COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE: A CASE STUDY OF EKLESSIYAR YAN UWA A NIGERIA RURAL HEALTH PROGRAMME, GARKIDA

BY

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DECLARATION

I hereby declare that this thesis entitled "Community Participation in Primary Health Care: A Case Study of Eklessiyar Yan Uwa a Nigeria Rural Health Programme, Garkida", has been written by me and that it is a record of my own research. It has not been presented in any previous application for the award of a higher degree. All references to other works have been duly acknowledged.

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CERTIFICATION

This thesis entitled "Community Participation in Primary Health Care: A Case Study of Eklessiyar Yan Uwa a Nigeria Rural Health Programme, Garkida" meets the regulations governing the award of the degree of Ph.D. of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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ABSTRACT

Community participation in health care has been identified by the World Health Organisation as the main strategy for attaining Health for All by the Year 2000. Full community participation in medical services, however, implies acquisition of a comprehensive knowledge of the principles of western medicine and the transformation of the knowledge into action. This is difficult to achieve in developing countries because of structural barriers and the priority given to the curative over preventive medicine. Another important factor is the problem of eliciting voluntary unpaid or poorly paid community services in an entrepreneural society. Even if the economy is basically agrarian, the communities conform more to Tonnies'(1955) conception of gesselchaft, which is a form of impersonal inter-dependence, than a gemmeinschaft, a close - knit community, in a number of important respects like the sharing of resources and exchange of labour. Because of this, some rural people who live in the same small communities hold divergent views on common problems and fail to cooperate in pursuit of a common goal.

It is within the context of these controversies surrounding community participation in modern health care that this study investigated the organisation and responses to the community-based Eklessiyar Yan Uwa a Nigeria Rural Health Programme in Garkida. A random sample of ten villages included in the programme, five of which had functional health posts and five whose health posts were defunct, were selected for investigation. A total of 731 households were studied in the ten villages.

It was found that most communities approached by the programme agreed to participate. The demands to form health committees, select health workers, collect money for, and, building the health posts were generally promptly completed after the agreements. Most communities, however, failed to maintain

the enthusiasm shown at the beginning when they were required to help the health workers, or raise more money for the upkeep of the health posts. The health committees were generally very weak in discharging their responsibilities. They did not for instance, solicit for the cooperation of organised village groups like the Boys Brigade, Girls Guide, Church Choirs and Women's Fellowships, found in all the villages. Each of these groups could be mobilised to assist in performing various tasks for the health post. Women in particular, the category of people who implement a large number of health lessons like nutrition, maternal-child care, domestic and personal hygiene were conscious of their marginalisation by the health committees, mostly made up of males, in the organisation of the health posts. An indepth interview with women organisations in two villages and uterances by women in other villages show that women believe that they are more committed and willing to maintain the health posts than men. These lapses have resulted in the closure of 62 percent of health posts ever established in the area studied. Some health workers however, continued to render services as long as there were funds to procure drugs even in the absence of community support.

With regards to the services rendered, the community members prefer the curative more than the preventive and promotive health services. Thus, 599(82.0%) of the respondents pointed out that they wanted their health posts upgraded to dispensaries to enable them have more elaborate diagnostic and curative services. The delivery of health education through drama and stories were rarely done due to lack of volunteers to learn and stage the dramas and poor turn up of audience respectively. The results are that only 197(27.0%) of households reported that they had comprehensively implemented the core tangible aspects of health education, namely; the provision of latrines, environmental sanitation, personal hygiene, provision

of nutritious food and immunisation. The maternal-child welfare services were, however, better utilised as 413(75%) of the 552 respondents who reported births in their houses since the inception of the programme said that the mothers and babies attended the services at the health posts.

The implications of the findings are that communities may not be willing to participate in the organisation of health services when this involves sacrificing time, labour and money routinely. The primary nature of the rural communities also militates against cooperation by all members as there is evidence of social differentiation and that conflicts on other issues are revived or displaced in the process of running the health services. It is concluded that the problems identified as militating against the effective organisation of community health services at the village level where communities are quite homogeneous may manifest themselves in more complex forms in urban settings and other areas where the communities are more complex when Nigeria implements her PHC system.

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ABBREVIATIONS

BHSS	Basic Health Service Scheme
CBM	Church of the Brethren Mission
CCP	Central Christian Pharmacy
C & S	Cherubim and Seraphin
EYN	Eklessiyar Yan Uwa a Nigeria
F/Reke	Fadama Reke (One of the villages having RHP Dispensary).
LCCN	Lutheran Church of Christ in Nigeria
LGA	Local Government Area
NHS	National Health Service
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
RCM	Roman Catholic Mission
RHP	Rural Health Programme
SIM	Sudan Interior Mission
SUM	Sudan United Mission (Danish Branch)
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USSR	Union of the Soviet Socialist Republic
VHC	Village Health Committee
VHW	Village Health Worker
WHO	World Health Organisation

CHAPTER ONE

I N T R O D U C T I O N

Health as a concept has ramifications which include the proper physical, mental and social functioning of the human being and not merely the absence of ailments and diseases. It is influenced by environmental and hereditary factors (Wilson, 1970, 4-12; WHO, 1978; Deliege, 1983). Attainment of health by individuals, and the community at large is, therefore, a societal concern because a society can function properly only when the majority of its members are healthy enough to perform the tasks which sustain it. Consequently, all known societies have institutions which provide health and medical services which perform the functions of preventing diseases, promoting health and treating diseases whenever one is sick (Calhoun, 1978). Like all universal social institutions, however, the philosophies which govern the health institutions and their organisational structures vary. These variations are mainly determined by what the cultural group considers to be the causes of illness and what constitutes a disease, which in turn determine the type of treatment and preventive measures to be taken.

In general, the conception of disease manifestation can be categorised into the natural and supernatural causes. The supernatural view regards diseases as being caused by such agents and factors like gods, spirits, retribution for sins and taboos committed, witchcraft and sorcery by fellow human beings. This system of thought was prevalent in medieval times in Europe and is still dominant in African and other Third World countries today.

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The indigenous healing institutions and traditional health workers are usually perceived to possess esoteric knowledge of spirits and ability to gain foreknowledge of other people which facilitate their 'diagnosis' of illness and gaining foreknowledge of future harms. Thus their tasks consist mainly of placating the spirits for both treatment and prevention, and counteracting the evil intentions of human beings (Field, 1960; Twumasi, 1975). In the process of doing these, physical substances like plants, minerals and animal parts may be used. Although the substances are often believed to be imbued with supernatural powers, some of them possess the powers to heal of their own accord (Sofowora, 1982; Negussie,1988).

