Implications of the Ranking of Community Participation Strategies in Health Development by Selected Rural Communities in O-Kun Yoruba, Kogi State, Nigeria

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Abstract: *This study investigated the relative ranking of community participation strategies utilized for health development among the o-kun Yoruba of Kogi State, Nigeria. Data for the study were generated mainly by means of multi-stage sampling technique through the use of structured questionnaire administered to 235 respondents randomly selected from 7 communities in the study area. Techniques of data analysis were mainly the use of Preference Based Analysis and non-parametric statistics including simple frequency distribution. Findings from the study revealed that there was no uniformity in the ranking of such strategies among the study population. And the study suggests therefore that, aside from the fact that participation does not just occur, every community seems to opt for a community participation strategy whose end they are able to see more clearly, and utilize more to advantage, among several alternatives. One major implication of this analysis is that health planners and policy makers in the health sector must appreciate the fact that whether in rural or urban settlements, health behaviour is always a rational one. This study also recommends that end-users of health programs should be sufficiently involved in the critical stages of project formulation, planning, implementation, evaluation and decision-making.*

Introduction

Part of the principles of participation is the belief that the prospect for success in any attempt to change people's behaviour depends on two factors. One is the readiness or otherwise of the target group to change and two, the method that the latter believe will enable them to change (Young and Kingle, 1996). The most obvious interpretation one can give to this is that participation is an important principle of behaviour change. No principle of behaviour has greater recognizability than the principle of participation. Participation has resurfaced as a dominant voice in development literature globally. Participation in itself has been regarded as a process through which the local people influence and share control over development initiatives and the decision and resources which affect them. The term 'community participation' is used loosely in many nations today for different primary health care (PHC) activities which cut across the economic, learning and political spheres. The economic dimension of community participation is believed to be dominated even when community members contribute resources-materials, money, labour-to health care system.

Participation as a health strategy has been used in several countries across the world to affect disease control. For instance, the technique was employed to fight tuberculosis in many industrialized countries (Morgan 1993). Mass participation has also been used as a health

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strategy for trachoma (eye disease) control as well as malaria and water-borne diseases control in several developing countries of Africa including Liberia, Ghana, Nigeria, Togo, Kenya, etc. (WHO, 2000). One major reason for the prevailing difficulties in promoting community participation for disease control in some developing countries has been traced to non-involvement of the local people at the design stage of such projects. They are mainly made to participate in the utilization stage.

Community participation is a two-key process in which both community members and health workers are involved. Quite often, the community share in defining needs, carrying on specific tasks or responsibilities as well as gathering and processing information relevant to health with a view to enabling community members and health workers to learn from each other.

Participation in a greater sense, therefore, is the involvement of members of a particular community in the formulation of public policy or its implementation and its usage. That is, it is the participation of local people in the development process as a whole (Green 1986, Huff and Kline 1999). The following are the three interpretations of participation which reflect the different aspects of development;

(i) Participation means, in its broadest sense, to mobilize people and thus increasing their willingness to respond to development programs, as well as to encourage local initiatives;

(ii) Participation includes people's involvement in decision-making process, in implementing programs, sharing in the benefits of development programs, and their involvement in efforts to evaluate such programs;

(iii) Participation involves organized efforts to increase control over resources and regulative institutions in given social institutions on the part of groups or movements of those hitherto excluded from such control (Pearse and Stielfel, 1979).

For the purpose of this analysis, the third interpretation of participation which defines participation in terms of the people's access to resources and rights is being adopted for this analysis. Quite often, it is forgotten that participation is more than the mere contribution of money, material or labour to a development programme by the target group. It is even more than the people getting involved in the planning, monitoring and implementation of programs, or sharing in the benefits of such programs. Beyond all these, participation is a political process which enables community members to acquire a 'say' in decision-making and they also have a measure of control over facilities' providers who are supposed to serve their needs (WHO 1984, Oakley 1989).

