosstabs

Community ways of supporting health project	Health Care System Performance					
	Very good	Good	Fair	Poor	Very poor	Total
The community provides manpower	47 9.0%	78 15.0%	361 69.4%	34 6.5%		520 100.0%
The community provides necessary materials	14 9.3%	24 16.0%	104 69.3%	8 5.3%		150 100.0%
The community makes financial contribution	9 5.2%	31 17.9%	116 67.1%	17 9.8%		173 100.0%
All of the above	27 11.3%	34 14.2%	158 65.8%	18 7.5%	3 1.3%	240 100.0%
None of the above	20 10.0%	36 17.9%	126 62.7%	19 9.5%		201 100.0%
Total	117 9.1%	203 15.8%	865 67.4%	96 7.5%	3 .2%	1284 100.0%

$r = 0.06$, $p = 0.01$

$\chi^2 = 44.013$, $df = 16$, $p = 0.02$

From Table 4.34 r is calculated at 0.06 or about 6% relationship between the ways community support health projects in the community and the performance of healthcare system. This shows that a significant relationship exists between the ways the community support health project the performance of health care system. This is significant at 95% Confidence Interval ($p<0.05$). The alternative hypothesis which states that there is significant relationship between community participation in health care financing and the performance of health care system is therefore accepted.

Based on the observations from Tables 4.27 to 4.34**,** we can reason that significant relationships exist between community participation in health decision-making, health care financing and the performance of health care system. Although the degree to which each of the variables will affect participation and consequently health care performance varies as Tables 4.27- 4.34 have shown. Usage of health facility is indicative of participation and it contributes about 26 per cent (Table 4.27) to health system performance. Community participation in health decision-making will include the ability of the community people to determine the type of health care services to be provided in the community, and this contributes about 21 per cent to the improvement in the health care system (see Table 4.28).

PHC strategy recommends a structure at the community level to represent the people of the community in the planning and management of the local health system. It should be noted however, that the existence of a structure alone does not translate into effective participation. Table 4.29 shows that the existence of

Development Committee contributes about only 2 per cent to health system performance. The ability of the community representatives to meet regularly and interact with health officials in various ways contributes about 11 and 30 per cent respectively to health care system performance (Tables 4.30 and 4.31). This is very instructive for the whole investigation on community participation. It is to be highly assumed that when community representatives meet regularly with health professionals to deliberate on health issues their ability to influence decisions is enhanced through this form of participation.

Community's leadership demonstration of representing various groups and their ability to present various groups' health matters in the community to the health officials contribute about 22 per cent to health system performance (Table 4.32). Community participation in health care financing also determine the performance of the health care system. As indicated in tables 4.33 and 4.34 above, the way(s) health care is financed and the way(s) community people contribute to health projects in the community determine about 5 and 6 per cent of health care performance respectively. This is an indication that what the community people perceive as participation is not merely contributing money to support health projects, but rather their participation should begin from how such projects are conceived a*b nitio*.

The existence of a structure through which community representatives and the health professionals can meet and dialogue on health issues affecting the

community can and do contribute to community participation. The frequency of meetings and interactions between community and health professionals, ability of community leaders to represent various groups' interests in the community, and community financing of health care will all contribute to community participation in health decisions-making and affect the performance of the health system though at varying degrees.

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CHAPTER FIVE

FINDINGS AND DISCUSSION OF FINDINGS

5.1 Introduction

This chapter presents the findings of the study based on the investigations on the forms of community participation in health care services in the communities. The findings are also discussed extensively in this chapter. The discussion centers on community participation and management of health care system in the communities, community action and health care delivery, health governance and PHC delivery, community participation and the politics of PHC delivery, and politics of health care delivery.

5.2 Findings

The study has been able to provide evidence that health service needs are largely determined by the government. Most health decisions are taken by the government bureaucrats and health professionals. The communities oftentimes are not consulted but are merely informed and co-opted mainly through their representatives for the purpose of mobilizing the communities' members to give a semblance of wider participation. The erosion of community participation in health decision-making consequently affects the performance of the local health system in meeting the health needs of the people.

The study also found out that community contribution to health care financing is low as people perceived themselves as mere recipients of government

programmes and not initiators. This is borne out of the fact that government largely determines the health needs of the communities. The study revealed that health care is mostly financed by the government and International organizations largely in terms of donation towards targeted programmes in the communities. This is partly responsible for the poor state of health care funding as the "Drug Revolving Fund" of the Bamako Initiative of 1988 which seeks to secure community funding of recurrent costs, amongst others, is virtually not operative in these communities.

The study also revealed that within the context of health governance in the country, PHC policies and the way they are implemented are still largely determined centrally by professional elite. The forms of the structures and political processes that create and sustain PHC are determined by the individuals and groups that have influence and wield the greatest political power. The study showed that community organizations do not possess political and administrative powers, neither do they have financial power that will enhance their participation in health care decision-making at the local level. The politics of 'patronage, which rewards loyal supporters in terms of selection to political offices especially at the local level creates disconnect between the government and the local populace.

5.3 DISCUSSION OF FINDINGS

5.3.1 Community Participation and Management of Health Care System

PHC as a strategy was developed for providing health care services, which involve community-based preventive, promotive and curative. Item IV of the Alma-Ata Declaration states that the people have the right and duty to participate individually and collectively in the planning and implementation of their health care (Alma-Ata Declaration 1978). Since the concept of 'community' is given a central position in PHC, participation must involve the community in planning, management, implementation, monitoring and evaluation of the local health system. Importance of community is evident when one examines the role that community participation plays in primary health programs (Wayland and Crowder 2000).

Participation of the community is critical to the successful implementation of PHC because the individual and community take part not only in the identification of their health needs but also in the implementation of health programmes.
As originally conceived within the context of PHC, community participation would ensure that individuals participate in planning, instituting and maintaining health systems that met their needs (Gardiner, 1994). Community participation is therefore a strategy that provides people with the sense that they can solve their problems through careful reflection and collective action (Zakus and Lysack 1998).

However, participation in health initiatives or health programmes may come in different forms and degrees. The members of communities' varying perception of participation in this study lends credence to the argument that participation can be conceived in several ways and this also has implication for the way people participate in real sense. According to the survey, some members of the communities perceive community representatives' regular meetings with health officials as participation, while others see it as the ability of their representatives to bring health matters to the attention of health officials. To some respondents, participation has to do with mobilization of community members by community representatives to support health projects and programmes in the communities.

Drawing from the literature, different interpretations of community participation has resulted in different form of practice, and there is no agreement about which forms is correct (Rifkin 1986). What is important is the extent to which community participation will bring the desired outcome and in this case, the improvement in the performance of health care system. But, the extent to which community participation will achieve the objective of improvement in health care depends on a number of factors. These range from the existence of community organizations to their ability to function alongside the medical professionals, not only in determining their health needs but also to participate in the implementation of health initiatives. According to Gardiner (1994, p.10) past experience has shown community participation to be highest where there is community consciousness of its right and responsibilities with regard to

development. The existence of an organizational structure for action and the identification of health as a priority matter have been demonstrated to be the hallmarks for community action in health.

Community's efforts at determining their health needs have implications for community participation in health care delivery. One of the reputed benefits of community participation is the belief that resources will be more often directed to the so-called 'felt needs' of those in the community, and that health activities will be carried out more appropriately when the community is given greater control (Zakus and Lysack 1998). Identification of health needs within the community may be a result of felt needs which the community people identified themselves and rely on health professionals to solve. On the other hand, it may be the result of health education by the professionals who thus help the community to convert a real health need to a felt health need (Ekunwe, 1996).

In the four communities investigated in the qualitative study - Akoka, Igbogbo/Baiyeku, Ijeshatedo and Ilado, community organizations comprise of members from the communities served as the community's representatives. Individual members played minimal role. Community participation is more evident in the activities of the community organizations.

One of our key informants gave an indication of how the community gets involved in identification of health needs which is taken as an aspect and a process of participation;

> The community organizations take part in what I can call 'community diagnosis' that is, finding out the health needs of the community and how they can help themselves, they visit the communities regularly to ask for the nature of any health problem and report back to the health centre (KII, Ijeshatedo, 2008).

When the health needs are identified by the communities, they are perceived as 'real health needs'. But as the study revealed, health needs of the communities are largely determined by the government. For example, in all the health facilities surveyed in Igbogbo/Baiyeku, Ijeshatedo, Ilado and Akoka, services provided include; Ante-natal Clinic, Child Welfare, Family Planning, Maternal Health Delivery, Health Education, General Outpatient and Outreach Services. These are health services whose guidelines and structures are predetermined by the government, though community organizations most times are called upon to participate in the implementation process. The implication of this is that the impact of participation is only felt at the implementation stage of the process (in terms of health care planning and implementation) of community participation. This is not consistent with the views expressed in the literature that primary health care implies that communities would become involved in both the delivery of and decision about health and health services in order to provide the type of health care most appropriate to their own circumstances (Rifkin, 1986, p. 240).

The inability of the community to participate in this aspect of the process of health care delivery has resulted in the unmet needs of those communities. Pre-determined health services without in-put from the communities might deviate from the actual health needs of the communities.

Active participation of the communities in the identification of their health needs would guarantee that their basic health needs would be met. However, for this to happen, a shift in emphasis from the institutional approach to community-based health care approach of the PHC will be required to give voice to community people in health decision-making.

However, a link exists between community organizations and management of health care system. Community organizations exist to facilitate the process of participation in health care planning and development. Community participation requires an arrangement which gives community members or organizations in which they participate, a more active role in health promotion (WHO 1981). Where such community organizations are well organized, their use for health care improvement cannot be overemphasized. Community organizations are well organized in these communities. Community Development Committees, Health Coalition Groups and Community Health Promoters are drawn from the Communities. They hold meetings regularly and mobilize supports of the people of the communities for health development when there is the need for such. These groups participate in varying degrees in community health activities. However, their participation does not translate to their involvement in the management of the local health systems.

The opinion of one of the interviewees suggests this much:

> We participate in mobilizing community people, we go out for out-reach programme with health officers here in this community, we help to pass information about health to people

> and we report back, for example, when there is health epidemic, we normally report to them but they don't take all our advice, so we can say that we don't really take part in the management of the community health system (FGD, Ilado, 2008)

A key informant in one of the health centre was also of this view:

> When we talk of participation in the real sense, I think there is deficiency somewhere, I think so! In spite of their various activities in health care delivery, community organizations do not participate in health care planning and management, no! They don't take part (KII, Ijeshatedo, 2008).

Though community organizations in Akoka, Igbogbo/Baiyeku, Ijeshatedo and Ilado communities engage in health promotion activities, it is evident that they do not play a crucial role in health care decision-making. Initiatives on health matters are left to the medical professionals. Another key informant in one of the communities expressed this point aptly:

> The much they could do is to provide health information about the people in the community but even then, not all their suggestions are taken into consideration, when it comes to real decision-making, community people don't take part (KII, Akoka, 2008).