The naturalistic view of disease causation on the other hand, emphasises objectively identifiable causal agents. Dominant in this regard is the germ theory which attributes sickness to the invasion of the body by pathogenic micro-organisms which manifest in symptomatic and asymptomatic components. Another prominent aspect of the naturalistic causation of disease is based on the anatomy and physiology of the human body which is viewed as being made up of component parts, arranged in specific ways so that derangements in structures of such organs or cells could manifest as sickness. Diagnosis, therefore, consists of identifying the disease agent or abnormal organ while treatment is through chemotheraphy, surgical remedy or a combination of both. Prevention of diseases consists mainly of getting rid of the harmful germs through chemoprophylactic and environmental interventions. Thus people are immunised, health educated, and directed to subject their environments to conditions

inconducive for the survival of the germs. The promotion of health on the other hand, involves taking positive, practical actions to make the body components function well like eating clean, nutritious foods, maintaining regular exercises and observing basic health rules.

Although these two categories of causes of diseases are not mutually exclusive to any given culture, the perception from the naturalistic perspective is the most dominant in modern western cultures. It has given rise to bio-engineering medicine which has permeated most other cultures of the world in varying degrees (Turner, 1987). The organisation of modern medicine, unlike the indigenous ones still prevalent in most developing countries, is centralised. Medical services are usually provided in institutions especially hospitals or health centres and is usually overseen by the Ministry of Health. Similarly, the personnel are trained in standardised formal institutions known as Medical Schools or Colleges of Medicine. Government policies, organisational structure and delivery of services however, vary among nations.

Health Care Policy:

According to Terris (1980), the health policies of all countries can be categorised as follows; (a) National Health Service; (b) Health Insurance; and (c) Public Assistance.

Within the national health service policy, the national government takes responsibility for the health care of all citizens and treatment is free at the point of delivery. In the Health Insurance Policy, medical care is pre-paid by the health consumers

or rendered on fee-for-service basis. Finally, there is the public assistance where the governments strive to subsidise medical services for their citizens. Private health care providers and Voluntary Agencies are, therefore, allowed to run health services to augment the governments' efforts. Under all the policies, however, governments play significant roles in public health matters and in the standardisation and regulation of medical practice as well as the coordination of training of medical and health personnel in their respective countries.

The adoption of the various health policies result in variations of medical services in terms of coverage of citizens and quality of services available to health consumers. As at 1980, the national health service policy was in force in fourteen countries, comprising 33% of the world population. Prominent among the countries were Britain, China and USSR (Terris, 1980). Health insurance was practised by 18% of the world population in twenty-three countries including Canada, Japan, New Zealand, U.S.A. and most countries in Western Europe (Terris, 1980). The governments of countries which have the Health Insurance policy, do, in addition, provide health care to the aged and poor in varying degrees. Such services may, however, be rendered quite inadequate and inaccessible to the target groups due to prevailing social and cultural inequalities (Knowles, 1977; Covell; 1981; Harwood, 1981).

Public assistance, the system in which governments' efforts in providing health services are augmented by private and voluntary organisations is practised in 108 countries in which 49% of the world population live (Terris, 1980). Most of these are the developing

countries of Africa, Latin America and Asia. Taking the world as a whole therefore, it can be deduced that as at 1980, 67% of all people in the world were subjected to institutionalised differential access to medical care through the liberal national health policies of health insurance and public assistance. Inequality of access and quality of services also obtain in the national health service but in lesser degrees since one of the major problems in this system is the long waiting periods to obtain specialised services. In the United Kingdom, however, the inequality is exacerbated by the presence of private medical practitioners working outside the mainstream of the national health service (Widgery, 1980).

In concluding this section, it is necessary to point out that the inequalities in the distribution of services invariably work to the disadvantage of the poor citizens and rural dwellers of developing countries in particular. The net effects are, though, that the morbidity and mortality patterns differ for the privileged and underprivileged citizens of all nationalities irrespective of the state of development of the nation(Abel-Smith and Leiserson, 1978).

Modern Medicine in the Third World:

Modern medical services in developing countries began with trading, especially slave trade in Africa, missionary activities, and the eventual colonisation and political domination. The nature of western modern medicine provided both before and after colonisation reflected the dominant interest of the colonialists which was economic exploitation. For instance, the medical services were

initially meant to take care of European traders and their employees, and later to take care of the colonial civil servants, with little or no services being provided for the colonised citizens by the government (Schram, 1971; Patterson and Hartwig,1978).

The high prevalence and endemicity of debilitating diseases such as hookworm, malaria, yaws, smallpox, sleeping sickness, leprosy and other diseases, however, constituted serious threats to the economic interests of both the colonial governments and business organisations. Such diseases attracted attention especially if they affected the whites or interferred with the production of items of trade (Doyal, 1979; Brown, 1979). The immediate response to this was to establish hospitals in the places where the whites lived and worked which were mainly urban areas. Another approach was the vertical control of the various epidemic and endemic diseases some of which began in the early 1900s. In addition, medical schools such as the London and Liverpool Schools of Tropical Medicine and Hygiene were founded in the United Kingdom while the Harvard and the Johns Hopkins University in the United States of America were adequately funded by Foundations towards the end of the 19th and early twentieth centuries with the specific objectives of gaining mastery of tropical diseases(Brown,1978).

Christian missionaries, some of whom had started working in the developing countries before colonisation also provided medical services. Apart from the maternal and child welfare services, most of the missionaries' medical services were curative, but open to all, including the indigenous people. The motives of christian missionaries for providing medical services have been viewed from various perspectives.

Political economists' perspectives as in Doyal(1979) and Brown (1978; 1979) assess their predominantly curative, maternal and child health care services as indices of colaboration with the imperialists' interests because the services helped in keeping the indigenes healthy enough for production, but others have reasoned to the contrary. For instance, Arole and Arole (1975), Nugroho (1975), Behrhorst(1975) and Barrion (1980) have presented case studies of christian mission medical services as having populist orientations. Each of the missions studied had devised ways of making health services available to the ordinary and especially underprivileged citizens. Some of them had designed programmes to increase the earning capacity of poor families through self-help in their areas of operation, thereby vindicating the humanitarian claims of the missionaries. It must be pointed out, however, that such community-oriented programmes were relatively few and the majority of christian health services had been curative especially at the initial stages.

It should, therefore, be emphasised that both the colonial governments and voluntary agencies had been more interested in the provision of curative than preventive medical services in the Third World countries, which practice was maintained on the attainment of political independence. New health institutions established after independence reflected the curative orientation of the already existing ones. Moreover, there was little or no coordination between the various organisations such as the government, private practitioners, christian missions and other voluntary agencies which provided medical services. Most ignored by the government were the various indigenous medical belief systems and their practitioners on which about 66% of citizens of developing countries still depended by 1978 (WHO, 1978).