Participation as a process has been widely recognised and accepted as both a basic right of people and of crucial importance to the success of development efforts generally. The challenge of development in the broadest sense is to improve the quality of life. In the world's poor countries especially, a better quality of life generally calls for higher income, better education, high standard of health and nutrition, less poverty, more equality of opportunity (Green and Raeburn, 1990). Although thinking on development is believed to have shifted repeatedly during the past five decades, the method of community participation, especially, has been one of the enormous efforts or strategies devised to improve the lives of millions of disadvantaged people in the world (Oakley, 1989).

It is in the light of the above, therefore, that the link has been made between participation and programs designed to improve people's health. It is believed that since many people in the world do not have ready access to health services and must rely on local knowledge and traditional practices for health care, it is, therefore, necessary to have a fund for local experience and resources in many parts of the world, which could be mobilized to support health programs.

Health Development and Grassroots Involvement in Nigeria

The current level of involvement by the communities in health care in Nigeria is believed to be quite limited in the public health sector. It is rather only at the grassroots level of village health worker/traditional birth attendants and village district health development committee where some participation in health care exists. Administratively, at the grassroots level, the community is represented at higher levels of primary health care and secondary health care planning and management by its representatives in Local Government's Area's (LGA's) administration (Metiboba, 2005). It is also instructive to note that there are lay-members appointed to the various states' Health Management Boards. Several rural communities in Nigeria have provided for themselves some health facilities like clinics, cottage hospitals, maternity centres and basic health centres through self-help. The people's expectation has always been that such facilities provided through their own sweat be immediately equipped by government with relevant material or drugs. The fact on ground, however, reveals that there is a yearning gap between their expectation and reality.

Several studies relating to this topic have revealed that beyond the provision of labour, money and material by community members for health development in several communities in Nigeria, their involvement in community-based health projects, especially at the critical stages of project planning, decision making and evaluation is still relatively low. It is sometimes argued that their relatively low level of involvement in community-based projects can be attributed, partly, to the increasing loss of faith in government officials and their programs.

Critics in some quarters tend to justify the apparent apathy of community members in health projects in developing societies because of the abysmal failure of these programs in times past to meet people's expectations and yearnings due to mismanagement of money and materials, ethnicity and flagrant abuse of due process. On the other hand, some health providers even detest the participation of the ordinary man in health matters because health issues, they claim, involve certain technicalities and skills which are often beyond the intellectual and professional horizon of a majority of the rural dwellers (Tumwine 1989, World Bank 1994).

The Need for Community Participation in Developing Societies

Several factors have been advanced for the desirability of citizen participation in health development among the rural dwellers in particular in developing societies. One of such factors is the seemingly alarming spate of rural-urban migration in most of these countries. Aside the undue pressure on the existing utilities and infrastructure, and an additional population from the rural areas to the urban centres, there is an urgent need to develop the relatively poor and scanty facilities in these rural areas. Quite often, most development programs in developing societies, especially the rural areas, do fail because of the non-involvement of the target group for which such programs are designed. Immunization programs in Northern Nigeria are a relevant case in point.

It has been estimated that families in the rural areas of most developing societies spend between 3-5 percent of their annual income on health care, and that government's funding of health has been relatively increased over the years. This increase in health allocation, however, seems not to have had a commensurate effect on mortality and morbidity in these communities. This development has been attributed partly to the non-involvement of the target population in the several health programs designed for them (Behm 1979, Palloni 1981).

Besides, in Nigeria, as well as in many African countries, the etiology of diseases has been discovered to be rooted in magico-religious factors. Some scholars have attested to the relationship between magic and medicine among the Yoruba of Nigeria (Oloyede 1985). Some others have also observed that magic and medicine are dependent on spiritual belief and inevitably connected with the supernatural and divinities or spirits. Where the concepts of disease and health are amplified by such magico-religious factors, it appears imperative therefore that health care can hardly be noticeably developed without the involvement of a vast majority of the people, at critical stages, who hold such beliefs (Awolalu 1979, Dopamu 1979).

