THE INFLUENCE OF CITIZENS' PARTICIPATION IN PRIMARY HEALTHCARE SERVICE DELIVERY IN ADO-ODO/OTA, OGUN STATE, NIGERIA

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Abstract

An efficient and effective healthcare system is one that is inclusive, equitable and comprehensive. In achieving this, a holistic understanding of the needs of the various stakeholders is very imperative, particularly the citizens, who are deemed the recipients of the health care services. Studies conducted in various countries around the world, show that citizens' participation has led to observable health status changes in different communities. The Nigerian situation shows low level of citizen participation in health care as a component of the national health policy as well as state health plan towards the achievement of Universal Health Coverage. This study adopts descriptive survey through the use of questionnaire to provide evidence on the level of citizen's participation in the implementation of the Strategic Health Development Plan using Ado-Odo Ota local government in Ogun State, Nigeria as a focus. Findings show that despite the incorporation of the plan and citizen's participation component, there is little participation of the citizens in the community. It is therefore recommended that local governments seek citizens' attention not just informational through community associations but collaboratively with the use of town hall meetings and programmes that take cognizance of the education level, need and advice of the citizens within the community.

Keywords: Ado-Odo/Ota, Citizen participation, Health care, Implementation, Nigeria, Ogun State

1. INTRODUCTION

The well-being of a nation is the responsibility of a government. One of the fundamental ways to enhance the well-being of citizenship is to have a well formulated and implemented healthcare system. This is to say, a healthy person is a secured and productive member of society, able to be a full participant in community development and nation-building (Reisman, 2007). In 1962, the World Health Organization popularised the slogan "Health is Wealth" to highlight the role of an effective healthcare system in the development success of countries (World Health Organization, 1963; Campbell, 2007; and Sama & Nguyen, 2008). To reinforce

the importance of health to a nation's development, at the First International Conference on Primary HealthCare in Alma-Ata, USSR, in 1978, over 100 developed and developing countries, including Nigeria, joined the agenda of "Health for All by 2000". Community participation was a key component in achieving the set goal, where individuals and families are engaged as active participants in their own healthcare agenda (WHO, 1978).

Citizens' Participation is the active participation of individuals along with their policymakers in the decision-making process of their healthcare programmes. Highlighting the possibilities of participation in the decision-making process has become a key issue of discussion in various studies as well as within diverse policies, especially with participation being central to democratisation (Williamson, 2014). Studies on participation incorporate issues such as citizens' involvement in the execution of health programs, decision in health insurance selection, and inclusion in policies. The studies showed that citizens' participation influences decisions that can achieve health realities (Goldhill, 2013). What has emerged from these processes is that participatory arrangements that are interdependent of actors such as (citizens, policymakers, health workers) are more able to solve the collective national health problems because they are based on diverse, complete and quality decisions of the actors (Reisman, 2007).

The results in such studies as that of Omoruan, Bamidele, & Phillips (2009); Scott-Emuakpor, (2010); and Farmer & Nimegeer, (2014), thus far in primary healthcare has been modest, because not all the citizens are able to participate the same way in the decision-making process. What has become obvious is that the beneficiaries of primary healthcare participation have been the more educated or well positioned in urban environment; the rural dwellers that are in greatest need have not had their voices and needs met. This case is apparent in Nigeria, where it is observed that the population is predominantly rural, its national health policy is based on primary health care with a key component being community involvement, and its health status is primarily rated on the low spectrum (Abdulraheem, Oladipo & Amodu, 2011; Farmer & Nimegeer, 2014 and Ndegwa, Mavole & Muhingi, 2017).

Furthermore, citizen participation has proved to be an important strategy for overcoming the many shortfalls of the health systems. Shared responsibilities, attachments and accountabilities in services rendered, aside from being a good practice of democracy, it delivers better and cheaper returns on investment due to the knowledge and possibility mentality developed (Mukandala, Fox & Liebenthal, 2006, Matos & Serapioni, 2017).