It became clear to medical and health workers in the developing countries, therefore, that a radically different approach to health care from those inherited had to be devised if a large number of people have to be covered with medical care (Gonzalez,1965; King,1966; Bryant,1972; Djukanovic and Math, 1975; Nawell,1975). The various issues they addressed in recommending alternative approaches to health care in developing countries included the facts that the governments were too poor to provide curative services to cover all citizens, most citizens of developing countries were ignorant of the biomedical principles of diseases and were also too poor to obtain the necessary material resources for healthy living (Abel-Smith and Leiserson,1978). Thus within the period 1960-1970, the first decade of independence of most African countries, King(1966) formulated an alternative approach to medical care for developing countries based on an International Symposium organised at Makerere University, Uganda. He propounded a group of twelve axioms on which health care should be based in developing countries taking into account the indigenous cultural beliefs, ignorance of western medical principles, poverty of both governments and citizens and the employment of apptopriate technology. The summary of the twelve axioms are as follows:

1. Medical services should be provided for the common man.
2. Medical services in developing countries should be organised on principles which are distinct from those of developed countries.
3. The maximum return in human welfare must be obtained from the limited money and skill available.
4. Provision should be made for steady growth in both quality and quantity of medical care.

5. Patients should be treated as close to their homes as possible.
6. Remedies for common illnesses should always be made available in communities.
7. More priority should be given to people of lower social status than higher ones in the organisation of medical services.
8. The role of the doctor differs significantly in developing countries from those in developed ones.
9. The role of the auxiliary staff is more important in developing countries than developed ones.
10. All medical staff are obliged to educate their patients on health issues.
11. In developing countries, medical care requires the adaptation and development of its own methodology.
12. Medical care and the local culture should be closely linked (King 1966, 1:7).

These axioms therefore reflect the need to make modern health services readily available to people in developing countries and to indoctrinate the people to imbibe the tenets of the medical system.

The Role of the World Health Organisation in PHC:

The World Health Organisation (WHO) founded in 1948, is a specialised agency of the United Nations Organisation which acts as the directing and coordinating authority on international health matters. Its main objective as spelt out in its constitution is to make all peoples of the world attain the highest possible level of health within their socio-economic circumstances. The organisation defines health as not merely the absence of disease or infirmity but the complete physical, mental and social well being of the individual. WHO's

activities, therefore, vary a great deal as its definition of health encompasses very many components. The organisation's activities include control of endemic and epidemic diseases, setting standards for drugs and international quarantine regulations, promotion of the development of comprehensive health service, improvement of environmental conditions, and a host of other activities all directed at the attainment of health by all people in various situations (WHO, 1989; UN, 1989).

Since its foundation in 1948, WHO has embarked on international health programmes such as campaigns to eradicate/control diseases like malaria, yaws, schistosomiasis, smallpox, river blindness, leprosy, sleeping sickness, yellow fever and other epidemic and endemic diseases. The campaigns and other programmes have succeeded in varying degrees in various countries, but the most remarkable is the global eradication of smallpox achieved in 1977.

The organisation realised, however, that the vertical control of diseases did not attain the highest possible level of health (Gonzalez, 1965; WHO, 1965). To alleviate this, the Basic Health Service approach was introduced (Djukanovic and Mach, 1975, Abel-Smith and Leiserson, 1978). This was further perfected in 1978 by instituting Primary Health Care (PHC) as the strategy for attaining health for all in all its ramifications as defined by WHO.

The main premises of the 1978 declaration of PHC at Alma - Ata are that disparities in access to health services and health status of people are unacceptable. The declaration specified that by the year 2000 A.D, everybody would have attained a level of health which will make them lead productive lives, through PHC which was defined as:

> ...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual families in the community through their full participation and at a cost the country and community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO/UNICEF, 1978,3).

In addition, the declaration specified the main areas of concern of PHC as follows:

> ... primary health care should include at least: education concerning prevailing health problems and the methods of identifying, preventing, and controlling them, promotion of food supply and proper nutrition, an adequate supply of safe water, and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; appropriate treatment of common diseases and injuries; promotion of mental health, and the provision of essential drugs (WHO/UNICEF 1978; 23 - 24).

The uniqueness of PHC lies in its proposed comprehensiveness, global coverage, community participation and the utilization of all relevant resources in pursuit of health. These approaches are innovative ways of implementing on a global scale the measures which had improved people's health status in developed countries. For, it had long been observed that improvement in living standards and sanitation in developed countries, rather than mere availability of drugs contributed most to the reduction in morbidity and mortality (Rosen, 1958; Wilson, 1970; Abel-Smith and Leiserson 1978; Doyal, 1979). The attainment of equitable access to the basic services and material possessions, factors associated with high standard of health, however, imply the application of both social and distributive justice which are

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often abused in national health policies of developing countries (Bryant 1969; 1977; Van der Geest 1982; 1985).

WHO has specified the roles it will play in helping countries to implement PHC. These include colaborating with other agencies of the UN, especially the United Nations Childrens Fund(UNICEF) in persuit of PHC, fostering inter country cooperation in health work and helping individual countries in conducting research on all aspects of PHC. Details of WHO's strategies and specific recommended courses of action for PHC have been published in its numerous publications since 1978 some of which are; WHO(1979; 1981; 1983a; b; 1986; 1987).

Factors Affecting the Implementation of PHC:

PHC is based primarily on western modern medicine which has been implemented mainly from the curative perspective. On this account people are likely to look upon PHC as a variant of curative health services. In developing countries in particular, the high prevalence of diseases make people more preoccupied with seeking for treatment than prevention, thereby strengthening the curative component more than the preventive aspect of medicine (Werner, 1983; Newell, 1983; Jobert, 1985). This perception relegates the socio-economic factors which are primarily responsible for the high morbidity and persistence of preventable poverty-and-dirt inflicted diseases like malnutrition, diarrhoeal diseases and tuberculosis to the background. Other factors which militate against the effective implementation of PHC include poor funding, poor community mobilisation, lack of basic infrastructure, conflicts among professional groups in the health industry, poor conditions of service for health staff and poor staff-patient relationship (Rogers, 1977; Werner 1980; Morley, Rohde and

On attaining independence in 1960, Nigeria continued with the colonial government practice of giving undue priority to institution-based curative health services inspite of guiding principles in her development plans which lay emphasis on public health, attainment of higher standards of living and mass coverage of citizens with health services (National Development Plans 1946 - 1956[1];1962 - 1968; 1970 - 74; 1975 - 1980; 1981 - 85.). The ineffectiveness of the efforts in meeting the health needs of the nation was, however, realised and steps were taken to broaden the coverage of more citizens with health services.