From time immemorial perhaps, communities in Africa had organized themselves to take care of collective and individual needs. However, the question remains: why have so many attempts aimed at getting people involved and taking responsibility for community based development (CBD) failed in the last decades, especially in most of these underdeveloped countries? Prominent among the reasons being mentioned by some development experts for the failures in several participatory development efforts is the infusion of external management funds and technology controlled from distant places (World Bank, 1995).

In most parts of Tropical Africa, the concept of community participation is a kind of cultural heritage. Indeed, self-help efforts through which local communities provided several social amenities had their genesis in Africa even long before the attainment of political independence. Since no local, state or federal arm of government can meet all the demands of its people, the need for participation in development projects has therefore become highly desirable in most societies of the world in recent years.

The health status of some developing countries in the world till now is still quite worrisome. Even though life expectancy is believed to have improved in recent years in these countries, mortality rate is still relatively high. Diarrhoea and respiratory illness, exacerbated by malnutrition and several communicable diseases, still prevail in these countries. All these reduce productivity through workers' illness (WDR, 1993). The effect of this is the enormous problem in developing countries which cannot be tackled from one direction alone, making citizens participation quite an imperative.

Government's capital expenditure on health in most developing countries may have improved over the years but is still quite far from the WHO's minimum standard of 5% of total capital expenditure. In many countries in sub-Saharan Africa, between 1994 and 1998 for example, budgetary allocation to the health sector was not more than 3.5%. Available data revealed that the capital expenditure on health in Nigeria in 1994 was only (1.1%) of total capital expenditure, in 1995(1.1%), 1995(1.0%), 1997(3.5%) (Medupi, 1998). In comparison to other sectors like Defence and Industry, etc. the allocation to health has been abysmally poor. Similar scenario also obtains in budgetary allocation to health to many states and local governments in most of the developing countries such as Ghana, Togo, Republic of Benin, Liberia, etc (World Development Report, 1995).

Even though records have shown that families in these countries spend between 3-5% of their annual income on health care, and that government funding of health has relatively increased over the years, the effect of these seem not to have commensurate lowering on morbidity and

mortality in most developing countries. This partially has to do with the non-involvement of the target population in the several health programs designed for them (Behm 1979, Palloni 1981).

The role of ubiquitous socio-cultural factors in the aetiology of illness and the development of health care generally suggest that the attitude and values of the people for whom health services are designed are very crucial. It is a strongly held view for instance, among some social epidemiologists that the way in which illness is perceived by the people or evaluated tend to influence their reaction at the onset of the ill-health (Mechanic 1978, Igun 1989). One basic flaw in our society is that development studies tend to treat people as objects to be studied rather than subjects of their own development. It is the contention of modern development scholars that if we understand the role of socio-cultural factors in development issues, then it is possible to know the way in which attitudes and values are themselves formed. One will also be able to conceive individuals reflecting their own background and experience in a set of attitudes which, in effect, affect their behaviour (health behaviour inclusive).

A review of relevant literature on obstacles to participatory health development identifies some major obstacles hindering community participation in many developing countries. (Clark 1993; Jegede, 1998); these obstacles include, ignorance, emphasis on fund raising and leadership problem. Others are bureaucracy, nature of programme designed and the lack of political will.

Participation and Project Performance in Health

An analysis of rural and urban development since the 1970s has found high correlation between project performance and level of participation across nations of the world (Moench 1993, Morgan, 1993). Some scholarly works have revealed that participation was an important determinant in project performance and sustainability. In Kenya in particular, a report revealed that in agriculture, participation as a development technique succeeded in improving the living standard of many farmers and promoted the adoption of new techniques (Norton and stephens,1994).