The views expressed by the members of the community suggest the level of their involvement in local health decision-making. Decisions as to what type of health services to be provided in the communities are left largely in the hands of medical professionals. This corroborates with Scott-Samuel cited in (Bambra, Fox and Scott-Samuel, 2005, p.191) that when we conceive of ill-health as episodes of disease manageable by the delivery of health care, we are transferring the responsibility for health from society as a whole to elite possessing what we

define as the necessary professional and technical expertise for the management of disease.

When this happens, the preventive and promotive aspects of PHC approach are relegated to the background. This is because these are health care activities that require effective community participation in terms of providing necessary training for the Community Health Workers (CHW) and Volunteers in order to impact such knowledge on the community people.

Community participation largely takes the form of involvement of the community in implementation of health programmes in the communities. This situation precludes the community from having the power to decide on health goals and means of achieving such goals.

Where health needs are largely determined by the government, the implications may include greater health care financing on the part of the government, while the community members make little contribution towards health care financing in the community. Health care financing refers to the strategies for paying for health care expenditures and these are for services and goods whose primary aim is to promote health. It is one of the major factors that drives health care delivery generally and PHC in particular (Nigerian Health Review 2007). The sources of finance of the health sector as well as the mechanisms used to allocate those resources within the health systems directly affect poor people’s access to health services, and thus the final health outcome (Sida in Nigerian Health Review, 2007 p.73).

The revised National Health Policy of 2004 provides a comprehensive strategy of health care financing in the country. The main mechanisms of health care financing in the country are; Government Funding, Donor Funding, Health Insurance and Out of Pocket payments (OOPs) also known as user fees.

Specifically for PHC financing, the federal government provides budgetary allocation to PHC department of the Federal Ministry of Health (FMOH) and NPHCDA. Also, there are budgetary allocations to various PHC activities in the country, such as malaria control programme, immunization programme, HIV/AIDS amongst several others. Financing of day-to-day health facility functioning is largely provided by local governments (Nigerian Health Review, 2007).

Other sources of funding for PHC include, Donor Financing, the Mandatory or Social Health Insurance (SHI), Voluntary Health Insurance, Community Based Health Insurance, Drug Revolving Fund (DRF) and Out-of Pocket payments (OOP) or User fee.

Government funding takes the largest share of health care financing in the country. Where this is largely effective, health care financing and consequently health care service provisions is likely to meet the basic health demands of the people to some extent. Paradoxically government provisioning for health care services has been on the decline. The Table below shows total expenditure to health sector in the country between 1999 and 2005.

Table 5.1 Distribution of Total Expenditure to Health Sector (N millions) from 1999 – 2005

Year	Description	
	Allocation	% Budgetary Allocation
1999	16,180.00	1.7
2000	18,181.80	2.6
2001	44,383.50	4.4
2002	59,778.20	5.9
2003	47,934.70	3.9
2004	54,927.40	3.9
2005	77,473.60	4.3

Source: CBN Statistical Bulletin 2007 adapted from Nigeria's Social Indicators for Policy and Legislative Guide 1999 – 2007.

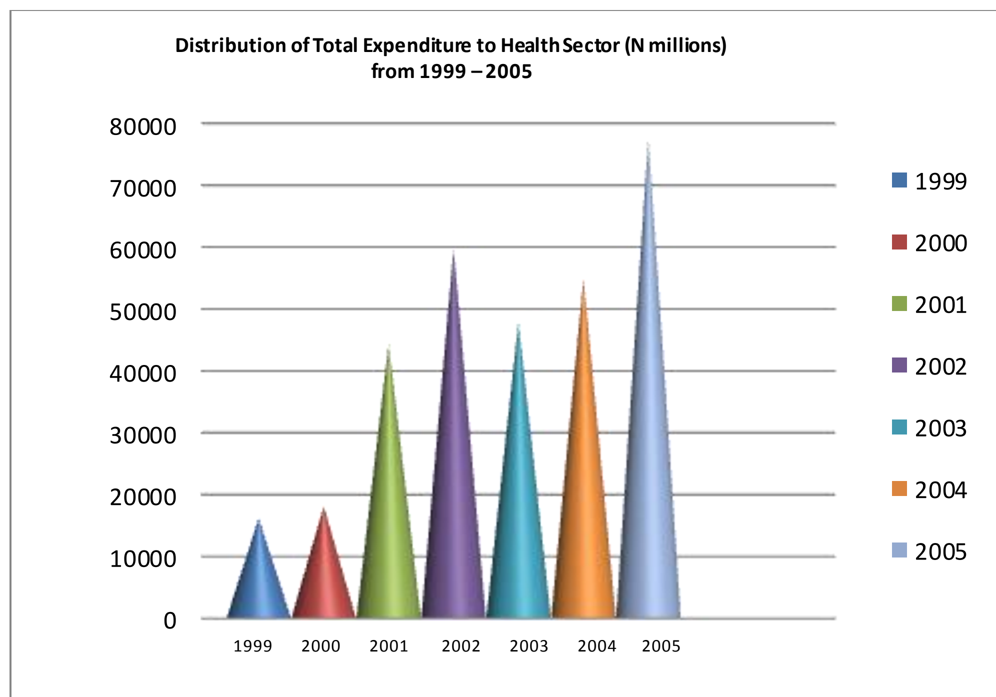

Figure 5.1 Distribution of Total Expenditure to Health Sector (N millions) from 1999 – 2005

The Federal Government's commitment to health care varied considerably as indicated by the above data. The table shows that the highest budget allocation to the health sector was in 2002, which was 5.9% after which there was a decline in the two successive years; 2003 and 2004 with a percentage of 3.9 each.

The year 2005 however witnessed increase in the budget allocation from the two preceding years. What is instructive here is that government's commitment and budgetary allocation vary considerably. It is conditioned by the total resources available to the government to base its appropriation. Within this context health sector has to compete with other sectors in the system and its appreciation depends on the value the government places on health care development.

Community financing for health is a mechanism whereby households in a community (the population in a village, district or other geographical area, or a social-economic or ethnic population group) finance or co-finance the current and/or capital costs associated with a given set of health services, thereby also having some involvement in the management of the community financing scheme and organization of health (Ojo, 2006, p. 215-216). However, direct payment / user fees also known as Out-of-pocket payments (OOPs) is very common in developing countries although there has been calls for its removal in response to evidence of its regressive impact and its role in enhancing social exclusion particularly in primary care level (Nigerian Health Review, 2007).

Evidence from our survey revealed that about 24.2 per cent of the respondents paid for health services at the facilities while, 69.1 per cent claimed they do not make payment.

The Bamako Initiative (BI) of 1988 introduced a strategy of health care financing where community operates the 'Drug Revolving Fund'. The main purposes of the initiative are to secure community funding of recurrent costs, enhance essential drug supply system and strengthen community participation and control (Oliveira-Cruz, Hanson and Mills, 2003). Most efforts of the communities at resources mobilization for health care are carried out by the community organizations in the communities. One of the interviewees avers:

> Committee members raise money among themselves to buy drugs although we follow orders from the nurses as to what type of drugs to buy, this we sell and the profit saved for other future use, but you see we are finding it difficult now to even raise money to buy the drugs because of the economic situation which is affecting most of us or how do you ask someone that cannot feed himself and the family to come and contribute money for drugs? (FGD, Ilado, 2008).

Evidence from the qualitative study shows that community members are not positively disposed to making financial commitments towards health care development. This is consistent with what our survey on quantitative study revealed that about 70.2 per cent of the respondents said they never made any financial contribution towards health project in their communities. Furthermore, 'Drug Revolving Funds' are either not in existence anymore or not been run effectively in some of the communities studied and this affects availability of

drugs in most health facilities. This resonates with the reports of the survey carried out by NPHCDA in 2001 which states that there has not been an improvement. The NPHCDA health facility survey of 202 LGAs measured the availability of essential drugs list and drug revolving fund system. The reports indicate that drug supply is inadequate in public sector PHC facilities (Nigerian Health Review, 2007). We can argue that the exclusion of communities from core decision-making also affects their participation in health care financing in the communities.

5.3.2 Community Action and Health Care Delivery

Collective action is often seen as a fundamental component in definitions of community participation (Askew and Khan, 1990). Participation at the community level requires the collective actions of health officials and the communities themselves. This is evident in many activities that incorporate both the community and the health/medical professionals. The 'Outreach services' for instance involves both the health officials and Community Organizations in the communities. The involvement of community organizations in the provision of this service becomes important because according to one key informant:

> We don't have enough personnel to go round all the communities which this facility renders services to, so, the community groups complement our efforts not only in mobilizing the community people to come to the facility but they also help in passing information to them and report back to us as well. Though we have health educators that go out with megaphone to pass information to the people, but they still go out with the community groups (KII, Akoka, 2008)

The case of Ilado community demonstrates the importance of community action as it relates to the 'outreach services' and the sustenance of health care delivery. One PHC centre located at Ilado provides health care services to the following communities, Aradagun, Imeke, Igbanko, Ago-Ajo, Obele, Ilado, Iworo, Esepe-Mushin and the "river-rine areas" which comprise of Ikotun, Maba, Okogbo, Ojogun, Dadi/Luwi and Ago-Ilaje. These communities require that health officials visit them once in a week, but a key informant remarked:

> That is not possible, where do we get the personnel to do that? We lack the personnel at the health centre, we can only visit them once in a month, but even with that, we still rely on the community health coalition groups and volunteers to help out, as I said before, we don't have enough staff to do most of our activities, so the community development and health coalition groups are always around to help us (KII, Ilado, 2008)

This is equally the situation in other communities investigated. One health centre at Igbogbo/Baiyeku provides services to Ibeshe, Ewu-Elepe, Selewu area, Ofin and Orita communities. The health centre at Baruwa caters for the whole community in Ijeshatedo. The responsibility thus falls on the community organizations to provide the required manpower to complement the efforts of the health officials. The groups visit on a regular basis, the communities that are quite far away from the health centre. The visit is done to ascertain their needs and, again reports any health issue in the communities to the health officials. Health information is equally passed to the members of these communities through members of community organizations who visit the communities regularly.

Collective responsibility of the community and health professionals is also manifested in the mobilization of the community for health care actions. This comes in form of various activities such as mobilizing the people for participation in health care programmes in the community, contributing towards the implementation of health care programmes and projects, and ensuring that community are aware of and, they are sensitized to health programmes. In Igbogbo/Baiyeku, for example, the community donated plots of lands for the construction of children's hospital at 'Ewu Elepe' community in Ikorodu. 'Selewu' community also donated two plots of land for the construction of health centre in 2008. A health centre was built by the people of Okogbo community in Ilado to cater for the health needs of the community.

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Dissemination of information on health programmes is also done through the community organization groups that move from one location to the other to inform the community of such programmes and to mobilize them towards action. In Akoka, CDAs and members of Health Promoters mobilized members of communities for health programmes such as immunization, by distributing pamphlets, and using public address system to create awareness of such programme in the communities. The community organisations are seen to be complementing the activities of health officials in these communities.

However, it should not be misconstrued that collective action between the community organizations and health professionals will function without conflicts.