In 1973 for instance, an international symposium entitled Priorities in National Health Planning was organised in Ibadan with the specific objective of formulating appropriate health policies for the country. The topics of discussion for the various sessions were:

(a) Priorities in health care

(b) Integrated approach to health care

(c) Preventive versus curative medicine

(d) Economics of health care in the context of the Second National Development Plan.

(e) Meeting the Nation's health manpower needs

(f) Problems of population control and Family Planning.

The topics are self-explanatory with regards to the nature of the existing health problems of the country. The main issues raised, therefore, included the general shortage of health manpower at both highest and lowest levels, the insufficient number of training institutions for health personnel, medical manpower brain drain,

poor knowledge of health education among citizens resulting in recurrence of preventable diseases as well as the inequality in the spatial distribution of health resources(Akinkugbe, Olatunbosun and Essan, 1973).

The problems were identified with a view to remedying them. The symposium, therefore, helped in formulating the framework on which the Nigerian Basic Health Service Scheme(BHSS) was based as outlined in the 1975 Third National Development Plan.

The BHSS was, however, geared towards making institution based health services available to all citizens. The mode of implementation included the establishment of new and expansion of existing Teaching Hospitals to meet manpower needs, the retraining of experienced nursing and midwifery staff as community health officers, and the establishment of schools of Health Technology to train community health supervisors, assistants and aides. The expectations were that health services provided by these categories of health personnel would be available to all Nigerians through the health institutions to be established in each Local Government Area(LGA) of the country as follows:

(a) 1 Comprehensive Health Centre

(b) 10 Primary Health Centres

(c) 20 Health clinics.

(d) 5 Mobile Clinics.

In addition to the primary and secondary levels of care provided at the LGA level, tertiary care was to be made available at Specialist and Teaching Hospitals.

maternal and child health clinics, teaching health education and reproductive health, and directing community health campaigns. The clinical works of the village health worker is guided by a standing order and supervision by Community Health workers from the district level.

There is also a health committee at the district level which in addition to other responsibilities ensures community participation in health activities. The district level Primary Health Centre serves as a higher level curative health institution and a reference centre for a number of health posts in addition to performing community directed health activities. The Local Government Headquarter on the other hand, is to coordinate activities at the district and village levels and provide both curative and preventive services at the Primary Health Centre in close colaboration with the State Ministry of Health(Ransome-Kuti,1989; Ransome-Kuti, Sorungbe, Oyegbite and Bamisaye, nd).

On their own side, the WHO and UNICEF have selected five LGAs each to serve as their own experimental areas for the implementation of PHC, Nigeria being one of the countries selected by them as one of the PHC model countries in the WHO African Region(Brew-Graves,nd.). Some of the efforts made for achieving the Alma-Ata declaration by these organisations are to be noted. These include WHO spearheaded nation-wide projects to eradicate guinea worm, onchocerciasis and yellow fever. Above all, the Expanded Programme on Immunisation, Rural Water Supply, Sanitation and Oral Rehydration Therapy now in progress have scored notable successes.

Other areas in which some progress is made is population control. The Federal Ministry of Health has enacted a population policy which

advocates a maximum of four children per woman, a minimum age at marriage of eighteen years for females and the discouragement of women from having babies after thirty-five years of age. Family planning services are to be made available to all women, while international agencies like the United States Agency for International Development(USAID) which have population control programmes have been asked to carry out their activities within the Nation's PHC institutions in Nigeria(Merrill;nd; Ransome-Kuti;1989).

Perhaps the most notable commitment Nigeria has made in support of PHC is through her 1988 National Health Policy which is based on PHC philosophy of social justice and equity. The health policy, drawn up with the aim of rectifying the anomalies in the formulation and execution of former health policies stipulates an integrated and well coordinated approach to the pursuit of health in all its ramifications. It spells out the tasks to be performed at the Federal, State and Local Government levels, which in turn are to be effectively managed and coordinated. It provides for a good referral system, effective ways of procuring drugs and equipment and cooperation with non-governmental organisations which provide health care services.

In August 1990, an International Conference was held in Abuja on PHC at which progress reports were made by some Nigerian zonal, state and local government PHC coordinators. Most of the reports indicated successes in implementation of PHC pursuits especially in terms of responses to immunisation programmes. With respect to community participation, however, these were rather limited to selection of health committees and collection of money to procure what are needed to equip the curative aspects of the services (Eke, 1990; Ayitogo, 1990; Muhammad, 1990). A high degree of community participation is therefore

yet to be attained in Nigeria.

Significance of Study

The Eklessiyar Yan Uwa a Nigeria (EYN) Rural Health Programme provides health care services in rural areas through community participation. The health activities of the programme conform to most of the integral components of PHC pursuits as spelt out in the Alma - Ata declaration. The experience of the programme in organising a community based health care will therefore help us to predict what to expect when Nigeria embarks fully on PHC in all its ramifications. This study will, therefore, provide information on the areas of strength and weakness of rural community participation in health care which knowledge can be applied in implementing Nigeria's national PHC system.

Objectives of the Study:

The broad objective of this study is to assess the PHC recipient communities' responses to the demand on them to organise health services for themselves. The study will identify social factors which facilitate community participation in the organisation of the services and implementation of health measures.

Against these broad objectives, the following specific objectives are proposed:

(a) To identify the roles of structural, administrative and socio-cultural factors in aiding or militating against adherence to the stipulated mode of functioning of the programme.

(b) To evaluate the effects of the availability of alternative medical services(which, where available do not demand community participation in their organisation) on people's willingness to participate in PHC.

(c) To test individual families' awareness of their health needs and their efforts in meeting such needs.

(d) To use performance indicators to assess the success of the health post with specific reference to community members, health workers, village health committees and the programme itself.

Hypotheses:

The hypotheses for this survey are designed to address fundamental issues in community participation like the felt health needs of the people; the contributions that people are willing to make to meet the health needs; the social, economic, logistic and geographical factors affecting community participation. Getting information on these will enable us deduce what measures to introduce to enhance more effective participation. The hypotheses put forward are as follows:

(a) Maintenance of the health posts by community members is determined by their perceived health needs and the extent to which the programme meets the needs.

(b) Members with higher levels of education will participate more fully in the programme than the less educated.

(c) Intra-community revalries arising from conflicts between individuals, lineages, religions and differential intergroup values reduce community participation.

(d) The more inaccessible a village is from other sources of modern health service, the greater will be the enthusiasm shown by its community in organising the programme.

commendable health status. Berman (1982) agrees that the selective approach is useful but argues that its needs might not be equally applicable to all developing countries. The cost of attaining it is also said to have been underestimated by Walsh and Waren.