In the area of health, the world health organization (WHO) has been found to play an important role in the promotion of community participation. Since the 1970s, WHO has actively supported a range of activities, and has begun to examine community participation in different fields of health practices so as to define clear strategies (Niaconsult, 1993). Therefore, community participation or involvement in health has become a common feature of several studies conducted in over twenty countries including Nigeria, Liberia, and Kenya. Research is also going on in thirteen others. The implication of this is that community participation in health is now central to health promotion or development and needs to be considered by all health professionals and administrators (WHO, 2002).

Although the concept of community participation in health is increasingly becoming a common phenomenon, its level of success varies from one country to another. Sometimes, certain extraneous variables such as ideologies, type of political system, kind of leadership, etc tend to have tremendously influenced the level of success of participation. For example, in 1972, Benin was reportedly the leading innovator in providing primary health care to rural population through the involvement of the local citizens. Benin developed a unique, state of- the- art primary health care strategy, covering the entire country, with little outside help. In spite of this, fifteen years later, however, Benin's primary health care was reportedly ranked among the poorest in Africa. One reason given for this result in Benin is that Benin had long been a Marxist state.

Leadership style sometimes provides a penetrating insight into how health workers could successfully promote participation. In Zimbabwe for example, by freely allowing the rural people to be involved in decision-making in health care services, an outbreak of measles was successfully checked among the local populace. From this explanation, it can be seen that community participation in health must be understood against a particular socio-cultural milieu.

Although participation seems to have resurfaced as a dominant voice in development literature, a closer examination at participatory practices of agencies with substantial experience in this field reveals that meaningful and broad-based participation is not easily achievable and it is not without cost or risks (Oakley and Marsden 1985). It is sometimes conceived that the benefit of participation outweigh the costs.

However, it is still quite unclear as to why despite such reported benefits of beneficiary participation, so many attempts aimed at getting people involved in community based projects tend to have failed in many underdeveloped societies in recent decades.

Approaches to the Analysis of Community Participation

The richness of the participation concept from the review of the relevant literature is reflected in the variety of approaches that can be used in its analysis. One feature of the reappraisal in the health sector has been the concept of 'participation', i.e. the idea that whatever material forms the development process may take; the active participation of the local people in any activity proposed or undertaken is quite paramount. A distinction can be drawn between spontaneous, induced and compulsory participation (Pearse and Stiefel, 1979, WHO 1989; Oakley 1989). ***Spontaneous participation*** is based on local initiatives which have little or no external support

and which have the capacity to be self-sustaining. ***Induced participation*** is said to result from external initiatives seeking support or endorsement for external plans or projects.
Compulsory participation however implies that people are mobilized willy-nilly to undertake activities in which they have little or no say or control.

A review of the literature on participation reveals a disagreement as to whether participation is essentially a process, a programme, a technique or a methodology. A cursory examination of the variety of interpretations suggests that there is no single form of participation that is relevant to all situations. It is also observed that different forms of participation have profoundly different consequences (Oakley and Marsden 1985).

Some scholars have argued that the emergence of community participation in health development programs has inevitably resulted in some deficiencies (Newell 1975, Donoso, 1978). These deficiencies include the following: (Morgan, 1993 Nyemetu, 1999).

i. Failure to encourage people to think or act for themselves in an attempt to solve their health problems, thereby making them to rely upon external sources for action and solutions.
ii. Failure to provide adequate training has made local people to be incapable of maintaining the service that had been set up. Available service could not be sustained by local resources and knowledge.
iii. Little active community involvement in program design and implementation.
iv. A lack of community interest in externally promoted health programs had often created conflict between health workers and the local people themselves.

Mobilization for Participation

Participation, according to some authors on this subject, will not just occur except it is mobilized (Sanda,1980). Mobilization may be self-propelled or externally propelled. Self mobilization takes place when a group, community or organization, conscious of the need to achieve a defined purpose, organizes itself to act to achieve that purpose. However, external mobilization occurs when a group or community may not be conscious of the reason to act to achieve certain objectives. Either form of mobilization could be voluntary or be as a result of the application of force (Nyemetu 1999).According to Famoriyo (1989) Mabogunje has distinguished three forms of mobilization as follows:-

i. *Natural mobilization:* individuals within a given society realise a mental perception or indicate some tendencies or inclination or intention towards an area or objective.
ii. *Representative mobilization:* individuals within a given society delegate the participation through ‘surrogates’ as it is in an electoral process.

iii. *Operational mobilization:* individuals within a given society fully and actively participate in a specific project. It is a kind of collective action.