Conflicts abound not only between health professionals and the community organizations, but also between community organizations and the people of the communities. Wayland and Crowder (2002), express this view that an emphasis on the shared nature of community obscures the importance of power struggles and ignores the existence of differing wants, needs, and desires. The implication is that the differences in wants, needs and desires will produce a situation of conflicts especially in situations where resources are scarce. It has been suggested that, perhaps 'it is more accurate to view a community as 'a set of power relations in which individuals are grouped into different categories' Navarro as cited in Wayland and Crowder (2002, p.233). While success of community participation in health care promotion is feasible, many factors operate to diminish its success. Two of the most basic factors are the nature of communities themselves and the realities of collective human action (Zakus and Lysack, 1998). These two factors invariably have implication for our analysis of collective responsibility of the community and health professionals.

The observation is that communities are heterogeneous entities, not only in their demographic composition, but also with respect to their interests and concerns. This diversity has a profound impact upon every step of the community participation process, and while there may be little disagreement about the desirability of community participation, the diversity of those groups called communities can create real problems for selection, representation and accountability of individuals (Zakus and Lysack, 1998).

This study offers evidence that community do not always act together as expected. The positions of community representatives are sometimes directly and indirectly questioned especially when people feel that they are not adequately represented. Members who are representatives of the people are often accused of corruption, hence, the reason why they pursue government agenda on health with much vigour. One of the interviewees explained that:

> Sometimes the community members looked at us with suspicions when we tried to talk to them on a particular health matter, especially if the issue has to do with contributing money for health project. Most times we really have to convince them of the benefits that everybody will enjoy by participating (FGD, Ilado, 2008).

The assumption that community people are homogenous group and will always act together may therefore not be tenable.

The study observed that where health facilities are inadequate in terms of health personnel and availability of essential drugs there is likely to be a decline in community participation as evidenced in the communities studied. One of the key informants remarked that:

> The health facilities and the personnel are not enough to cater for all the communities to make sure that health services reach them, if we consider the number of communities that one health centre caters for then you will agree with me that we lack adequate facilities and staff (KII, Igbogbo/Baiyeku, 2008).

Another informant also expressed that:

> When people come to the health centre and they don't get what they want, they get discouraged and they are not likely to come back, for example, when they come for immunization of their children and the vaccines are not available at the clinics, they get discouraged (KII, Ijeshatedo, 2008).

The Table below shows the distribution of health care facilities in the country.

Table 5.2 Distribution of Health Institutions in Nigeria, 1999- 2007

Year	Health Institutions			
	Primary Health Care	**Secondary Health Care**	**Tertiary Health Care**	**Total**
1999	8,970 (90.5%)	892 (9.0%)	51(0.5%)	9913
2000	10,149 (91.1%)	936 (8.4%)	51 (0.5%)	11136
2001	10,393 (91.0%)	982 (8.6%)	51(0.45%)	11426
2002	15,266 (87.4%)	1,976(11.3%)	219(1.3%)	17461
2003	16,137 (88.0%)	1,990(10.8%)	221(1.2%)	18348
2004	17,453 (88.6)	2,015(10.2%)	228(1.2%)	19696
2005	20,347 (87.7%)	2,569(11.1%)	274(1.2%)	23190
2006	20,847 (87.7%)	2,631(11.1%)	292(1.2%)	23770
2007	21,020 (85.7%)	3,210(13.1%)	305(1.2%)	24535

Source:CBN Annual Report and Statement of Account, 2007 adapted from Nigeria's Social Indicators for Policy and Legislative Guide 1999 – 2009

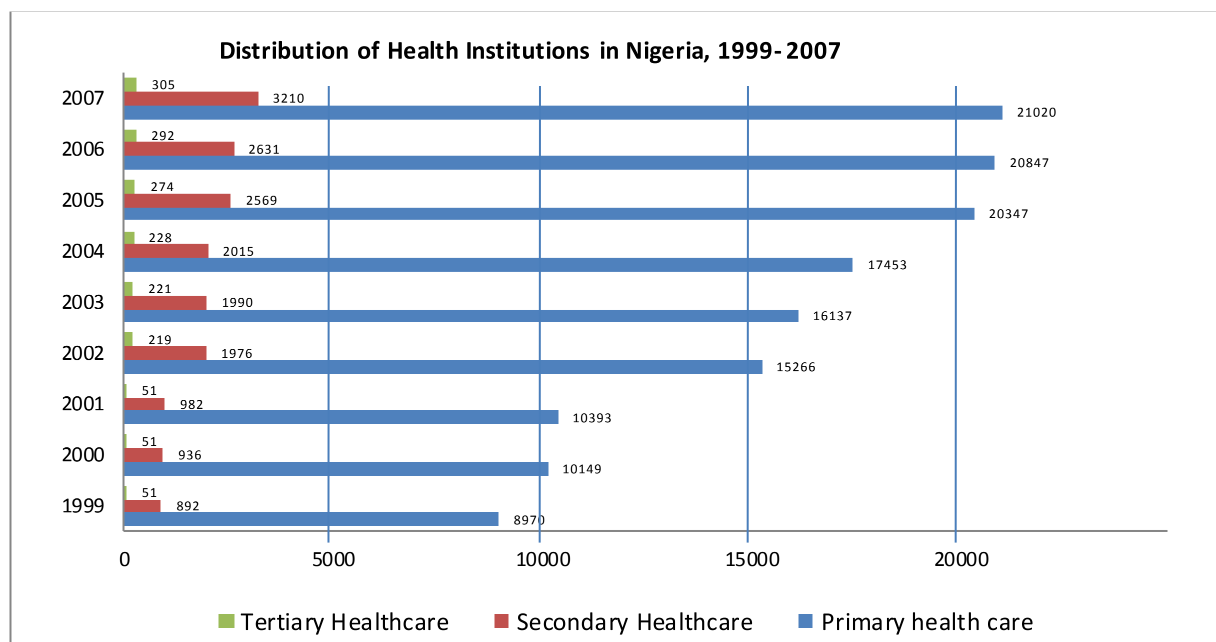


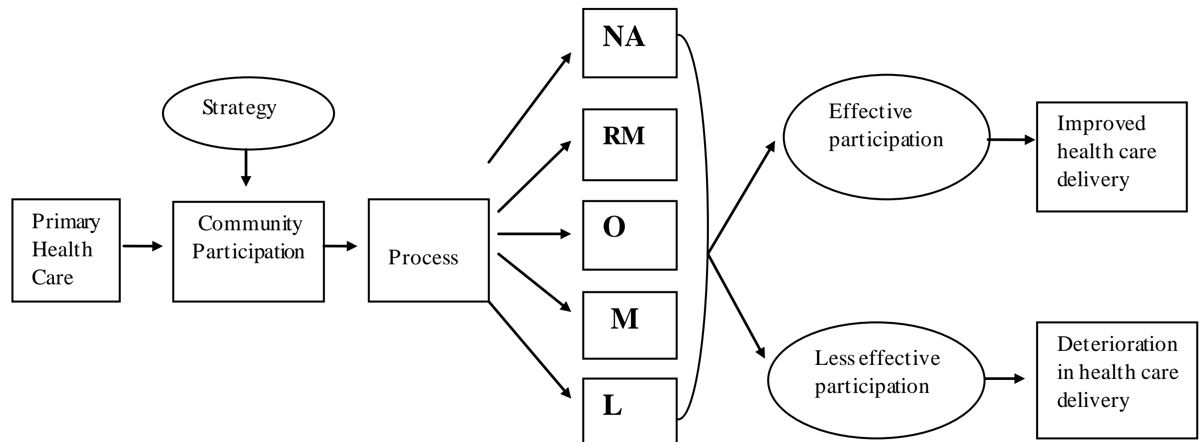
Figure 5.2 Distribution of Health Institutions in Nigeria, 1999- 2007

Deducing from the above Table, while it is appreciated that there are marginal Increase in the three tiers of health care facilities for certain period, it is also noticeable that percentage rise in PHC facilities is lesser than that of secondary health facilities. If we take years 2004 and 2005 for example, there was a decline in PHC facilities by 0.9%, while secondary had an increase of facilities of 0.9%. Also in 2007, there was a decline of 2% in PHC facilities (85.7% in 2007 as against 87.7% in year 2006). Secondary facilities in the two years under consideration; 2006 and 2007 experienced an increase of 2% (13.1% in 2007 as against 11.1% in 2006).

This suggests that as at 2007, there are 21,020 primary health centres in the country a number which is still considered to be low compare to the population of the country which as at that period was about 120 million people.

Availability of health facilities will encourage regular use and this in turn will enable members of community to assess the performance of the local health system and be able to make contributions towards its development. Where health facilities are inadequate for health care services, principles of equity, social justice and universal access of PHC cannot be achieved.

Figure 5.3 Conceptual Framework for Community Participation in Health Care Delivery adapted from Rifkin et al. (1988) Process Indicators.



Process Indicators: Needs Assessment (NA), Resource Mobilization (RM), Organization (O), Management (M), Leadership (L).

The framework above represents the process of community participation in the communities studied. The study demonstrated that the communities participate although in different degrees in identification of health need, resource mobilization and in other activities that promote health care delivery. The extent to which their participation influences health decision-making however depends on the degree of their involvement in these activities. Effective participation of the communities in health decision-making will lead to improved health care delivery, while less participation is more likely to bring about deterioration in health care delivery in the communities. Contextualizing community participation in this way is consistent with Rifkin, Muller and Bichmann's process indicator

framework (1988). That community participation may take this form of participation is not in contention, especially, since the PHC approach takes as its fundamental principle community participation in health care development. But the critical issue has to do with the determining factors which affect community participation in health care delivery. The process of participation as the study revealed involves interaction between community representatives and professional health officials and community-based Non-governmental organizations in health decision-making. However, the effective participation of the community is constrained by many factors. These form part of the discussions in the next two sections.

5.3.3 Health Governance and Primary Health Care (PHC) Delivery

Health governance concerns the means and rules by which relevant stakeholders set and achieve their health objectives. It includes the mechanisms, which incorporates structures and processes necessary for the working and realization of the goals of public health. Health policy then becomes the guiding principle which structures and directs the activities of various institutions and actors that participate in the process of health care services. The World Health Report (2008) stresses the importance of effective public policies for health:

> The first groups of critical public policies are the health system policies on which primary care and universal coverage reforms depend. The second group relates to public health policies that address priority health problems. These encompass the technical policies and programs that provide guidance to primary care teams on how to deal with priority health problems. The third set of policies is known as "health in all policies" which is based on

> the recognition that population health can be improved through policies that are mainly controlled by sectors other than health (World Health Report, 2008:64).

However, a governance debate needs first to be based on the realization that health cannot be addressed without a real involvement of people and their organizations at all levels (Xhafa, 2007). This will involve effective participation of those stakeholders in health decision-making. Participation gives the people the opportunity to share in the responsibilities that determine their health outcome. However, effective participation that engenders positive health outcome is constrained by many factors. Successful community participation in public health planning projects and their implementation requires overcoming barriers at a number of levels namely the participants, the community, the operational and the structural levels (Murray, 2004).