This paper therefore seeks to ascertain the influence of citizen participation in primary healthcare policy implementation in various wards of Ado-Odo/Ota, Ogun State, Nigeria. The paper adopts the descriptive survey through the use of questionnaire obtained in the course of a pilot study to ascertain the level of citizens' participation in primary health care policy implementation in Ogun State, Nigeria between 2009 and 2018.

The paper is outlined as follows: introduction, literature review, brief information on Nigeria, research methodology, discussion of survey findings and conclusion/recommendations.

2. LITERATURE REVIEW

The Concepts of Health and HealthCare

The idea that good health, when not accounted for, can lead to loss of production due to worker's illness, reduction in enrolment of children in schools, thereby hindering their future contributions to the society; and the hindrance or reduction of resource utilization due to disease/illness management, among others necessitate the goal of good and collaborative health (Omoruan *et al*., 2009; Omoleke, 2010; Nnamani & Chilaka, 2012; and Baatiema, Skovdal, Rifkin & Campbell, 2013). Health and wellbeing are the consequence of an array of factors such as family medical history, individual lifestyle, community networks, socioeconomic conditions and cultural habits. These show that the conversation on health, the policy on health is not solely located within the respective "ministries of health" but are holistic societal discourses touching on every aspect of individual's life from infancy to elderly. Therefore the discussion on health needs a collaborative and interconnected viewpoint in order to engender robust healthcare system (Dahlgren & Whitehead, 1991).

Healthcare is the management, prevention and treatment of illness through services offered by healthcare professionals and organizations. It includes all the service properties designed to individuals or to populations", the medical care as well as the external parties involved in the care (WHO, 2000). Healthcare, when effectively applied, operates on three levels: primary, secondary and tertiary. The primary level is managed at the local level. It is the point of first contact with the national healthcare system for the sensitisation of health, healthy lifestyle, basic care being managed not always by a doctor but by the lower

level personnel such as nurses, midwives, community health workers. At this level, care should be reasonable, if not affordable due to less complicated cases. Care managed by local government is perceived to be more responsive, accountable and controllable; it brings healthcare close to where the citizens live and work, thereby backing the first element of a continuing healthcare practice (Adeyemo, 2005; WHO, 2014). While recognizing the place of secondary and tertiary healthcare within the system, for the focus of this paper attention is given to primary healthcare as the first point of influence in the service delivery of a country.

The Concept of Primary HealthCare

Primary Healthcare (PHC) is a first point of contact by individuals, families and communities to the healthcare system of a nation; it enables services to be close to the people where they work and live; thereby contributing to the continuity of the healthcare process through its tiers of operation. According to the 1978 International Conference on Primary Healthcare, Declaration of Alma-Ata, PHC is "essential healthcare 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 which the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, 1978:1). It was the brainchild of Professor Halfdan Mahler, the then Director General at the World Health Organization, that included over 150 countries (Lambo, 2015).

Primary Healthcare is also a policy that aims at moving the first level of care from sickness to development of both self and national health (Australian Government Department of Health, 2008; Rasak, 2013). That is, it is an overall and all-embracing system that seeks to provide care in an integrated way rather than as a vertical disease-specific programme, which takes the unique citizens wants and needs into account (Olukoya & Ferguson, 2003).

Principles of Primary Healthcare

There are five (5) main principles(objectives) that must exist in national health policies to show that primary healthcare is being practised efficiently and effectively (WHO, 2003: 2-7).

i. Equitable distribution: means universal care access to healthcare services irrespective of ability to pay, gender, age, location, mobility and ethnicity. This means making primary healthcare available and affordable. In many developing countries, including Nigeria, many care and services are readily available to the urban areas, those who are buoyant to afford the care, while the rural populace and urban slums are underserved.

ii. Community participation: full participation of the community and its resources in defining, implementing and evaluating specific health agenda.

iii. Inter-sectorial coordination: being aware that health and well-being are not the exclusive responsibility of the health sector but inclusive of others such as: government, businesses, private and non-governmental organizations (NGOs), implying "all hands on deck" approach to continuous care and services: primary care to tertiary, with the full inclusion of family and community;

iv. Appropriate Technology: the use of medical technologies that is feasible, affordable and culturally appropriate to the individuals and communities especially to reach communities with limited to no access to healthcare services. Creating a health equity for social justice; and

v. Health Promotion: helping individuals and communities to be aware of socio-economic, political, and environmental conditions that add to good health; taking ownership of one's own health and well-being.