According to Nyemetu (1999), Strategies of mobilization for participation include the following:

i. Raising of consciousness
ii. Providing incentives for participation
iii. Building of coalitions and encouraging networking amongst the relevant segments of the community which is to be mobilized.
iv. Involvement in identifying health needs selection, financing and management of the program.
v. Occasional subvention by the government to community health projects.

On the whole, the success of mobilization for participatory health development depends on the extent to which such mobilization has been able to enhance understanding of development issues that are sustainable both within and between interest groups, and also the level of communication reached among members of the community. It also depends on the network of committed individuals and institutions as well as re-negotiation of responsibility between interest and joint action for sustainable development (Oluwasola 1999).

Appraisal of Reviewed Literature

In this section, an attempt is made to appraise the major positions of the pertinent issues of community participation in health development as reviewed in existing relevant literature on this subject. On the conceptualization of health development, this study has taken particular cognizance of the fact that development process in the health sector is more than building up health infrastructure at different levels and introducing health practices based on 'western' concept of health care. This is quite instructive because true development in the health sector can not be divorced from a general societal transformation in any country. Before we can talk of development therefore in the real sense of the term, as far as health issues are concerned in any society, one should ask: what is the level of poverty in the community? One should also know what is happening to malnutrition, communicable diseases, urban congestion and ignorance or illiteracy in the rural sector of the economy?

This study has also viewed ultimate challenge in the health sector to be an enterprise far more than just reducing mortality and morbidity and so forth, but also to include higher income, better education, and high standard of nutrition as well as ensuring greater individual freedom.

It is also germane to note that while recognizing the variables influencing health development as propounded by some authors, it is important to also note that the role of the ordinary people must not be de-emphasized. Though the input received from experts and informed individuals in health matters cannot be under-stressed, it is crucial to note also that the input of the ordinary people who may not be knowledgeable in bio-medical science and western concepts of health and diseases, should also be captured for over-all health development.

With regards to the analysis or the concept of participation in this work, the distinction between spontaneous, induced and compulsory participation may just be for a mere academic or analytical purpose. This is because, under real life situation, they may not be mutually exclusive. One form of participation can dovetail into another, for example, spontaneous participation can become induced and a compulsory participation at the initial stage may end up as a spontaneous one.

Also, the view that community participation as a political process empowers people to have a 'say' in decision-making about health, is also subject to debate. This is because, quite often, this 'empowerment' can be a cosmetic one. It is obvious that even when ordinary people are involved in the early stage of health planning in many underdeveloped countries, they are hardly carried along during project monitoring, implementation and evaluation.

Further, some of the assumptions of community participation in health activities in most developing countries may not be realised. For instance, it is not known the extent to which the ordinary people can have some control over health workers who are supposed to serve their needs. It is also quite uncertain the real extent of improvement in the quality of decision-making through the participation of the ordinary people in health actions.

Most of the strategies of mobilization for participation reviewed above are far from being exhaustive. A relevant example in this regard is that of Nyemetu. For instance, the list glaringly leaves out mobilization through commendation and appreciation. Thee role of commendation or praises and conferment of titles and special honours with regard to mobilizing community members for participation in health projects cannot be over stressed in traditional societies in Africa where the conferment of titles, giving of accolades, honours and paying tributes is highly revered.