> At the structural level, there is a need for professional support and commitment to community health and community participation, expert skills, local human resources, resource dedication to support participation policies, and an appropriate health care structure that is responsive to local involvement. At the operational level, a number of inputs are important to optimize the success of involving community in health planning namely political will, bureaucratic and political support, again a health care system which has principled aligned with that of community participation, coordination, collaboration, communication, available information and administrative support (Murray, 2004, p. 2).

Community stakeholders, Community Organizations, Non-Governmental Organizations, Governmental Organizations and Professionals, need to have certain strengths to increase the likelihood of successful and sustainable community health planning with community participation.

Within the framework of the study, the role of institutions in the process of policy formulation and implementation assumes great importance. The structure of government institutions may have important policy consequences.

The implication of this for PHC is that the effective performance of PHC policy is hinged on the effectiveness of the government institutions responsible for its operation. The processes of PHC formulation and implementation are influenced by relationships and procedures within and between these institutions.

The National Health Policy provided for a health system with three tier health care (Primary, Secondary and Tertiary) and functionally integrated three-tier structure for the nation's health service. The first level is the primary health care (PHC). The philosophy of health care at this level is that health care must be available and accessible to majority of Nigerians wherever they are found. It is for this reason that PHC is community-based.

PHC institutions include health clinics, primary health centres, maternity and child centres, dispensaries, family planning clinics etc.

The second tier in the National Health Care delivery system is the Secondary Health Care (SHC) level. SHC comprises the care provided through specialized

services on referral from primary care services through out-patient and in-patient services at hospital centres for general, medical, surgical and pediatrics' patients. The institutional components of SHC are mainly hospitals of various kinds i.e. general and district hospitals as well as comprehensive health centres.

The Tertiary Health Care (THC) level is the apex of the National Health System. It is comprised of highly specialized services which provide care for specific diseases and conditions of specific groups. THC institutions include teaching hospitals, specialist hospitals, orthopaedic, eye, psychiatric, maternity and paediatric hospitals. These institutions provide specialized services in the clinical, scientific, diagnostic and technological spheres.

Within the three tier structure, the local government is responsible for the provision of PHC services, the state government takes the responsibility of secondary health care, while the federal government handles the tertiary health care. The delegation of PHC to local governments was intended to bring decision-making and services closer to where people lived and worked, thereby permitting the delivery of health care to be adapted and fine-tuned to local needs (Nigerian Health Review 2007). PHC is the first level of contact of the people with the nation's health care system, and it is at the grassroots level that this contact is made. By extension, the people at this level are to take responsibility for their health by taking part in the planning and management of the health system.

The study demonstrates that the people of the community have knowledge about the role of local government in PHC service provision including health care services, but at the same time they expressed dissatisfaction with the role of local government in the entire process.

Our interviewees were very explicit on the issue:

> local government is not ready to assist the community on some of the health projects and so it is affecting our way forward, but for our personal contributions, especially the health coalition groups and volunteers, some health projects would have collapsed but we always try our best to make sure that the projects continue, but the problem is that we are not rich in this community and we need government to assist the community (FGD, Igbogbo/Baiyeku , 2008)

Another interviewee remarked:

> No way for only committee to work successfully without help from the Local Government. The Local Government should at least bring staff, provide drugs, and money. The local Government should have effective participation with the community to assist primary health care. Good health care delivery system is the local government primary responsibility (FGD, Igbogbo/Baiyeku, 2008)

The above remarks give the impression that local governments should take the blame for the malaise in the health care system, but at the same time, the people of the community see local government as the panacea for health care delivery especially at the local level. However, as Lucas (2006) observed, that although the responsibility for PHC has been properly assigned to local governments, it is unrealistic to expect that this level of government can on its own meet the requirements for this critical foundation of the country's health services.

Within the system of health care administration and health care financing, local government is constrained in its function as the provider of basic PHC services in the country.

Financing of day-to-day health facility functioning for example is largely provided by local government. The federal and state governments are expected to provide logistical and financial assistance to the LGAs, primarily for programmes of national importance such as the National Programme of Immunization, or controlling the spread of HIV/AIDS (Nigerian Health Review, 2007).

Local governments get 20% of statutory allocation from the federation account. They are expected to internally generate revenue to meet their assigned responsibilities. In these areas, local governments are confronted with daunting challenges that invariably constrained them in performing. The 20% statutory allocation to local governments is channeled through the state governments. It is no gainsaying that the experience of local governments in this respect has been tales of woes as state governments oftentimes divert local governments' allocation for other purposes.

Furthermore, the nature of inter - governmental arrangement which specify areas of operations amongst the three tiers of government is dysfunctional. Opinions have been expressed concerning the nature of the relationship between the three tiers of government as it relates to their roles and responsibilities in health care

delivery. According to the Appraisal Report of African Development Bank (2002),

> The organizational structure of the Nigerian health care system suffers from lack of specificity and ambiguities in the definition of roles and responsibilities of the three tiers of the system, the Federal, State and Local Government levels. Even when roles are clearly assigned there are instances where some tiers of Government take on responsibilities that are clearly not within their mandate (ADB, 2002, p. 18).

A former Minister of Health, Osotimehin was reported to have said that:

> The greatest problem facing the Nigeria health sector is not funding but weak co-ordination. Those responsible for the stunted growth of the primary health care according to the Minister are the three tiers of government. Governments at all levels are not playing their roles and this weakens the health sector (The Nation, August 31, 2009, p. B8).

Lack of effective coordination of various institutions responsible for the provision of health care services is one of the factors responsible for the crisis of health care delivery in the country.

Nwakoby (1999) is of the view that the institutional and functional divisions of the three tiers of government are not mutually exclusive, they are to complement each other with a view to realizing the objectives of the National Health Policy.

The poor definition of roles and responsibilities of actors in the health sector has contributed to the confusion and haphazard implementation of PHC policy in the country. Furthermore, the local government which is assigned the responsibility of PHC has been described as the 'weakest and poorest' tier of government

(WHO, 2003). The implication is that "when parts of the health system malfunction, or are misaligned, the overall performance suffers" (World Health Report, 2008).

The inability of the government to coordinate various institutions responsible for health care delivery in-line with the assigned roles and responsibilities has led to the adverse state of health care delivery system in the country.

Additionally, there is the concern with the scope and nature of operations of International agencies and donors in the health sector. The government receives assistance for the health sector from bilateral, unilateral agencies, and Non-Governmental Organizations (NGOs). These Organizations support projects covering priority areas such as HIV/AIDS, reproductive health and family planning, health systems development and capacity building (ADB, 2002).

The Table below provides an indicative summary of selected ongoing donor support to the sector.

Table 5.3 Selected Development Partners, Estimated Level of Support in Health Sector and Programme Focus

Agency	Est. level of support in US $millions			Program Focus				
	Federal	State	LGA	BHS	EPI	Civilworks	Rep.Health/FP	HIV/AIDS/STD
World Bank	8.0	42.0	70.0	x				x
UNFPA	3.0	8.0	9.0	x			x	x
JICA	3.0	10.0			x			
WHO	6.0	39.0	60.0	x	x		x	x
UNICEF	3.0	36.0	70.0	x	x		x	x
USAID		40.0	80.0		x		x	x
Ireland Aid		60.0	48.0	x	x		x	x
DFID (UK)	5.0	20.0		x	x	x	x	x
Canada	3.0							

Source: Adapted from ADB (2002) – Appraisal Report. OCSD ADF/BD/WP/2002/50.

According to African Development Bank's Report 2002, all the major donors operating in the health sector have committed finance, on a parallel basis, to assist in the expansion and strengthening of the PHC services with a special focus on mothers and children. The problem however, has always been with the nature and form of collaboration which most times are not done in a formal way with clearly designated structures.

Development assistance is most effective when it is harmonized (through use of common procedures for all donors) and aligned (by supporting countries' own priorities and delivery systems) (High Level Forum on the Health MDGs, 2004).

This study provides evidence of the activities of International agencies in the communities. The USAID funded global programme on child survival - BASICS I and BASICS II were in operation in these communities before 'Community Participation for Action in Social Sectors' (COMPASS) was introduced. COMPASS is also a USAID project which was launched in 2004 and was to run through 2009. COMPASS' activities in the communities include building of health centres, organizing seminars and workshops for community organizations to create awareness and sensitizing them to major health issues in the community. The community people gave evidence on the activities of these agencies.

According to them:

> We have been working with NGOs since the days of BASICS I, BASICS II and now COMPASS. They always organize seminars and workshops and enlightenment programmes for the representatives for us to be able to mobilize the people. For example, on the issue of malaria, they come around to teach us how we can use the treated malaria nets and give us education on how we can keep the environment clean to prevent mosquitoes. So I can say that we participate better when these NGOs are involved, because government is not really responsive to community needs like all these organizations (FGD, Ilado, 2008).

While the impact of the International agencies and NGOs in enhancing community participation through the involvement of the people of the community

cannot be denied, the challenge is usually with the continuity of such programmes when the agencies disengage. The reason lies in the fact that most of these programmes are not integrated into the country's overall health care delivery system, but merely 'selective intervention'. Selective intervention has been argued not to be beneficial in finding solutions to emerging problems in health (Jurgens, 2004). The main criticism of the focus on selective medical interventions is that they raise false hopes about improving health and neglect the process whereby better health is sustained (Rifkin and Walt, 1986). In a similar manner, the World Health Report (2008, p. 13) made a critique of 'selective or vertical' approaches:

> Selective" or "vertical" approaches focus on individual disease control programmes and projects… A focus on programmes and projects is particularly attractive to an International community concerned with getting a visible return on investment… many have hoped that single-disease control initiatives would… strengthen health systems as interventions were delivered to large numbers of people, or would be the entry point to start building health system where none existed. Often the opposite has proved true... short term advances have been short-lived and have fragmented health services…. (World Health Report, 2008)

WHO-PHC Review (2003, p.59) has also observed that:

> Although donor agencies contributed in implementing PHC, sometimes their efforts were not well coordinated. In some countries, the donors 'dictated' their involvement in health work, and more often than not, were seen to drive selective PHC. The concentration on a few selective elements of PHC contributed to failure to promote the comprehensiveness of PHC. Lack of effective ownership of PHC projects in host communities is common, probably because these communities were not properly involved in the decision-making process. The PHC policy formulation process did not clearly seem to have involved

> people's participation at grass-roots levels and managers of lower structures in the health care hierarchy. This top approach weakened the policy formulation content and jeopardized the effective ownership of PHC projects by the communities.

When health programmes in forms of intervention are introduced, the positive impact of such programmes may be visible at the beginning, but this can only be sustained when the people of the community are part of the decisions that led to the introduction of such programmes.

5.3.4 Politics of Health Care Delivery

To the extent that PHC delivery requires the participation of the people of the community, the health professionals, non-governmental and governmental agencies alike, then it can be described as a complex social and political process that requires political decision-making.

The political context of PHC in Nigeria can be linked to the efforts of various governments to implement PHC policies in line with the principles of the International Declaration of 1978 – (Alma-Ata Declaration on Primary Health Care). The Declaration stresses the need for a comprehensive strategy that not only provides basic health services for all, but that also addresses the pervasive underlying social, economic and political causes for poor health (Werner, 2003). It was recognized at Alma-Ata that the promotion and protection of the health of the people is essential to sustained economic and social development and contributes to better quality of life and to world peace (Primary Health Care Review, 2003).