The Concept of Citizens' Participation

Citizens' participation is the process by which members of a community share power with public officials in making fundamental decisions related to a particular issue or set of issues (Robert, 2008). Citizens are societal members and individuals that do not hold any public office or government positions, nor works with any particular agency that are in a community.

It is an integral principle of democracy that gives legitimacy, transparency, accountability, fairness and other democratic ideals (Lukensmeyer & Torres, 2006). Citizens' participation is the involvement of individuals that reside in a local government area in the administration of public goods and services, successful execution of public services for the citizens "well-being" (Mirzaei, 2013). Therefore, for an effective primary healthcare policy to be well executed, it should have at its heart the people for whom the policy is made (Metiboba, 2012). The policy execution and see it to a logical conclusion by the people for the people with the people

being active in the policy process which is all-encompassing with such procedures as identification, promotion, and administration.

Aims of Citizens' Participation

a. Citizens become self-reliant due to all the levels involved in the understanding of health.

b. Citizens build critical awareness and freedom to access situations on the ground.

c. Citizens develop problem-solving skills from the interaction with self and external parties for community development (Metiboba, 2012).

Benefits of Citizens' Participation in Primary Healthcare Policy Implementation

Listed below are the direct benefits to the citizens' from their participation, which in turn can help government to achieve it healthcare goals:

a. Drawing from local knowledge regarding the needs of the community.

b. Shifting healthcare from the control of government to the individuals.

c. Creating locally relevant programmes.

d. Developing self-reliance, empowerment, self-confidence, and problem-solving skills.

e. Increasing and enhancing transparency and accountability from those involved.

f. Promoting democracy in the society and this enables fairness and justice in healthcare development.

Background Information on Nigeria

The Federal Republic of Nigeria is a West African country bordered by Gulf of Guinea to the South, Niger and Chad to the North, Benin to the East and Cameroon to the West, with latitudinal degree of 10.00^{o}N and longitudinal 8.00^{o}E. Its climate varies between equatorial, tropical and arid with the Niger River entering it from the Northwest to the South, exiting into the Gulf of Guinea. The 2006 Census puts the population at 173,938,000 million, and based on a population growth rate of 2.44%, its current population is estimated at 186,053,386 million, ranking seventh in the world population (Federal Republic of Nigeria, 2010:9). The country is predominantly rural in nature at 52.2 percent though with some major urban cities scattered across the states. Its national health expenditure is 3.7 percent of the Gross Domestic Product (GDP) as at 2014, and this is used to promote, restore or maintain the national health. It has a physician ratio of 2.3 per 10,000 of the population while WHO stated that anything less than 23 health workers per 10,000 would not suffice to achieve the primary healthcare coverage (IndexMundi, 2017).

There have been many attempts at reforming the healthcare system in Nigeria throughout the years but each has met with setbacks in either convincing, implementing or managing the issues involved. Issues have arisen from drugs and facilities undersupplied and available, understaffed or unqualified personnel; patients paying user fees and purchasing their own medication which sometimes they cannot afford. There is also the prevalence of manageable diseases such as malaria, typhoid, measles, tuberculosis that have remained major causes of death, including HIV/AIDS. Furthermore, many states and local governments lack the system to support her citizens in the course of an emergency. In the mix of these circumstances is the lack of coordination or understanding among the three tiers of government in Nigeria on what health plan to execute and by whom (Nnamani and Chilaka, 2012). Unfortunately, the aim at accessible health for all has not been achieved in Nigeria.

During the leadership of former Minister of Health and Human Resource, Professor Olikoye Ransome-Kuti (1985-1992), a National Health Policy was promulgated and based on the Primary Health Care principles contained in the Alma Ata declaration of 1978 (Olukoya & Ferguson, 2003). It described the goals, strategies, structure and direction of the Health Care system of Nigeria. PHC implementation became the responsibility of Local Government Areas (LGAs) in Nigeria, with the objective of attaining quality, accessibility and equity administration through the different health facilities: health post, health clinic and primary health centres. They will be supported by the States Ministries of Health, Federal, Private and diverse international donors and agencies such as United States Aids for International Development (USAID), World Health Organization and UNICEF (Alenoghena, Aigbiremolen, Abejegah & Eboreime, 2014).