On the various problems identified in the literature concerning obstacles to participation in health development, it is quite obvious that factors such as corruption, ignorance, leadership or even bureaucracy do not as much as economic factors negatively affect success in health participation efforts. The factors of emphasis on fund-raising cited in the literature as a major obstacle to

participation in health projects tends to underscore the view in relevant literature that health behaviour, even among pre-literate and semi-literate people is almost always an economic-rational action. Some scholars have contended that where people refused rationally positive action even when their lives were seriously in danger, something must have disturbed their rationality (Zola, 1964).

It is also quite important to stress that the manifestation of these problems or obstacles to participatory health activities varies from one culture to another and from one form of health project to another. Literature reviewed in this work also touched certain areas of health care financing. It is necessary to stress that much of what a country spends on health care as a proportion of their total national income depends on how much value they place on health care in comparison with other categories of goods and services.

However, it is instructive to note that participation does not just occur. Its success is a function of interplay of several factors including socio-cultural variables such as belief systems, customs, norms and values of end-users of community-based projects (CBPs). The strategies employed for such participation, if they do not fit into the people's cultural values, scholars have argued that the participatory scheme will fail. The health belief model underscores this assertion as it assumes that the beliefs and attitudes of people are crucial determinants of their health related actions (Rosenstock, 1966).

It is within this context that this study wants to examine those participation strategies that the rural dwellers in O-kun Yoruba of Kogi State, Nigeria tend to prioritize over and above others in participatory health development.

Specific objectives of the study include the following;

i. To identify those participation strategies that are in use in health programs in the study area.
ii. To determine the relative rankings of those participation strategies among the study population (O-kun Yoruba of Kogi State, Nigeria)
iii. To highlight implication of such rankings for health development in O-kun land in particular and Nigeria generally.

What is Participation?

There is no single working interpretation of the concept of participation that has been universally acceptable. A variety of interpretations exist, giving rise to different forms of practice (Oakley, 1989). The concept of participation, however, in the study is used to include the mobilization of people, thereby increasing their willingness to respond to development programs as well as encourage local initiatives (Tumwine, 1989; UN, 1971, World Bank, 1994).

For this study, participation in also conceived to include the involvement of the local people in decision-making, planning, implementation, evaluation and sharing in the benefits of such programs.

Community Participation Strategies

Relevant literature on the subject under discourse had highlighted a number of strategies that are mostly patronized across nations in health participatory programs (UN, 1971; Adebayo, 1992; Alakija, 2000; Metiboba, 2005). Community participation strategies include the following;

i. Provision of free labour for construction and maintenance of health units
ii. Provision of accommodation, office and clinical supports
iii. Payment of utility bills (e.g. water, electricity)
iv. Payment of salaries
v. Payment of drugs
vi. Payment of selected services
vii. Monthly fees to community associations
viii. Ad-hoc fund raising
ix. Formation of health co-operatives
x. Contribution to health funds
xi. Donations from “friends of community”

Study Area

This study was conducted in 7 communities in O-kun land of Kogi State, Nigeria. The O-kun people are a sub-ethnic group within the Yoruba nationality. Located in the western senatorial district of Kogi State, O-kun group refers to a distinct socio-linguistic unit of Yoruba cultural group.

Materials and Methods

Data for the study were generated mainly through multi-stage sampling technique by the use of structured questionnaire administered to 245 respondents randomly deleted from 7 communities in O-kun land of Kogi State, Nigeria. Out of a total of 245 questionnaires distributed to subjects on the issue under study, 235 turned in their completed questionnaires. This forms 96 per cent of the

total. This is considered statistically significant enough to continue with the study. To determine the respondents' ranking of community participation strategies in health development programs, they (respondents) were asked to rank the various participation strategies in use in their locality on a scale of preference between 0 and 10. The individual ranking score of each participation strategy was summed up and averaged to obtain the mean-index of each participation strategy in the study area. The ranking order of each participation strategy gives identification for the independent variables (X_1 – X_{11}) in each community. The criteria for ranking the community participation strategies (CPs) include the extent to which each of the CPs can induce the respondents (rural dwellers) to the following;

i. Attending community rallies/meetings
ii. Contributing money or levies to health project
iii. Donating labour, land or materials to health projects
iv. Utilizing health facilities
v. Getting involved in projects planning, decision-making and implementation.