The AAD proposed a paradigm shift in which a more consultative process involving the communities would replace the traditional top-down approach to the delivery of health care (Nigerian Health Review, 2007).

The Declaration, according to Abubakar (2006), has established the critical role of the state in the provision of health care by making it a political, social and economic issue of which only the state has the capacity and powers to realize the goal. This is consistent with the dominant perspective in the literature that "in spite of its changing role the state to a great extent retains its central position in selecting and legitimating policy goals" (Peters & Pierre, 2006, p. 219).

What is at issue here is understanding the nature and character of the state responsible for policy decisions. The Nigerian state has been characterized as a 'fragile state' and this has implication for its policies and how the policies are implemented.

A fragile state, according to Osaghae (2007) may be defined as a distressed state that lacks the elements necessary to function effectively. Specifically, fragile states are characterised by one or more of the following:

- Weak, ineffective, and unstable political institutions and bad governance, conducive to loss of state autonomy; informalisation; privatisation of state, personal and exclusionary rule; neo-patrimonialism; and prebendal politics.
- Inability to exercise effective jurisdiction over its territory, leading to the recent concept of 'ungoverned territories'.

- Legitimacy crisis, occasioned by problematic national cohesion, contested citizenship, violent contestation for state power, perennial challenges to the validity and viability of the state, and massive loss and exit of citizens through internal displacement, refugee flows, separatist agitation, civil war and the like.
- Unstable and divided population, suffering from a torn social fabric, minimum social control, and pervasive strife that encourage exit from rather than loyalty to the state.
- Underdeveloped institutions of conflict management and resolution, including credible judicial structures, which pave the way for recourse to conflict-ridden, violent, non-systemic and extra-constitutional ways in which to articulate grievances and seek redress.
- Pervasive corruption, poverty, and low levels of economic growth and development, leading to lack of fiscal capacity to discharge basic functions of statehood, including, most importantly, obligations to citizens such as protection from diseases like AIDS and guarantees of overall human security (Osaghae, 2007 p.692).

Nigerian state exhibits some of the above characteristics of a failed state. The fragility of the Nigerian state is manifested in its inability to provide the basic needs (including social amenities) for the citizenry. Furthermore, the unsettled issue of poverty in the country has consistently made any meaningful development strategy a mirage.

The Federal government adopted the primary care approach as the principal health care development strategy and consequently, the Nigeria's National Health Policy which affirms the centrality of health to social and economic development was enunciated in 1988 (ADB, 2002). The policy seeks to empower local communities by emphasizing greater decentralization of decision-making through the devolution of greater autonomy to the State, Local Governments and Communities. But as Rifkin (1986, p. 244) points out:

> Any decision which involves people who traditionally have not been included in that decision is a question of power and control. In most cases, it means those who have had a monopoly on a certain kind of power are asked or forced to give up that monopoly. The transfer of power is likely to result in a range of conflicts which reflect both policy and implementation (Rifkin, 1986, p. 244).

As it relates to the community having power over decisions, Ransome-Kuti (1998, p.8), emphasizes that "it is not easy to convert a community from passive recipients of services to assertive owners and for health workers to accept these new roles for the communities". These observations provoke a question which directs our analysis on the nature of politics of health care in the country; is it possible to explain the development in PHC in terms of the impact of a relatively few groups in the health arena? Which group(s) possesses greater relative power in the process of its implementation?

It is important to note here that health has always been an important component of successive development plans in the country. The National Health Policy that was

adopted in 1988 and revised in 2004 identified PHC as the cornerstone of the national health system and adopted its strategy for its health care delivery.

Inextricably linked to the successful implementation of the PHC components as contained in the Alma-Ata Declaration are the five principles of equity, community participation, universal access, appropriate technology and intersectoral collaboration (WHO, 2003). Objective assessment of the performance of the PHC Policy will find meaning within these five principles since the success or failure of each of the five principles invariably affects the implementation of the PHC.

Operation of the five principles requires effective legislation on the part of the government. This process involves a complicated interaction amongst government institutions and actors; legislators, ministers, health professionals and bureaucrats in the ministries and relevant agencies, also included are non-governmental agencies and the communities at the local level. The relative power of these actors to influence decisions determines the extent to which the objectives of PHC are achieved. The question again is what group(s) wields greater influence on PHC decision-making?

Determining who wields greater influence on PHC decision-making depends on the relative position and powers of the actors in the process. The argument is that there is a great difference between the powers individual actors bring to the table to negotiate. The relative strength of each of the actors determines whose interest gets reflected in policy.

The health policy makers, the medical professionals, and the community people all have interests. Where there is a convergence of interests between the community people in relation to what the people expect from the health system, and the health professionals, as well as policymakers (refers to here as the elites) then we can begin to talk about health care decisions reflecting the needs of the people. But at the same time, where there is a divergence of interests, decisions are not likely to reflect the wishes of the people.

PHC requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of PHC, making fullest use of local, national and other available resources; and to this end develops through appropriate education, the ability of communities to participate (Alma-Ata Declaration 1978). For this to happen, there must be political commitment and all health cadres should appreciate the value of community participation (Adeyemi, 1999, p. 45). Suffice it to say that power to make decision on PHC should reside with the people of the community. This supports the opinion of Murray (2004) that the level of participant's influence or control of decision-making, actions and outcomes are often key to the descriptions of community participation. What this means is that not all the people, particularly those with the greatest needs participate in policy-making process.

In the opinions of some of the interviewees in this study:

> Initially decisions are taken by both community and health officials at least to an extent, but now political sentiments have come in, what I mean by political sentiment is that your

> community can only get what you need if you have people with the right connection. We no longer take part in health decision-making, we cooperate more with NGOs and whatever little achievement we have, they should take the credit (FGD, Akoka, 2008).

This expression indicates that community participation in health care delivery is an issue of 'who gets the 'what' of health care service, when it is available, and how this is done'. And like all issues of politics this depends on the relative power of the participants in the struggle.

The implementation of PHC is more than a mere translation of its objectives into routine procedure, it involves fundamental questions about decision-making on how functions are allocated, and resources appropriated. These are political issues that engender conflicts in the society. For example, budgetary allocation to the health sector; in 2008, was N138.2 Billion. This represents 5.6 per cent of total Budget of N.748 Trillion and 14.4 per cent above the sum allocated to the sector in 2007. However, this is still below the 15 per cent Abuja Declaration (NigerianMuse, 2008).

The Table below shows budgetary allocation to health sector in Lagos State between years 1999 and 2007.

Table 5.4 Lagos State Distribution of Expenditure (Recurrent and Capital) to Health Sector from 1999 – 2007

Year	Description	
	Recurrent	Capital
1999	87, 688,667.00	105,000,000.00
2000	314,369,258.00	505,500,000.00
2001	136,514,404.00	660,000,000.00
2002	578,165,479.00	650,000,000.00
2003	792,132,488.00	600,000,000.00
2004	1,323,872,266.00	1,690,000,000.00
2005	1,902,578,802.00	2,496,505,000.00
2006	2,042,834,882.00	3,000,000,000.00
2007	2,795,885,963.00	6,800,000,000.00

Source: Lagos State Government, Ministry of Economic Planning and Budget

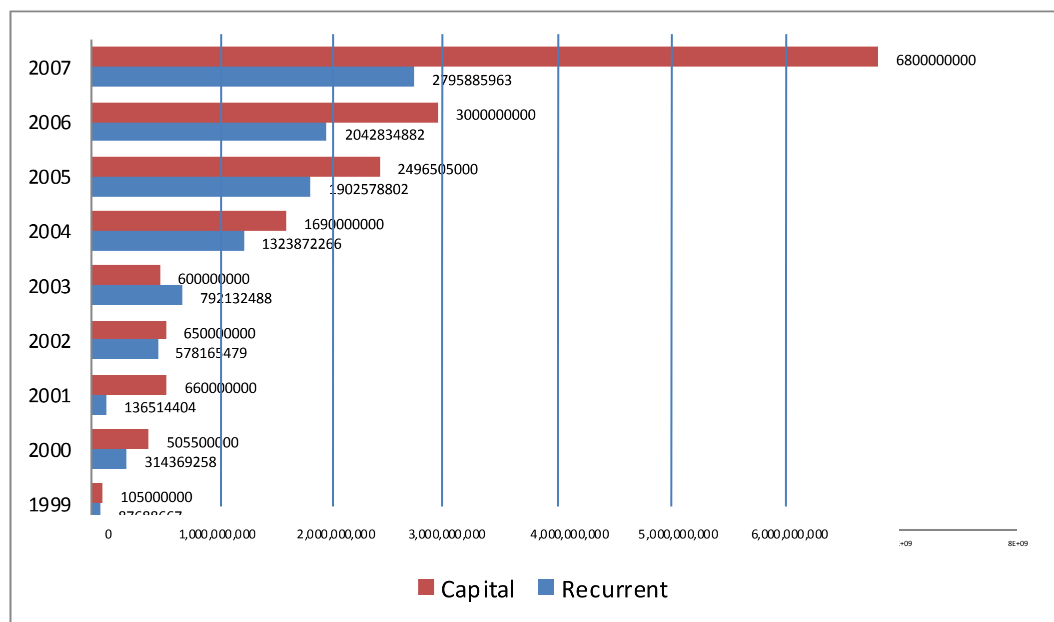


Figure 5.4 Lagos State Distribution of Expenditure (Recurrent and Capital) to Health Sector from 1999 – 2007

From the above Table, there was appreciable increase in allocation to health in the year 2000 for both expenditures. For instance, money allocated to recurrent expenditure increased from 87, 688, 667.00 in 1999, to 314,369,258.00 in year 2000. While capital expenditure increased from 105,000,000.00 in 1999 to 505,500,000.00 in year 2000. Recurrent expenditure dropped in 2001 but picked in 2002 and since then, there has been marginal increase in allocation up till 2007. There has been consistent increase in allocation to capital expenditure except for years 2003 and 2004 that witnessed slight decline.

As discussed earlier, budgetary allocation to health varies considerably. It is determined not only by the amount of resources available for appropriation but also by government's commitment to health and its ability to commit resources to health care services, since the health sector has to compete for resources with other sectors in the economy.

The premium that any particular government places on health will determine the extent to which such government will make resources available to meet its demands. The point is that, health care is a political issue that generate conflicts because "the extent of a country's investment in the health and welfare of its population, and how the money set aside for this purpose should be spent, are clearly issues which can never be settled in a way that satisfies everyone" (Douglas and Thomas, 1977, p.9).

The level of resource allocation to health care services is expected to have a resultant impact on health policy and consequently determine both the satisfaction of health needs and overall objectives of the health sector.

The inability of the people at the community level to influence health care decision-making, not only in terms of their identification of health needs, participating in the planning of local health system, but also in health budgetary process at the local level is an indication of their relative marginalization in health care development. This makes the whole idea of community in PHC strategy suspects.