Since total PHC involves higher level of health care, the social, economic and political implications of its pursuit are likely to be the substantial issues that determine whether a country adopts it or not. It is imbued with equalitarian ideologies which advocate high governmental expenditure on health and equality of access to services across spatially and socially distinct groups. It also involves more governmental expenditures on other social services such as education, water-supply, housing as well as the redistribution of economic resources (Deacon 1984). It,therefore, follows that it is not the wealth of a country that determines whether it should adopt total PHC, but its ideological inclination. The socialist countries, for instance, USSR, China, Cuba and Tanzania which operate socialist/ communist health care systems in varying degrees were perhaps much poorer than their neighbouring states at the time they embarked on it. All of them have at various points in time attained reasonably more equitable coverage of their citizens with health care compared to countries that did not adopt the socialist model. For instance, compared to the British National Health Service (NHS) which is basically welfarist in nature, these countries are ahead of it in terms of the equitability of quantities and qualities of services rendered to citizens. This is because Britain allows and supports private medical practices so that services by the NHS doctors are less preferred than what can be purchased from the private practitioners by those who can afford to pay (Widgery, 1980).

Giovannini and Brownlee(1982) raise the issue of staffing and

strings attached to donated PHC programmes in developing countries. Some apparently humanitarian aid to developing countries have turned out to be avenues of creating markets for the donor's products. Moreover, some donors specify the terms of operation which usually include the active participation of foreign staff who might not be familiar with the social situation in which they are operating. To minimise the effects of this incomprehension, Giovannini and Brownlee (1982) recommend that foreign participants in health projects in developing countries should be trained in situations similar to those in which the programme is located. Taylor (1975) recommends that foreign workers should be exposed to the realities which simulate the actual situations in which they will eventually work, even if this involves abject poverty and its consequences like going hungry.

Pre-1978 Forms of Community- oriented PHC Programmes :

Before the 1978 Alma Ata declaration on PHC, primary health care was basically conceived as the provision of rudimentary health services in terms of treatment of minor ailments and preventive measures. It also designated the first stage of contact with medical services by patients needing care. Within these contexts, primary health care was conceptualised as a simplified form of medical care rendered to people either in the form of curative or preventive services(Hicks, 1976; Williams, 1983).

Based on these definitions, several governments and non-governmental organisations had realised the dismal state of health services and health status of people in developing countries and tried to extend services to the deprived people through special programmes designed to deal with the situations (Newell, 1975, Jobert, 1985); Newell's (1975) edited book is a report on some pre-1978 forms of community enlightenment and involvement in health promotion. It presents a wide variety of community

oriented programmes ranging from Government stipulated ones like meeting the basic health needs in Tanzania through appropriate manpower development, to the Cuban and Chinese national health systems, which had infact preceded Tanzania's in community-based health pursuit.

Among voluntary agencies, the Christian missionaries were pioneers of providers of modern health care to most citizens of developing countries (Ayandele, 1966; Schram, 1971; Brown 1978; Hartwig, 1979).In some countries such as Nigeria their services were curtailed by the taking over of their health institutions on attainment of independence by the national governments, while other countries such as Kenya and Uganda allowed them to operate uninhibited. A large number of church missionaries have instituted PHC-like programmes in their areas of operation. Such programmes are found especially in Latin America, the Philippines, East Africa, India and Indonesia (UN, 1977; Sommer, 1977; Johnston, 1983; Rifkin, 1983; DeBoer and McNeil, 1989; Bently, 1989; Matomora, 1989).

The following policy orientation of one of the programmes established in India is to a large extent representative of others:

> We had formulated the following criteria for establishing a viable and effective health system.
>
> 1. Local communities should be motivated and involved in decision-making and must participate in the health programme so that ultimately they "own" the programme in their respective communities and villages.
> 2. The programme should be planned at the grass roots and develop referral system to suit the local conditions.
> 3. Local resources such as buildings, manpower and agriculture should be used to solve health problems.
> 4. The community needs total health care and not fragmented care; promotional, preventive and curative care need to be completely integrated....(Arole and Arole 1975, 71).

Another christian donor agency the German Bishops Development Fund,(MISEREOR) has similar aims and activities of helping people to be self-reliant as follows:

> MISEREOR, operating since 1959, gives preference to such projects which aim at removing the causes rather than the symptoms of poverty, hunger and disease, helping those in need regardless of nationality, face or religions. Preference of financial support is given to local initiatives and counterpart scheme(UN,1977;16).

It is however necessary to point out that the degree of community involvement and initiatives outlined by both programmes are not likely to be achieved spontaneously among poor oppressed people who need such assistance most (Crandon,1983). To achieve this, it would require Freire's(1972) idea of conscientization, a form of adult education which inculcates the art of developing critical consciousness of one's situation and taking appropriate actions to remedy the problems.

Werner (1980) has noted, however, that some programmes which proclaim their policies as liberating the people over-play their roles of animating the people to help themselves. Such programmes end up deciding virtually everything for the people, even when such decisions are actually not in the people's interests. In community health programmes, such oppressions are manifested in the limited training given to community health workers and the restrictions on treatments they can administer. These render the health workers helpless even in situations which the less trained but unrestricted drug sellers can deal with.

In the next section we shall discuss community participation in its various ramifications as defined in the Alma-Ata declaration and examine the implications for its attainment.

Community Participation in Health Care:

One of the fundamental changes introduced by PHC in the organisation of modern medicine is community participation in health care. Community participation in PHC is defined and explicated on in the Alma Ata declaration as:

> ...the process by which individuals and families assume responsibility for their own health and welfare and those of the community, and develop the capacity to contribute to their community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realise that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable (WHO/UNICEF, 1978, 49).

This definition and explication of community participation bestow on the medical laity an unprecendented autonomy in organising modern medical services for themselves. The practical realisation of this ideal is however fraught with several problems when we ask such question like who are the bonafide members of the community to make decisions and are all bona fide members eligible to participate equally at all decision-making? Besides, are all community members knowledgeable enough in Western scientific medicine to make decisions that would effectively tackle their health problems?

Based on these and similar questions, sociologists have expressed reservations about community participation in health care. Ojofeitimi(1988) for instance rightly defines community participation in health care as involving the making of contribution to health by

individuals irrespective of their educational background, economic status, gender, ethnic group, religion and political affiliation. In Nigeria and in fact most countries of the world, all these factors form the basis for social differentiation. They are woven so much into the fabric of social organisation at both national and local levels that they are expected to militate against absolute egalitarian decision making. It can therefore be argued that no society is likely to be so liberal in its social organisation that these major determinants of social status and social stratification would not result in differential degree of involvement and power in participation.