Data obtained through the questionnaire were analyzed through the techniques of univariate, Pearson Product Moment Co-efficient of Correlation and Preference-Based Analysis and discussed under the various sub-heads as related to the subject matter.

Quality Control

The study was subjected to some quality control tests such as validity tests and pre-tests. This was carried out by lecturers in the Department of Sociology, Kogi State University, Anyigba, Nigeria. A reliability co-efficient of 0.80 was obtained, using Pearson Product Moment Correlation Co-efficient.

Results and Findings

Table 1: Health Facilities in Selected Communities in O-kun Yoruba

Communities	PHC	Cottage Hospital	Private Clinic/Hospital	BHC
Iyara	**1**	**1**	**2**	**1**
Ekinrin-Adde	**1**	**1**	**1**	__
Aiyetoro	**1**	**1**	**1**	**1**
Egbeda-Egga	**1**	__	**1**	__
Ogidi	**1**	__	__	__
Iyamoye	**1**	**1**	__	**1**
Iya-gbede	**1**	__	**1**	__

Source: *Ijumu Local Government Secretariat, 2010*

Code:
PHC = Primary health Care
BHC = Basic Health Clinic

Table 1 above is a distribution of the health facilities in the selected 7 communities under study. It is instructive to note that all the facilities were built through participation (partnership) of health workers with the communities. The analysis shows the paucity of health facilities in the study area. Even in Iyara which is the local Government headquarters, there is only 1 PHC, 1 Cottage Hospital, 2 private clinics and 1 Basic Health Clinic. Ekinrin-Adde has only 1 PHC and only 1 Cottage hospital and 1 private Clinic. Aiyetoro has 1 PHC, 1 Cottage hospital, 1 BHC and 1 private Clinic. Iya-Gbede has only 1 private hospital, 1 BHC and no cottage hospital at all. A cursory look at Table 1 above shows that most of the needed health services including pre-natal and anti-natal services are in great jeopardy. Besides, tracer diseases such as measles, malnutrition, malaria, diarrhea, pneumonia, have a high tendency to constitute serious health burden for these urbanizing communities.

One important lesson one can draw from the analysis above is that since virtually all the health facilities put in place in the communities were through public-private partnership, it is very likely that if appropriate, culturally relevant participation strategies are employed for health projects in the area, there would be positive response from the local populace.

Table 2: The Ranking of Community Participation Strategies by Respondents

	COMMUNITIES						
CPS	**Iyara**	**Ekinrin-Adde**	**Aiyetoro**	**Egbeda-Egga**	**Ogidi**	**Iyamoye**	**Iya-Gbede**
1	1(7.03)	2(6.12)	1(6.04)	1(6.08)	1(3.02)	3(4.18)	1(4.18)
2	11(2.0)	1(6.50)	11(2.04)	7(3.16)	11(1.55)	4(3.50)	2(4.15)
3	10(2.15)	8(3.10)	7(3.18)	2(6.05)	10(1.96)	5(3.46)	10(2.10)
4	8(3.14)	4(4.08)	2(5.25)	6(3.80)	8(2.05)	6(3.45)	4(4.10)
5	7(3.16)	9(2.45)	8(3.16)	11(2.08)	7(2.08)	11(2.22)	11(1.85)

6	2(6.15)	3(4.10)	3(5.05)	3(5.10)	4(3.23)	7(3.30)	3(4.13)
7	3(5.12)	5(3.18)	9(3.14)	10(2.10)	6(2.10)	1(4.20)	9(2.25)
8	4(4.20)	6(3.17)	4(5.04)	4(4.12)	5(2.13)	2(4.19)	5(3.55)
9	5(4.10)	7(3.12)	5(4.25)	5(4.10)	3(3.42)	8(3.28)	6(3.52)
10	6(3.18)	11(1.50)	6(4.12)	8(2.50)	2(4.82)	9(3.25)	7(3.50)
11	9(2.50)	10(2.20)	10(2.08)	9(2.12)	9(2.01)	10(2.85)	8(3.35)