Developments in the health sector in the country increased the decline of the community participation in PHC planning and management. The consequence is the poor performance of the health care system and its failure to solve the basic health problems in the country. The prevalence of diseases such as guinea worm, river blindness and meningitis amongst others, and the recent outbreak of major diseases in the country indicate the precarious state of the country's health care system. The Sunday Punch, March 8, 2009 p.17 reports that:

> Nigeria might be paying the price for neglecting its health care system, especially at the rural level after the outbreak of Meningitis, Lassa fever and Polio that have claimed several lives. The same tabloid reports that "millions of Nigerians now face a precarious health situation following inadequacies in the nation's health care system.

In the same vein, the Nigerian Medical Association declared in 2009 that "the nation's health sector is now near total collapse and there is very little cause for hope" (Sunday Punch, March 8, 2009, p. 7). The country is not spared from International embarrassment either. Also in 2009, the Fifth Session of the Advisory Committee on Poliomyelitis Eradication, in Geneva informed the World

Health Organization (WHO) that Nigeria posed a high risk to the International Community.

The Health Minister also reported that "the number of polio endemic countries has reduced from 125 to only four countries, namely Nigeria, Pakistan, Afghanistan and India with Nigeria retaining the unenviable title of the only country in the world with all the three wild polio varieties in circulation" (The Nation, April 7, 2009, p. 9).

The reason for pallous health situation is not be far-fetched. In the words of a former Health Minister, Osotimehin;

> The truth is that these meningitis outbreaks are just a symptom of a bigger problem that had been there for years. For too long, we have abandoned the Primary Health Care System, which would have taken care of major disease treatment and management at the lower levels. For too long, we had concentrated on general and specialists' hospitals to the detriment of the PHCs, which would have helped us carry out routine immunizations and disease management at the villages (Sunday Punch, March 8, 2009, p.17).

The point is that many of the diseases ravaging the country could have been prevented from the onset if there were effective ways of detecting them before their onslaught on the population.

Alubo (2010) raises the issue of how medical care can solve problems whose root causes is political and economic. 'The common diseases in Nigeria are nutritional such as kwashiorkor and marasmus; parasitic like malaria and water borne such as

cholera and guinea worm. How can cure to these conditions be achieved without attending to the root causes? (Alubo, 2010 p.11).

Effective dissemination of information on the nature of diseases and how to prevent them, using local resources and local technology is one of the strategies of PHC delivery, but which has not been effective within the health care delivery system. Rather, attention has been focused more on the curative aspect of disease management.

The Health Minister also observes that:

> We have been driving health from the centre in Abuja, thus disempowering efforts in the state and local governments. Now we want to decentralize the efforts to take the leadership from the states so that they can make sure that local government chairmen take control in their states (The Nation, March 31, 2009, p.51).

The Minister observation reflects the perspective of the Nigerian government on health problems and how they are been addressed. Alubo (2010), notes that there is a huge imbalance in health investment in favour of cure. This he argues is a deliberate ideological strategy for:

> Reducing problems of political and economic origins to medical problems serves an important legitimacy function for the capitalist system: makes people believe that structural problems can be resolved through the individualist approaches of modern medicine. It diverts attention from poverty and deprivation, the resolution of which will pose threats to the accumulation process. This is because ‘by situating the diagnosis and treatment of disease at the level of the individual, (Medicine) provided the ruling class with a means of social control: patients would fail to make common cause with each other or to protest the external, underlying conditions that make them ill. The effect is to

> depoliticize malnutrition, alcoholism, drug addiction and mental illness by defining them as medical problems' (Alubo, 2010 pp. 11-12).

Opinions from other quarters also suggest that health services in Nigeria are still largely dictatorial. "The occasional consultations and retreats with selected informants do not make up for the need to establish a process in which communities participate through the involvement of their credible representatives. There is still a tendency to pronounce policy changes without adequate consultation of the communities" (WHO, 2008, p. 68).

This is an indication that the community is experiencing double jeopardy. While the politics at the higher level conspires to exclude them from health decision-making, at the same time the politics at the local level also tends to disempower them. Ruling parties at the local government level have often been accused of favouring only party members within the communities while neglecting others.

According to the report from the community people:

> We are not part of decision-making, not really, politicians are in charge nowadays, we don't have information as to what is happening, information are hidden from us except you belong to the ruling party, even at that, you must belong to the right caucus even at the ward level, so politics is the in-thing (FGD, Igbogbo/Baiyeku 2008)

It is therefore to be seen that, within the overall context of the nature of decision-making at the local level, health care decision may exclude certain groups within the community.

While the rhetoric about community having power and taking responsibility for their health care persists (rhetoric because successive government in Nigeria had made effective community participation in health care delivery a slogan), implementation seems to belie the initial policy declaration. This tends to underscore the argument on the political context of the policy process. Politics can influence both the design process and design outcome in a number of ways (Ingram and White cited in Furlong, 1995, p. 57).

Politics of 'populism', 'partisanship', 'patronage', 'ideology', 'professional and technical predisposition', bureaucratic' and 'self-interest' can affect the quality of public policies (Sharkansky, 1992, p. 516-518). Implementing PHC policy of community participation may become a daunting task for the policy makers within the country's policy environment.

The view of the World Health Organization cited in Murray, (2004, p. 4) expressed this point clearly:

> It is a challenge for people working in local authorities, health authorities and other agencies to move from passive processes of participation that focus on the levels of providing information and consultation, to more active levels and genuine involvement processes which entail advising, joint planning and delegated authority. To achieve this some organizational change may be needed to ensure that resources, coordination, structures, processes and cultures within the organization truly support the effective development of tools and techniques for community participation and integration into decision-making practices.

In a situation where the political expediency does not encourage participation of the people in health care development, achieving the objective of better health for

the people may become impossible. The former Health Minister, Osotimehin's comment lends credence to the above. In soliciting the cooperation of State Commissioners to enable the elevation of the health delivery system in Nigeria and to achieve better health outcomes, the Minister expressed the view that:

> The first is the revitalization of our primary health care system. This can only happen if the state governments…work with our local governments' counterparts to ensure that robust attention that is required at community level is given to primary health care. This will mean adequate provision of resources, the engagement and retention of human resources and the guarantee of an optimal commodity supplies management (The Nation, April 6, 2009, p.4).

Considering the relative strength of the community vis-à-vis that of other actors in PHC decision-making, advocacy, lobbying and action for the effective participation of community in the implementation of PHC can only be meaningful when other actors within the process perceive the need for such. This tends to underline our earlier discussion on the issue of power in policy-making.

The decision about 'who gets what, when, and how' in PHC are made within the framework of power and influence. Those who influence decisions within this policy network are the powerful actors. Their action and inaction have consequences for other actors who are less powerful and not likely to influence decisions.

This brings to the fore the question whether the relative strength of the communities vis-à-vis other actors is sufficient enough to enable them participate effectively in health care delivery. Saltman (as cited in Singer 1995) notes that a sustainable participatory process in health care and social services will probably require that citizens be empowered with real influence in budgetary and resource allocation decisions. Communities are disempowered in the implementation of the PHC services because they do not have administrative, financial and political power to influence decisions. Decisions as to how health care services are to be distributed are left largely in the hands of professional and bureaucratic elites. Eboh and Dickson (2008) make this explicit, according to them, "the politics of health care in Nigeria disempowers the majority of the citizens by denying them the fundamental basic knowledge of what, how, where and when the issues of health care are being planned and implemented. And once a professional group approves a political agenda, it becomes the right policy for the country irrespective of the faults and deficiencies". The study finds evidence for the exclusion of the people in health care decision process.

One of the interviewees expressed this:

> The government is not really creating enabling environment for community to participate, sometimes we feel we don't even know what is happening, when you have this type of situation how do you participate? (FGD, Igbogbo/Baiyeku, 2008).

Another interviewee remarked that:

> Development Committees and community groups are close to the people, we are in a better position to influence our people, but we need to be empowered, let the government help in this matter, because if we are not empowered there is little we can

> contribute to our health care development (FGD, Igbogbo/Baiyeku, 2008).

One of the key informants makes the issue of community empowerment more comprehensible:

> The community organization groups are doing a lot of work, they should be encouraged. Imagine one health educator and his team in the local government, how much grounds can they cover, who will mobilize the people? If the government can have a way of compensating their work fine! The Community Health Extension Workers, Traditional Birth Attendants and the Community groups, all these people need to be encouraged. If you take our Ante Natal Clinic for example, the number of women attending is less than those going to the TBAs. Private hospitals, Mission hospitals, and Public hospitals take only about 30%, while the TBAs take about 70%. The reason they always give is that '*Ti nkan ba yiwo*' (when situation gets out of hand) the TBAs will know what to do, they can maneuver. So we use the community groups to talk to them, to educate them and to mobilize them to attend this clinic. The community groups can still do more if they are empowered (FGD, Ijeshatedo, 2008)

Xhafa (2007 p.21) rightly notes that health constitutes a strong platform for democratic participation and people's empowerment. PHC is perceived to be a natural process of people's and communities' empowerment, which work together for better health through strengthening health determinants.

The point is that health policy is an important instrument for influencing the health of individuals, families, and communities. Since PHC approach emphasizes greater community involvement in the planning and management of their health

care system, using this approach within the context of health policy will engender effective participation. This however, can only become attainable within a virile health system. The failure of the health system to respond to the twin demand of effectiveness and efficiency has also made the country's effort at achieving the health related millennium goals futile.

The direct health-related MDGs 1, 4, 5 and 6 respectively - eradicate extreme poverty and hunger, reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases can be achieved within an effective health system.

Table 5.5 Millennium Development Goals with Health-related Indicators

Millennium Development Goals	**Health-related indicators for measuring progress**
Goal 1: Eradicate extreme poverty and hunger	Prevalence of underweight children under five years of age
Goal 4: Reduce child mortality	• Under-five mortality rate. • Infant mortality rate. • Proportion of 1-year-old children immunized against measles.
Goal 5: Improve maternal health	• Maternal mortality rate. • Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases.	• HIV/AIDS prevalence among young people aged 15 to 24. • Condom use rate of the contraceptive prevalence rate. • Number of children orphaned by HIV/AIDS. • Prevalence and death rates associated malaria. • Proportion of population in malaria risk areas using effective malaria prevention and treatment measures. • Prevalence and death rates associated with tuberculosis. • Proportion of tuberculosis cases detected and cured under Directly Observed Treatment, Short course (DOTS).

Source: Adapted from the Nigerian Health Review, 2007

These targets are not exclusive, but mutually reinforcing. For example, the achievement of improved nutritional status in children (MDG 1) will have

significant impact on the reduction of child mortality (MDG 4). Reducing the burden of malaria and HIV (MDG 6) has a major impact on malnutrition (MDG 1), child mortality (MDG 4), and maternal health (MDG 5) (World Bank, 2009 p. 27).