Indeed, PHC experienced progress at its inception through integrated services with the creation of over 50 PHC facilities in the Local Government Areas of Nigerian States, targeted health programmes, and education of individuals and the community in such areas as teenage sexual education, HIV/AIDS. The under-five

mortality rate dropped to 109 out of 1000 deaths against 128 out of 1000 deaths, an increase in life expectancy, high alertness on nationwide vaccination and free immunization of all children which achieved a success of over 80percent of the nations' children (WHO, 2017; Aregbeshola & Khan, 2018). However with time and change in leadership, and regime whose focus were away from the public's involvement, the strides of PHC in Nigeria regressed.

Ogun State Primary Health Care Status

Ogun State is one of the states carved out of the old Western Region of Nigeria in February 1976; Oyo and Ondo are the other two. It has a population of about 3.7million people, based on the 2006 Census, with population growth rate estimated at 3%, the current population is 5,275,449.672 out of which 40-50% live in rural areas. The state's health goal is to provide quality, accessible and affordable health care service to its people by ensuring that primary health care is available within 5km of the populations living homes (Ogun Strategic Health Development Plan, 2010:12).

Ado-Odo/Ota Local Government Area in Ogun State, Nigeria came into being at May, 14, 1989 and has become a popular and industrialised LGA in the state. It is populated by the Yorubas, specifically the Aworis and Egbados. The LGA has 44 health centres to service its population of 527,242 according to the 2006 Census (Ogun Strategic Health Development Plan, 2010:8).

3. RESEARCH METHODOLOGY

This paper on citizens' participation and primary healthcare policy is based on descriptive survey design, specifically questionnaire administered on citizens of Ado-Odo/Ota comprising 31 respondents, distributed among 3 wards. The respondents were chosen randomly, this is to ensure the possibility of anyone living within Ado-Odo/Ota to be sampled at the time of the research.

The questionnaire was designed to collect basic socio-demographic characteristics of the respondents as well as the mechanism and tools of citizen participation at the local level with the PHC policy, through a 5point Likert scale response of High Participation (HP), Participation (P), Moderate Participation (MP), Low Participation (LP), and No Participation (NP). They were rated 1 to 5 with one being the lowest level of participation and 5 the highest. This also provides the information on the most utilized form of participation in the LGA.

The data analyses were done with the statistical package for social science (SPSS) version 22 as follows: the socio-demographic characteristics were analyzed through descriptive statistics using frequency distribution that are presented on a tabular chart. The frequency distribution using histograms show the level of participation and ways of participation in the LGA. From this, conclusion was reached.

4. DISCUSSION OF FINDINGS

A total of 31 questionnaires were administered at the following wards, Atan (10), Iju (11), and Ota 1 (10) with 100percent collection rate. The descriptive results shows that 90percent of the respondents were married between the age group of 31-40years old. There were a large proportion of women respondents at 54.8percent, more than the men at 35.5percent. The educational qualification of the respondents was predominantly secondary school certificate holders (61.3percent) who are mainly traders by occupation. These characteristics are presented in Table 1.

In the course of answering this question of citizen participation in the health care system with regards the health issues, majority of them utilized Community Association (80.6percent). This association is part of the mechanisms and tools incorporating community and citizen participation as described within the national health policy (2004) and state strategic health development plan (2010). This is followed at a distance by the Market leader at 6.5percent. This shows that the citizens do not directly engage the health system except through an intermediary mechanism. This presents a broad exchange of ideas from the citizens using community associations' to advance the needs and questions of the citizens. The option that shows direct engagement is low among the 31 respondents at 3.2percent. These data is presented in Table 2