Adetoro(1989), based on reviews of other literatures, concludes that community participation in their development had been an integral part of Nigeria's and other African's social organisation before it was replaced by central planning for development on colonisation. He believes that the spirit of community participation in development is still present in Africans and can be revived to implement PHC requirements. Our reservation about this position is that colonialism and the imposition of Western values on Africans have changed the traditional organisation so much that to reconstruct and relive the pre-colonial forms of social organisation would infringe on some aspects of the newly developed values especially those pertaining to individual freedom. Pearce(1980) for instance clearly points out that the traditional forms of community participation were based on such criteria like family organisations, age grouping and gender organisations, under which individual participation could be either voluntary or compulsory. She therefore pointed out that the forms of participation by individuals will vary depending on the group involved and under which condition a person is participating. In her review of

case studies of community health projects designed to be run by communities in Nigeria, she found that community participation was basically poorly attained.

We must however take cognisance of the differences between endogenously and exogenously initiated development and health projects. Endogenously evolved programmes usually elicit better participation. Kabwasa(1986) describes the Savoir Vivre project, initiated by a village carpenter in 1960 in the Idiofa Bishopric of Zaire which excelled in success. Having realised that the attainment of political independence was not going to make life any better for the people, the carpenter conceived a self-help project for the village community. Applying his knowledge of the social structure of his community, he sought the consent of elders, who agreed but directed that every member of the village should be involved. Thus women were invited to and participated in the meeting which followed. Still applying knowledge of the community, families rather than individuals were made units of participation. The project was so successful that between 1960-63, it was able to purchase a cassava mill, built a dispensary and a school, and was executing other projects when a political rebellion broke out in the region. After the rebellion, the government banned community activities but the Savoir Vivre continued under the control of the Catholic Church, and has since recorded success in agricultural production. As observed by Stone(1989) therefore successful community participation in its development depends on how socially cohesive the community is.

In contrast to this are the exogenously conceived and planned programmes whose execution are expected to be carried out by community members. Although the planners usually claim to have acquired adequate

knowledge of the beneficiaries' situation, some crucial factors are usually overlooked which eventually affect communities' full participation. A typical example is the Danfa community health project in Ghana which worked as planned by the foreign funding agency but was too expensive to be maintained by the national government(Twumasi,1981).

In practice therefore, community participation has been interpreted and implemented in various ways with varying consequences ranging from achieving the objectives of egalitarian participation in problem solving to being a tool for controlling and monitoring people's activities. Muller (1983) has identified two types of participation which he christens as "direct participation" and "social participation". The direct participation consists mainly of mobilising community resources such as labour, money and other materials needed to carry out the programme, while social participation empowers the people to control the social, political, economic and environmental factors affecting their health. The qualities and effects of community participation therefore vary depending on which of the interpretations is adopted and the intrinsic value attached to communal endeavours in the community. Kadt (1983) has observed however that for exogenously initiated programmes, the nature of community participation is usually determined by the sponsoring agency. He expounds that government sponsored programmes are more likely to vest powers of decision-making in medical personnel thereby lessening social participation while non-government sponsors are likely to empower the people.

Another salient issue in community participation in PHC is the fact that, PHC as declared at Alma-Ata is based on western scientific medicine which is characterised by objectively verifiable cause of illness and application of "rational" treatment. But, Djukanovic and Mach (1975) have pointed out that only 15-35 percent of people in

developing countries have access to this type of medicine, while 65-85 percent can be presumed to be ignorant of it. The large scale inaccessibility and ignorance of modern medicine, much of which still prevails (WHO; 1988), lowers the prospects for successful community participation in modern health services. This is because to be able to organise an institution to meet a social need presupposes sound knowledge of the nature of the needs to be met and the mode of functioning of the institution. For PHC this implies knowledge of the basic principles of western medicine, its conception of disease causation, prevention and treatment. In fact knowledge alone is not sufficient, it is necessary that such knowledge be taken as facts and internalised for putting into practice.

In contrast to the expectation to socialise medical knowledge, the Western medical profession has maintained a high degree of dominance over other social institutions and marginalised health consumers as documented by several authors, prominent among who are Freidson (1970; 1975), Waitzkin and Waterman (1974), Illich (1976), Veatch(1977) and Werner(1980). Consequent upon this, the average health consumer has learnt to rely on the professional for medical decision-making. Downing (1989) has therefore argued that access to and acceptance of western medicine do not necessarily enhance community participation in organising health care. He expounds as follows:

> If PHC is to be made available to all people...there will be a strong temptation for agencies and governments to use the technique of PHC without the community base. This may work to achieve some measurable results such as immunisation or T.B. control. But without community ownership, the system remains merely techniques controlled by someone else, vulnerable to priorities and financies of the implementing agency.
>
> The challenge is immense, people in the west, despite their relatively good health and advanced technology do not control their health system... China is often cited as a model, but replication of this system are unlikely outside of centrally controlled societies or outside Asia(Downing, 1989; 1057-58).

The practical implication of this situation in western medicine is that when people in developing countries are asked to organise their medical service, they may feel incompetent and abandon decision-making to the technical staff.

Finally the issue we shall discuss as constituting problems for community participation in health care is the remuneration of the health workers. Community health workers are usually engaged as volunteers and paid stipends in cash or kind far below the minimum national wage. Since the time to be spent working interfers with the performance of the volunteers' business, there is usually a high turnover of volunteers (Hilton, 1983). Some of the health workers may make up for their losses by embezzling the proceeds of their sales. These problems can basically be seen as universal and have led to the collapse of many community health programmes (Jobert,.985).

Having discussed the concept of community participation and the inherent constraints in its full attainment at grass root level in laissez-faire societies, it is necessary to point out that some socialist countries have centrally planned community participation programmes,

which will be discussed in the next section.

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The Socialist Model of PHC:

The socialist model of PHC is based on equalitarian ideology. It entails the mass mobilisation of human resources for attaining health care for all citizens. Among those who have studied socialist models of PHC are Horn (1969; 1972), Sidel(1972), Sidel and Sidel (1973; 1975; 1977), Stein and Susser(1973), Navarro(1972; 1974; 1976) and Wang (1975). All of these authors have written on the health systems of either China or Cuba and demonstrated that people's enlightenment, involvement in and government commitment to the health of citizens result in the success of mass coverage, more equitable distribution and high degree of community participation. They portray situations for both China and Cuba in which the social distance between medical personnel and health consumers were greatly reduced and high degree of egalitarian relationships developed after the forceful overthrow of the governments and abolition of various forms of social stratification. To crown it all, the new governments took over the financing of the health sector, thus eliminating the profit motive in medical and allied profesions. This of course lowers professionalism and elitism in medicine which are identified as the bane of community participation and equitable distribution of health services in capitalist countries(Rogers, 1977; Bradshaw, 1978; Widgery, 1980; WHO,1988b).