Table 5.6 The Health-related MDGs and Nigeria's Current Level of attainment of Targets

Target	Indicator/Proxy Indicator	Level
MDG 1: Eradicate extreme hunger and poverty. Half between 1990 and 2015 the proportion of people suffering from hunger	Percentage of the population below $1/day. Income per capita. Prevalence of underweight in under 5. % of children <6months exclusively breastfed	58 29 17
MDG 4: Reduce child mortality. Reduce by two-thirds between 1990 and 2015, the under-five mortality rate	Infant mortality rate(per 1000 live births Under five mortality rate(per 1000 live births % of children aged 12 months vaccinated against measles % of children with diarrhea who receive ORT	100 201 30 40
MDG 5: Improve maternal health. Reduce by three-quarters, between 1990 and 2015 the maternal mortality ratio	Maternal mortality ratio (per 100,000 live births. % deliveries by qualified attendants	800 36
MDG 6: Combat HIV/AIDS, malaria and other diseases. Have halved and began to reverse the spread of HIV/AIDS by 2015. Have halved and began to reverse the incidence of malaria and other major diseases by 2015.	Adult HIV prevalence rate Contraceptive prevalence rate (all women) % using condom during last high risk sex: Female Male % of children sleeping under ITN TB incidence per 1000,000 TB cases detected under DOTS (%)	4.4 8.2 24 46 1.2 293 30.3

Source: Adapted from the Nigerian Health Review, 2007.

The current status in achieving health-related goals of the MDGs in the country shows a poor performance. As reported by the Nigerian Health Review 2007, Nigeria is the second largest contributor to child mortality worldwide. Annually, an estimated one million Nigerian children aged less than five years die, a figure

that represents 10% of the global total. Infant Mortality Rate (IMR) and under-five mortality rate (U5MR) stand at 100 and 201 per 1000 live births respectively. Maternal mortality remains a leading cause of death among women of reproductive age. While the country has only two percent of the global population, it contributes 10% to the global maternal mortality burden.

HIV/AIDS, malaria and tuberculosis are significant causes of morbidity and mortality in the country.

Nigeria has the highest TB burden in Africa and is fourth out of 22 TB high burden countries that contribute 80% to the estimated 3 million annual deaths from tuberculosis. The prevalence of TB in the country is 536/100,000 with an annual incidence of 283/100,000 and an estimated 105,000 deaths annually.

Malaria remains a major public health problem. Ninety percent of the population is at risk of malaria, with 50% having at least one attack of malaria annually. Pregnant women and children are the most vulnerable group with an estimated 300,000 children dying annually from the disease. Malaria contributes 30% to under-five mortality, 25% to infant mortality and 11% to maternal mortality in Nigeria (Nigerian Health Review, 2007:193-196).

The lack of significant progress towards the attainment of the MDG goals is not because technology for effective intervention is not available or that resources are not committed to it. The Nation Newspaper of April 7, 2009 reported that N57.3billion has been spent on the health sector since 2006.

The money which came from debt relief from the Paris Club, was the share of the Federal Government that it committed to a Virtual Poverty Fund meant to achieve the MDGs. Specifics of these are between 2006 and 2008. The sum of N16 billion was expended on immunization through the National Primary Healthcare Development Agency. The National Malaria Control Programme of the Federal Ministry of Health was supported with over N4billon for the Roll Back Malaria project while the HIV/AIDS programme was supported with N15 billion. The sum of N1.089 billion was appropriated through the Federal Ministry of Health for the take-off of the Midwifery Service Scheme with an additional N3billion in 2009. The CHIS in six pilot states target expectant mothers and children under five with an investment of N5 billion… (The Nation, April, 2009, p.7).

Even with the intervention, the health sector is yet to show a sign of improvement. The reason for the slow progress at achieving the MDGs may not be due to resource constraints, the major problem is that people especially those that are most in need of these interventions, do not receive them resulting in low utilization.

The attainment of the health-related MDGs depends on a functioning health care system anchored on PHC, that should seek to make the identified interventions, available, accessible and utilized through inter-sectoral collaboration and community participation (Nigerian Health Review, 2007).

In the face of the AAD, underscored by democratization process and complicated by economic recession, the health sector is therefore, challenged to devise structures and mechanisms to facilitate a bottom-up approach to management, community participation, a focus on the majority and the most vulnerable groups, accountability, cost containment and sustainability (Gardiner, 1994).

It is however, interesting to know that thirty years after the AAD, the country is trying to grapple with the fact that decentralization in the health sector may be the remedy for the country's ailing health care system.

This makes the role of ideology in health care delivery assumes an important dimension. Ideology of the leadership has a role to play in directing the nature of health care delivery in any particular country. Middle income countries such as Chile with its *Attencion Primaria de Salud* (Primary Health Care), Brazil with its 'Family Health Initiatives' and Thailand under its 'Universal Coverage Scheme' have shifted the balance between specialized hospital and primary care in the way that has contributed to significant improvements in health outcomes (WHO, 2008).

The failure of the health care system to produce desirable health care delivery may be explained within this lack of ideological orientation in the context of health care delivery.

This recognition reemphasizes the idea that:

> Without strong policies and leadership, health systems do not spontaneously gravitate towards PHC values or efficiently respond to evolving health challenges… health systems are subject to powerful forces and influences that often override rational priority setting or policy formation, thereby pulling health systems away from their intended directions (WHO, 2008).

In spite of the efforts of the various governments to improve the health system, their failure to evolve an ideology that will focus the country's health care delivery has continued to be the impediments to the effective performance of the nation's health care delivery system.

PHC approach with its emphasis on community participation though adopted by the country's health policy as a strategy of health care delivery has continued to be implemented in a way that does not reflect any ideological position of both policy makers and implementers. The philosophy and ideology of political leaders and policymakers of any country will shape and direct the objectives such a country wishes to achieve in relation to its citizens' well-being.

This underscores the importance of health policy as instrument of achieving the objective of providing basic health care services, and the whole notion of committed leadership towards health policy implementation.

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CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter presents the summary of the study, the conclusion reached by the study based on the investigation carried out in the communities, as well as the recommendations. The chapter also includes the study's contributions to knowledge in the area of research.

6.2 Summary

The first chapter gives a general background to the study. The statement of problem, the objectives of the study, research questions and scope and limitations of the study are all discussed. The chapter also provides the justification for the study and explains key terms employed in the study.

The second chapter provides the historical background of the development of PHC. It reviews literature on community participation, health and development and also explicates dimensions of policy process. The chapter examines the application of the processes of community participation across countries with the view to finding the gaps which the study fills. The chapter also discusses the theoretical framework employed in the study.

Chapter three is the methodology. It explains the choice of research strategy and its justifications. It discusses the data collection methods, sources of data, types of data sets and procedures for gathering data for the study. The chapter also discusses the methods of data analysis.

Chapter four is on data presentation and analysis. Data collected from the field survey are presented in this chapter. Two types of data sets- quantitative and qualitative are presented and analyzed.

In chapter five findings from the empirical study are presented and discussed extensively. The chapter discusses findings emanating from the empirical investigations of both the quantitative and qualitative study, and conclusions drawn from them.

The final chapter is the summary of the study, conclusion and recommendations. The chapter also presents contributions of the study to existing knowledge in the area of health care delivery.

6.3 Conclusion

The recognition that a poor state of health is a major hindrance to social and economic development makes health care delivery not only an issue of concern for governments, but also has made health care part of many policy initiatives in the country. The objective of promoting better health for the people remains an

agenda of governments in tandem with the global declaration of Alma-Ata in 1978, and in keeping with the Goals of Millennium Declaration of 2000. It is also in recognition of the fact that the health system is in shamble and consequently deterioration in health condition of the people.

The reason for the downward trend in health system performance is not far-fetched; the PHC strategy of health care delivery adopted by the country has not been effective in meeting the basic health needs of the people. The communities are not in control of the planning and management of their health care system. The situation is further engendered by the failure in the implementation of the strategy of health care delivery in the country.

PHC evolves from a country's own conditions and addresses the main health problems in the community. It is the first contact of the citizens with the health care system, and so it is the gateway to a country's health care system. Its effective implementation should lead to progressive improvement of health care for all while giving priority to those most in need.

The goal of Nigeria's National Health Policy is clear; to establish a comprehensive health care system based on PHC that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country, within the available resources, so that individuals and communities are assured of productivity, social well being and enjoyment of living. Therefore, the role of the community in health care delivery assumes immense importance as PHC

requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of PHC.

This study however, has provided evidence of the decline of community participation in the forms and the processes of health care delivery contrary to the approach of PHC which emphasizes the participation of communities in the planning of their health care development. Most of what has been described as community participation largely takes the form of incorporation of communities into implementation of health programmes. This situation precludes the community from having the power to decide on health goals and means of achieving such goals.

The root of the crises in the health sector therefore is the gradual disengagement of community participation in health care development. It is gradual in the sense that community participation has never ceased to be part of health care delivery pronouncements by successive governments in the country, (an indication of apparent decline in community participation in health care delivery). Beginning from 1975 when the BHSS was introduced, to the formulation of National Health Policy in 1988, through the revitalization of the nation's primary health care in 1999, community participation has continued to be the thrust of health care delivery. The present administration's focus on reforming the health sector in line with the demands of the MDGs also places community participation on a very high pedestal.

However, the ways PHC programmes are implemented belie the objective of making the community partner in health care development. Rather than be a partner, the community is turned subject of health care delivery. Why this is so lays bare the fact of the matter that, politics of health legislation, health care financing, health programmes development and implementation by successive governments disempowered the communities.

With the state of their powerlessness, communities cannot but be marginalized in the process of health care development. The trend is for successive government to view community participation in health care delivery as an issue which should be placed on the front burner. Therefore, while various legislations evolve, the rhetoric endures. This has continued to be the bane of health care delivery in the country.

The precarious state of health care system however requires the government moving from the state of rhetoric to pragmatic action in order to achieve a better health for its citizens. This can only be addressed when a functioning health system is in place, with the goal of providing better health for the people and when the political condition supports such. This is because health is not just a technical matter but inextricably linked to political concerns.

6.4 Recommendations

The effectiveness of health care delivery is hinged on the nature of "health governance". The study therefore suggests that a system of health governance that incorporates the complex nature of health care delivery in the country should be instituted. Mechanisms, processes and procedures of health care delivery, as well as roles and responsibilities of various levels of government and stakeholders in health care delivery services should be clearly defined and made operational within the inter-governmental arrangement in the country. This is necessary to avoid the often conflicting roles and responsibilities of various levels of government in health care delivery.

Since the alternative strategy of health care delivery is yet to be found, and PHC approach which incorporates community participation into its strategy of health care delivery is still enduring, the study recommends that government should device ways of reintegrating the notion of community participation into the strategy of health care delivery in the country and ensure that its implementation as much as possible is bereft of politics. The country's health care system should continue to be oriented towards primary health care with the main objective of achieving the health related Millennium Development Goals. Furthermore, Health Policy that uphold community based approach and promote a wider understanding of its purposes, functions and expectations should be sustained.

Community participation in health care delivery will be effective only when there are policies, pragmatic approach and deliberate action on the part of government. This should be done with a purpose of moving the people at the local level towards the realization that full participation in health care development will provide the benefit of attaining optimal health outcomes. Empowerment of the people should therefore be seen as a real possibility of engendering effective participation of the community in health care delivery. It is important to note however, that this can only be achieved when there is political commitment on the part of the policy makers to actualize the objectives of health for all.