Among the five (5) tools of participation: Fact Sheets/Flyers, Websites, Media outlets, Suggestion Boxes, Focus Group Discussion, Surveys, Phone Lines; Media Outlets and Focus Group Discussions were more utilized at 4percent, followed by Fact sheets/Flyers at 3percent then Suggestion Boxes at 2.5percent with Phone Lines being the least used. This is despite the high number of participation by the citizens. Overall, the citizens do not engage the PHC policy directly. The main sources of participation with the policy is through Community Associations which are citizen representatives, normally citizens of popular backgrounds, prominent families or the educated can speak well on behalf of the citizens to government

personnel. As this is a part of the mechanism proposed within the state health plan, it is an accomplished plan. However, the study revealed an overall low participation of the citizens in the health care system and this is in line with other studies conducted which reveal low citizen participation resulting in low performance of the PHC (Omoleke, 2005 and Azuh & Chinedu, 2014). In Ado-Odo/Ota, this performance rating real and further corroborated by Arnstein Ladder of Participation level-Manipulation: people are placed on rubberstamp committees or boards in which participation is likened to public relations mechanism for political elites. Public officials are the ones educating, persuading and advising the citizen (Arnstein, 1969).

5. CONCLUSION AND RECOMMENDATIONS

In conclusion, though Ogun State has recognized the need for citizen participation with its input desirable in the strategic health development plan, at the local level of implementation, this is low. The most utilized form of participation is through community associations which may be worthwhile, but does not really emphasise the ideals of participation as contained in the PHC. The aims of citizen participation according to PHC are the development of self-reliance, critical awareness of their situation and needs, and developing problem-solving skills from interaction with self and the external environment (community and government) for community development. While recognizing the low respondents for this study, it presents a sample of what to expect from a larger study.

This study recommends adequate funding for local governments that would allow for proper funding of each PHC facilities which would enable the needed staff strength for community education. It is apparent that the citizens need enlightenment on their health rights. This will allow them to make suggestions and ideas to the system. Also, with adequate funding, the community associations can mobilize for citizens' participation and be change agents in the narrative on public/primary healthcare delivery in Ogun State.

6. ACKNOWLEDGEMENT

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7. APPENDIX

Table 1: Socio-Demographic Characteristics

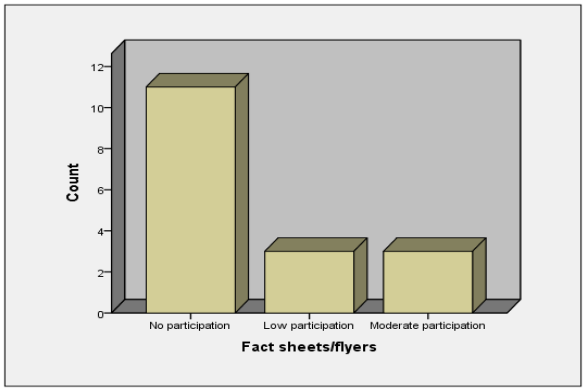
CHARACTERISTICS	FREQUENCY	PERCENT
WARD		
Atan	10	32.3
Iju	11	35.5
Ota 1	10	32.3
Total	31	100
GENDER		
Female	11	35.5
Male	17	54.8
Missing	3	9.7
Total	31	100
MARITAL STATUS		
Single	3	9.7
Married	28	90.3
Total	31	100
EDUCATION QUALIFICATION		
Primary	5	16.1
Secondary	19	61.3
Higher Education	7	22.6
Total	31	100
AGE		
21-30 years old	10	32.3
31-40 years old	12	38.7
41 years old-above	9	29.0
Total	31	100

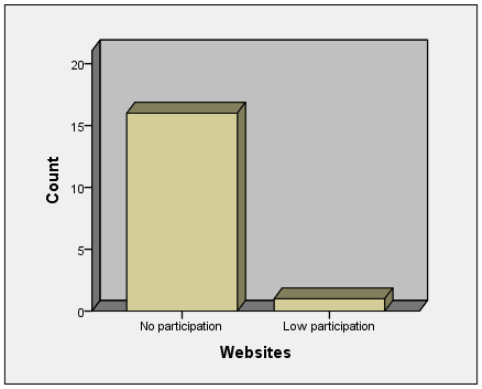
OCCUPATION	2	6.5
Unemployed	8	25.8
Professional	19	61.3
Trader	2	6.5
Artisans	31	100
Total		