In the case of China, the selection, training and working conditions of the community-based health worker (the barefoot doctor) are instructive on the creation of a sense of ownership of the health services among the medical laity. The collective system of production

naturally creates the groups which select a member for training. Training is on seasonal basis which serves the dual purpose of making trainee health workers continue to engage in production and keeping in contact with their production team. The ideological frame within which they are being trained and will work are taught. On graduation their payment is basically the same as those of other members of their production teams. When not rendering health services they engage in the same production activities like other members.

This category of health personnel are trained for all production teams irrespective of whether rural or urban-based. Through this equitable distribution of health care in conjunction with similarly equitable distribution of food, income, housing and other health-related resources, a marked increase in health status has been achieved. It has resulted in lower maternal and infant mortality rates, improved nutritional status and a sharp decrease in the prevalence of parasitic and infectious diseases since the 1949 revolution (WHO, 1983a). It has been observed by Sidel (1973) that health pursuit is seen in post-revolution China as an integral part of citizens' civic responsibilities. The perceived attainment of an egalitarian society and improved standard of living for formerly oppressed people are consciously evaluated as indices of triumph over the former feudal system. Seen within the socialist setting, community participation in health care becomes part of the political ideology which spurs members to be actively involved.

In the case of Cuba, there was also redistribution of economic resources and nationalization of some private property after the 1959 revolution. Private medical practice was banned which resulted in mass exodus of expatriate practitioners which formed the bulk of Cuban medical personnel. Cuba embarked on large scale training of indigenous

personnel for both high and low levels of services to meet her health needs. Citizens were conscientised on health matters as well as the political and economic reorganisation of the country. This elicited appropriate responses to mass health campaigns especially immunization of children(Fernandez, 1975).

However, the Cuban health system differs substantially from the Chinese because Cuba neither had the Chinese barefoot doctor equivalent nor did she incorporate indigenous medicine into the system. Unlike China she had initially relied on imported drugs. The level of community involvement has, therefore, been assessed by Werner(1983) as being minimal and to a large extent oppressive because of the bureaucratisation of the medical services.

Although the examples of PHC in China and Cuba differ in some respects, especially on the degree of community involvement, they are both based on the egalitarian ideology. Within the pursuit of the egalitarian ideology however, we should note that a great deal of coercion is often used which creates a false sense of uniformity. The clamour for democracy in the socialist countries in the late 1980s is an evidence of this. Where the coercion is not well exerted therefore, the mechanical creation of a communal way of life is bound to generate problems. Tanzania which simply decreed the socialist ideology in 1967 for instance had serious problems in creating the Chinese barefoot doctor equivalent as well as entrenching a sense of communalism in the villages. Klouda(1983) has, therefore, observed that Tanzania's attempt at mass coverage of citizens through community participation proved to be very expensive mainly due to her failure to develop a sense of community in the villages.

Socio Political Implications of Community Participation in PHC:

Many proponents of community participation in PHC such as King(1966), Hathirat(1983), Abudu(1985) and Green(1985) view it as an expediency resorted to to cover all citizens with health care. In contrast to these are other supporters who perceive community participation in health care as a political action whose overall goal is to liberate the socially and economically oppressed. Prominent among those propagating the liberating role of community participation is David Werner. He has for instance written a medical mannual, Where there is no doctor (1979) to help the medical laity, drug sellers and lowly qualified medical workers to prevent and treat diseases. There are many home remedies suggested for certain ailments which can help the laity a great deal. Thus the book is capable of breaking the medical profession's monopoly in dealing with a number of diseases. In addition to this, Werner and Bower (1986) have written on how to teach community health workers how to develop the critical awareness of their would be clients to enable them solve health and other related problems confronting them.

In similar ways other people have taken the side of oppressed people in promoting the oppressed's health. Love and Kalnins(1984) have, for instance analysed the superstructural factors which lead to malnutrition among the poor in Canada. They identified the monopoly of food production and sales by big business organisations which result in less competition, poorer food quality and higher prices. They therefore recommended that the poor should agitate to put an end to exploitative commercial relationships which affect health.

In developing countries, the exploitation of the poor usually takes a different dimension as manifested in low wages, landless peasants and rigid social stratification which preclude social mobility(Islam and Bachman, 1983).

In India, Djurfeldt and Lindberg(1975) found that poor rural dwellers in Tamil Nadu had adapted so much to their poverty-stricken lives that for any innovation to be accepted, the poverty must first be reduced. They argued that the economic pursuits of the people are so much tied up in the caste system which militate against accepting induced changes like family planning or other measures that would enhance upward social mobility.

Smililarly Tausig(1978) has attributed the failure of U.S.A. sponsored nutritional, development and health programmes in Columbia to poverty and low level of education. He observed that the largest population for the nutritional programme, women, were so poor, disillusioned and apathetic that all they were interested in when they came to the centre was the collection of their rations.

These failures notwithstanding, desirable community responses have been elicited from depressed communities in some areas. Ram(1978) for example describes the Miraj village health project in India which successfully engaged traditional healers and midwives and trained local residents. A Philippine example, the Makapawa self-help health programme, also recorded success after several failures in attempting to involve the community when it finally took cognisance of the social structures of the communities involved and the spirit of communalism ingrained in the planning and delivery of services (Barrion, 1980).

Thus, the success or failure of community health programmes in both developed and developing countries is a function of the socio-economic and political structures of such polities as identified by the UNICEF and WHO in the following words:

> In most countries the poor are not poor mainly because of an absolute scarcity of resources but because of the socio-economic structures which prevent them from working productively... In so far as ill health is related to poverty, attention needs to focus not so much on poverty but on what has made and keep the poor poorer. Health improvement in developing countries has to relate to the political economy of health and Primary Health Care approach cannot make significant progress unless these fundamental socio-political issues are acted upon (UNICEF/WHO, 1981; 21-22).

It is evident that attempts to change the social structure of societies are often opposed. In fact there are presently clamours for democracy even in the socialist countries which can be viewed as having succeeded in creating egalitarian societies (Chen and Tuan 1983; Klouda, 1983). In some countries, efforts made by health workers to make poor people aware of their relative deprivation and exploitation are considered as subversive and punished by the state (Haliman and Williams, 1983). Werner and Bower (1986) have advised that community health workers in such polities should be judicious in introducing confrontational issues, weighing the risks against the positive results to be derived.

Stark (1985) has undertaken a balanced analysis of some countries which highly value health workers' positive contributions to the state and the predicaments meted out by state agencies to health workers in other countries for allegedly inciting people. The countries where the workers were considered as national heroes and heroines include China, Tanzania, Mozambique and Democratic Yemen, where health workers were part of the centrally planned community-based health services and helped to provide services at the community level.

In contrast to these, some Latin American countries have outlawed community health programmes and imposed death penalty on any who decides to work as a village health worker. Stark points out that such governments have spies in villages to monitor those who are likely to pose as health workers.