This study recommends an integrated health care financing which incorporates all the stakeholders in health care delivery. Against the backdrop of the Bamako Initiative, community financing of health care should be resuscitated. This is most likely to make community people claim ownership and control of health facilities and thereby encourage participation. Likewise, appropriate strategy of mobilizing resources for health needs to be explored. Aside from government funding of health care, efforts should be directed at encouraging public-private partnership of health care funding with a framework for collaboration established.

This study recommends 'participatory development' ideology in health care delivery in the country. This is with the view that changing the social order as it affects health care delivery and its implications for citizens' health outcomes can be achieved within the context of an enduring ideology. Appropriate ideology that

reflects peoples' orientation and their own perspective of development will engender participation in health care delivery in the sense that those who matter will be involved in health decision-making.

6.5 Contributions to knowledge

- The study has shown the importance of partnership for improved health care delivery service. It has been able to demonstrate that communities matter in health care decision-making, and unless the Community Based Approach is accepted as the cornerstone of an integrated health care delivery system in Nigeria, the myriad of problems confronting the health care sector may remain unresolved for a long time to come with very severe consequences for the nation.

- The study has been able to demonstrate that an integrative health care financing will increase participation and bring about commitments on the part of the citizens to health care development at the local level.

- The exposition of political influences in health care policy as a catalyst to the poor state of health care delivery in Nigeria presents another perspective on health care delivery. This represents a contribution to the growing literature on the politics of health care delivery.

- The use of indicators developed from a model designed for qualitative inquiry which this study adapted for its quantitative method for a meaningful triangulation, reinforces the eclectic nature of health care research in developing

countries. This is a significant contribution to health care delivery knowledge in Nigeria.

- The study has also shown the need for a more integrative efforts towards the formulation, implementation and sustenance of health care policies which will directly impact on the lives of the people who are strategic to the developmental aspirations of any country.

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APPENDICES

Appendix I

DEPARTMENT OF POLITICAL SCIENCE

FACULTY OF SOCIAL SCIENCES

UNIVERSITY OF LAGOS

AKOKA, YABA.

LAGOS

Topic: Community Participation and the Politics of Health Care Delivery in Lagos State (QUESTIONNAIRE)

Dear respondent,

This is a research work being undertaken by a doctoral staff-candidate of the University of Lagos. The study is an academic exercise being pursued in the furtherance of the award of a doctorate degree.

This questionnaire is part of the work designed to find the forms and the extent of community involvement in the planning and implementation of Primary Health Care in Lagos State. Primary Health Care (PHC) is a strategy developed for providing health care services with the participation of the community. You are requested to complete the questionnaire in utmost good faith.

Thank you for your cooperation.

Please tick **[√]** as appropriate.

Quadri Maryam Omolara (Mrs.)

Questionnaire No.
Community/Village
Local Government
Date of Interview

Time commenced…………..... Time ended…………………

SECTION A: SOCIO-DEMOGRAPHIC BACKGROUND

	Question	Coding Categories	Code
1	Age group	25 -29……………………….1 30 -34……………………….2 35 -39……………………….3 40 -44 ……………………….4 45 – 49 ……………………..5 50 and above………………….6	
2	Sex	Male…………….1 Female…………..2	
3	Marital Status	Married………………….1 Single……………………2 Separated…………………..3 Divorced…………………4 Widowed…………………5	
4	Number of children	None…………………1 1 -3……………………2 4 – 6…………………..3 7 and above…………..4	
5	Religion	Christianity…………..1 Islam…………………2 Traditional…………….3	
6	Educational status	None……………….1 Primary school………2 Secondary school……3 Higher Education……4	
7	Occupation	Manager……………………..1 Executive Officer…………….2 Educationist……………………3 Health worker…………………4 Clerical Assistant …………….5 Trader…………………………6 Artisan………………………..7 Others please specify………….8	
8	Ethnic background	Yoruba……………………1 Ibo……………………….2 Hausa/Fulani………………..3 Others please specify………4	
9	Length of residency (minimum of five years)	………………………………………	
10	Were you born in the community or migrated?	Born…………….1 Migrated…………2	
11	Do you have any social position in the community	Yes……………..1 No……………….2	
12	If yes to Question 11	Specify……………………………….	

NEEDS ASSESSMENT

	Question	Coding Categories	Code
13	How many health centres/clinics or health posts are there in this community?	One…………………1 Two…………………2 Three…………………3 Four…………………4 Five and above……….5	
14	Which of these services are currently provided in this community?	(Please circle all that apply) Under 5 consultations………………1 Adult consultations……………………2 Antenatal services…………………..3 BCG Immunization…………………4 Measles Immunization……………..5 Blood tests laboratory services…….6 X-rays services……………………7 Others please specify……………..8	
15	Which of these services do you consider appropriate to the health needs of this community?	(Please circle all that apply) Under 5 consultations…………………1 Adult consultations……………………2 Antenatal services……………………3 BCG Immunization ……………………4 Measles Immunization…………………5 Blood tests laboratory services………..6 X-rays services……………………….7 Others please specify………… ……..8	
16	How often do you use the health facility in this community?	Every time…………………..1 Once in a while……………2 I don't use it at all………….3	
17	Who determines the type of health services in this community?	The Government……………………….1 The Community………………………..2 The Government and the Community……3 Others please specify……………………4	
18	Do you have any health programme(s) currently being implemented in this community?	Yes…………………….1 No……………………..2 Don't know…………….3	
19	Who introduced the programme to the community?	Government Health Officials……………….1 Non-Governmental Organisation……………2 The community identified the need for such programme and demanded for it…………….3	

RESOURCE MOBILISATION

	Question	Coding Categories	Code
20	How is health care financed in this community?	By the Government only……………………….1 By the Community only……………………….2 By Community based Organization only………3 By the Government and Community……………4 The Government and Community-based Organizations……………………………………5 The Government, Community and Community based Organization………………………………6	
21	In what way(s) does the community supports health projects in the community?	The Community provides manpower………….1 The Community provides necessary materials…2 The Community makes financial contributions towards the project………………………………3 All of the above…………………………………4 None of the above………………………………5	
22	Have you at anytime contributed money towards any health project in this community?	Yes…………….1 No……………..2	
23	Do you pay for the services provided at the health centre?	Yes…………….1 No……………..2	

ORGANISATION

	Question	Coding Categories	Code
24	Do you have Community Development Committee in this community?	Yes…………….1 No………………2	
25	Who determines the structure of the Committee?	Local Government Officials alone…………..1 The Community alone………………………..2 Local Government Officials and the Community…………………………………..3	
26	Does the Committee take part in the running of the health centre?	Yes……………….1 No……………….2 I don't know………3	
27	How often does the Committee meet with the health officials to discuss health matters in this community?	Once a week……………….1 Every two weeks…………..2 Once a month……………..3 Every three months…………4 Every six months…………..5	

MANAGEMENT

	Question	Coding Categories	Code
28	Does the community has a Board of Community Health Centre?	Yes………..1 No…………2	
29	Are there community representatives on the Board?	Yes…………1 No…………..2	
30	In what ways do community representatives participate in the community health care development?	By attending meetings with health officials to decide on health matters as they arise………..1 By bringing important health matters to the attention of health officials……………………2 By mobilizing community members to fund health projects………………………………..3 All of the above……………………………..4	
31	In what way(s) does the community participate in the implementation of programme and projects in this community?	By providing manpower for the project………1 By providing materials for the project……….2 By making financial contributions towards the project…………………………………………..3 All of the above……………………………….4	
32	In what way(s) does the community ensure the continuity of progammes/projects in the community?	By participating in the implementation of the projects ……………………………………….1 Through community's monitoring of the programmes/projects…………………………..2 Through financial support towards the project…3 All of the above………………………………..4	

LEADERSHIP

	Question	Coding Categories	Code
33	How would you rate the quality of leadership of the Committee?	Very High…………………1 High……………………….2 Low……………………….3 Very Low…………………4 Don't know……………….5	
34	Does the leadership represent all the various groups in this community?	Yes……………. 1 No……………….2 I don't know………3	
35	How does the leadership of the community health committee ensure that various groups' health matters receive attention?	By ensuring that different groups are represented on the community committee……1 By ensuring that various health matters are brought to the attention of the professional health officials……………………………2 Both ………………………………………3	

HEALTH SITUATION

	Question	Coding Categories	Code
36	What is the most common health problem(s) in this community?	……………………………………………	
37	Has it reduced in the last five years?	Yes……………….1 No……………….2 I don't know………3	
38	Why do you think the community suffers from this health problem(s)?	(Please tick all that apply) Poor access to water and sanitation………..1 Poor quality of water and sanitation……….2 Insufficient knowledge on prevention of diseases………………………………….3 Poor access to health facilities…………….4 Poor quality of health facilities……………5 High cost of treatmen……………………..6 Others please specify……………………..7	
39	How would you describe the quality of the health care service that you receive in the health facility in this community?	Very good…………….1 Good …………………2 Fair……………………3 Poor………………… 4 Very poor……………5	

Appendix II

INTERVIEW GUIDE FOR MEMBERS OF COMMUNITY DEVELOPMENT COMMITTEE, HEALTH COALITION GROUP AND COMMUNITY HEALTH PROMOTERS (FOCUS GROUP DISCUSSION)

Semi-Structured questions

Composition; Time of establishment; Main functions;

1. In what way(s) does the committee take part in identifying health needs of the community?

2. How do you get members of the community involved?

3. How do you get information on health matters across to the community members?

-What are the channels of communication?

4. In what way(s) does the community participate in mobilizing funds for health project in the community?

5. Does the committee take part in the planning of the health care system in this community?

6. Do you have any on-going health project(s) or health project(s) implemented not too long ago in this community?

-Who introduced the project(s)?

-In what way(s) is the community participating? Problems identified with the implementation

7. How do you ensure that various groups are represented in the committee?

8. How often do you hold meetings with health officials in this community?

9. Do you take part in taking decisions that affect the health of the community with health officials?

10. Would you say that involvement of the community people in health planning and implementation has led to the improvement of health care delivery in this community?

11. What do you think may assist community participation in health care delivery?

Appendix III

KEY INFORMANT INTERVIEW (KII) DISCUSSION GUIDE

Age……………………Gender…………………

Official Designation…………………………

1. What are the various services provided in this facility?
2. How do you identify the health needs of the community?
3. How adequate are the facilities provided for the community health needs?
4. Does this facility charge fees for treatment?
5. How do the community members participate in the planning of the health care delivery in this community?
6. Is there a Development Committee or any other Committee or Organization that work with this facility?
7. How does the Committee work with this facility?
8. How often do health officials meet with the committee to discuss health matters?
9. How do you get information on important health matters across to community members?
10. How do you get the community members opinion on health matters?
11. What are the prevalent health problems in this community?
12. What do you think is responsible for this health problem(s)?
13. In what ways are the community members mobilized to take part in solving health problems?
14. What do you think may assist community participation in health care delivery?

APPENDIX IV

APPENDIX V