Table 2: Mechanism of Citizen Participation

MECHANISM	FREQUENCY	PERCENT
Oba/Baale	1	3.2
Community Association	25	80.6
Market Leader (Iyaloja/Babaloja)	2	6.5
Local Government Chairman	1	3.2
Personal Engagement	1	3.2
Incomplete Response	1	3.2
Total	31	100

Figure 1: Tools of Citizen Participation Graphs





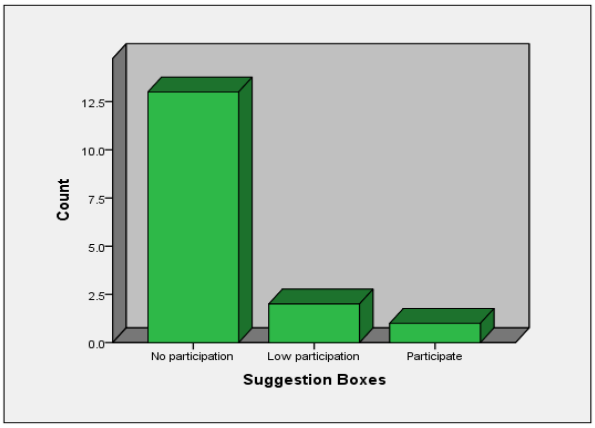
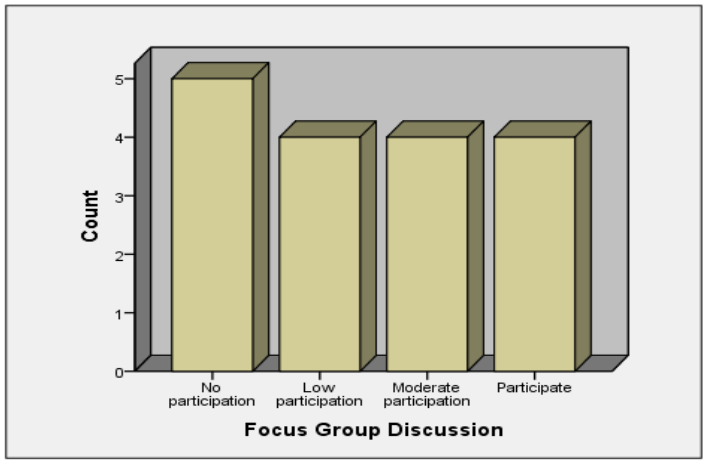
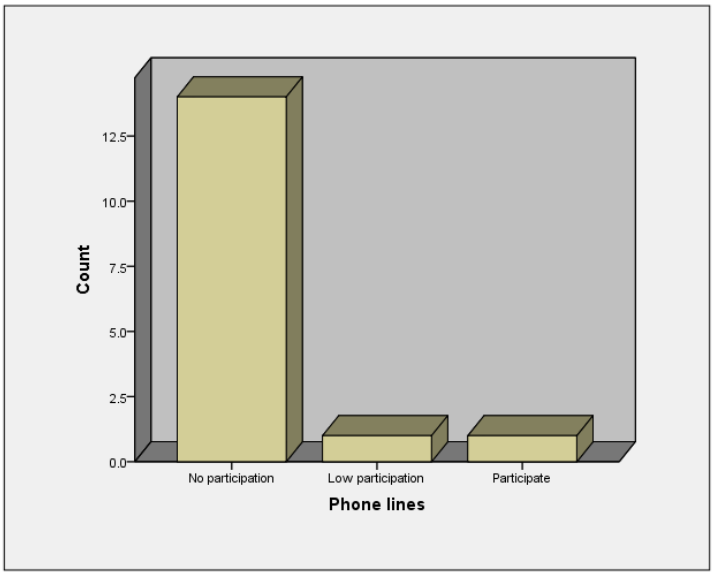


Figure 1: Tools Cont'd.





Source: Field Survey (2018)

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