Source: *Authors' Survey, 2010*

Community Participation Strategies (CPS):

Code:
No. 1 = Provision of free labour for construction and maintenance of health units
No. 2 = Provision of accommodation, office and clinical supports
No. 3 =Payment of utility bills (e.g. water, electricity)
No. 4 = Payment of salaries
No.5 = Payment of drugs
No.6 = Payment of selected services
No.7 = Monthly fees to community associations
No.8 = Ad-hoc fund raising
No.9 = Formation of health co-operatives
No.10 =Contribution to health funds
No.11 = contributions from "friends of community"

Note: Respondents were asked to rank the Community participation Strategies (CPS) on a scale of preference between 0 and 10. The mean preference score of each CPS was used as the criteria for ranking.

Table 2 above depicts the ranking of each CP strategy by the 7 communities under study. There is a clear picture that there is lack of uniformity in the ranking of most of the community participation strategies by different communities. The implication of this is that in terms of the participation strategy these communities wished to be involved in, there were differences in their ranking. However, there was some agreement or similarity in the ranking of 3 of the community participation strategies. These are numbers 1, 6 and 8 namely: provision of free labour for construction and maintenance of health unit, payment for selected services and Ad-hoc fund raising respectively.

It is crucial to observe from the Table that 5 of the communities (Iyara, Aiyetoro, Egbeda-Egga, Ogidi, Iya-Gbede) ranked provision of free labour for construction and maintenance of health unit 1^{st} while the other 2 ranked it 2^{nd} and 3^{rd} respectively. In like manner, payment for selected

services was ranked 3rd by 4 communities while 3 communities rated it 2nd, 4th and 7th respectively. Also, Ad-hoc fund raising was ranked 4th by Iyara, Aiyetoro and Egbeda-Egga while the 2 communities (Ogidi and Iya-Gbede) ranked it 5th, 5th respectively and the remaining 2 (Ekinrin-Adde and Iyamoye) ranked it 6th and 2nd respectively.

One inference that can be drawn from this analysis is that the non-uniformity in the ranking of these CP strategies by the communities suggests that every community will want to opt for a CP strategy whose end they are able to see more clearly, and utilize more to advantage, among several alternatives. The ranking in the Table above explains, at least in part, why many in O-kun Ijumu tend to detest community-based participatory programs. It is due to the seeming emphasis on imposition of levies or fund-raising or payment for services of one kind or another.

Summary and Conclusion

This study has investigated the prioritizing of community participation strategies in health development among selected rural communities in O-kun Yoruba land, Kogi State, Nigeria. The analysis highlighted the existing participation strategies in the study area, having interpreted the kind of participation as drawn from relevant literature, which is relevant to the study. With the use of structured questionnaire designed to elicit information from the respondents on their ranking of participation strategies that are in vogue in the 7 communities, and using Preference Based Analysis (PBA) as the main technique of data analysis, it was discovered that there was no uniformity in the ranking of such strategies among the study population. And the study suggests that aside the fact that participation does not just occur, every community seems to opt for a community participation strategy whose end they are able to see more clearly, and utilize more to advantage, among several alternatives.

It has also been discovered in this study that strategies which tend to place undue emphasis on imposition of levies or fund raising or payment for services of one kind or another will continue to attract less patronage from the rural populace. The implication of this study for health development is obvious. One, health planners and policy makers in the health sector must appreciate the fact that whether in rural or urban settlements, health behaviour is always a rational one. Second, it should be clearly known also that social factors, such as income, belief systems, etc. are strong determinants of participation in community-based health programs. Finally, but by means the least, the people for whom health programs are designed should not only be treated as rational beings by health workers but also should be sufficiently involved in the critical stages of project formulation, planning, implementation, evaluation and decision-making.

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