In general most of the documented harassment of community health workers are in rigidly stratified societies (Newell, 1975; Rifkin, 1983; Morley, Rohde and Williams, 1983). Such societies are usually characterised by the presence of landless peasants and other unemployed people who may be easily mobilised for insurrection. In African countries where the land tenure systems enables most farmers to have access to lineage lands, Samba (1981) has argued that community health workers can neither play the role of political educator nor constitute threats to the government. This implies that community health workers' tasks are to be confined to technical health work like immunisation, oral rehydration therapy and health education. Such services are needed in view of the ignorance and misconceptions prevalent in African societies (Igun 1982) but is not enough. There are current developments in African countries and Nigeria in particular, characterised by large scale farming and eviction of peasant farmers from their lands that are likely to seriously disrupt the traditional land ownership patterns and render many people landless, thus increasing the number of rural and urban proletariat.

In concluding this review of literature, we observe, based on the conceptions of PHC and community based health programmes reviewed that PHC and community participation in health care are not mere technical health pursuit endeavours. They are closely linked to and reflect the national government's ideology and the social structure at the primary group level.

The success of PHC on a global scale as envisaged by WHO therefore depends on how the various countries' national policies on health and other social services are supportive of equalitarian distribution of resources to enable all citizens have meaningful access to health services and thereby participating meaningfully in organising such services. It also depends on how governments are to accommodate initiatives that would be made by communities if enlightened participation were successful at the grassroot level. Equally problematic, however, are the prospects of achieving equalitarian involvement of all members at the grass root level in view of the existing age, gender, religion, social stratification and other social barriers which militate against free and egalitarian association of all people in one form or the other in virtually all human societies. Advocates of equalitarian community participation in health care must grapple with these realities.

CHAPTER THREE

THEORETICAL FRAMEWORK

Social Change in Primary Health Care

This study is an investigation of how rural communities which are spatially remote from western type of medical services respond to a health programme's intervention to provide western type health services for them through their own active participation. In theory this can be seen as an induced social change in the communities' medical system, health care and health seeking behaviours. It also implies the emergence of new types of relationships among community members for the organisation of the services. The organisation and rendering of services are through community participation which is also a novel phenomenon in medical services. Our theoretical frame of reference is, therefore, focused on social change.

Theodorson and Theodorson(1969) define social change as:

> Any modification in the social organisation of a society in any of its social institutions or social roles. Usually social change refers to significant change in social behaviour or a change in some larger social system rather than to minor changes within a small group. Thus social change refers to changes in established patterns of social relationship (Theodorson and Theodorson, 1969, 384).

In the context of this study, the change affects the existing therapeutic, preventive and health promotive systems prior to the advent of the programme.

The change is unprecedented because for the first time in the history of western medicine in the area, a plan was made to cover all community members with health care through community members' active participation. This is a significant diversion from the hitherto scanty, curative institution-based medical personnel centred system of health care.

Social change as a concept, however, has ramifications; the basic ones of which are the evolutionary, modernisation and revolutionary/ conflict perspectives (Smith, 1977; Stasser and Randal, 1981). The evolutionary perspective views changes in social institutions as being a gradual hardly recognisable progression to perfection. The modernisation perspective, although viewed as a variant of the evolutionary perspective as it is branded "neo-evolutionist" connotes the adaptation of social institutions and behavioural patterns to current situations. The revolutionary/conflict perspective on the other hand, views social changes as arising from the conflicting interests of social groups within the society which is usually achieved through the violent overthrow of the privileged by the underprivileged categories. Afonja and Pearce(1984a) have extensively explained the various era and social circumstances under which these perspectives of social change and their ramifications emerged. They have also critically assessed their applicability in analysing social phenomena in the African context. Based on Pearce's(1984) analysis of the "modernisation" of the medical sector in Nigeria, they concluded that no single theoretical frame of reference can explain the social process in health seeking behaviour in particular. In view of this, they recommend the open system paradigm which takes account of much broader view of the social situation to include the individualistic, sociologistic, cultural and environmental conditions being studied (Afonja and Pearce, 1984b; 250-252).

In the case of our study, we subscribe principally to this view because this is a case study which involves a combination of virtually all aspects of a community-oriented health programme. However, the modernisation perspective of social change as explained below will be the theoretical focus.

Steward(1967:4) defines and explicates on modernisation as the:

> ... sociocultural transformations that result from factors and processes that are distinctive of contemporary industrial world. It means more than cultural change, for change may be essentially cumulative when culture traits are merely incorporated into the existing pattern of a society. Modernization is evolutionary in that basic structures and patterns are qualitatively altered. This use of evolution, however, does not imply...stages of transformation, specific alterations of particular societies that must be determined empirically in each case and that may or may not be cross-culturally similar (Steward, 1967:4).

While Steward is specific in viewing the industrial societies as models to be copied, Weiner(1966) views modernisation as universal behavioural patterns, belief systems, character traits, socio-political organisations and states of knowledge characterised by the following:

(a) disposition to accept new ideas and try new methods;

(b) readiness to express new opinions;

(c) a time sense that makes men more interested in the present and the future than their past;

(d) a better sense of punctuality;

(e) a greater concern for planning;

(f) a tendency to see the world as calculable;

(g) a faith in science and technology;

(h) a belief in distributive justice.

(Weiner, 1966: 4).

Even this position is highly laden with western values which regard punctuality, objective verification of phenomena, freedom of expression, reliance on technological devices to perform tasks and ability to predict coming events as being very important for both individuals and the various formal institutions. Smith (1977) identified three views of modernisation, the first connotes being "recent" and progressive, the second view refers to a historical phenomenon designating a distinction between a new and old era, while the third refers to practical attempts to update the social conditions of developing countries to those of developed ones.

All these perspectives of modernisation, therefore, connote either currency, progression or significant modification in social organisation so that the preceding arrangements are seen as obsolete and replaced by the new.

The PHC approach conforms in many ways to Weiner's attributes of modernisation. It is, based on scientific medicine, makes provision through health education for clients to acquire and apply scientific ideas about diseases. PHC is democratic in principle and advocates distributive justice by directing services to all and also through its condemnation of disparities in health services to people (WHO/UNICEF,1978).

Further more, in societies which have not imbibed western cultures, PHC seeks to introduce western medicine and to devise ways of modifying the indigenous medical practices to conform with western standards. Aspects of indigenous medical beliefs and practices which do not conform with scientific medicine are encouraged to be modified to conform or discarded. The objective therapeutic efficacy of substances and practices employed in other medical systems are assessed scientifically(Bannerman, Burton and Wen-Chieh, 1983).

Viewed in these lights, PHC pursuit is seen as a modernisation process in this study.

CHAPTER FOUR

GEOGRAPHICAL BACKGROUND OF THE AREA OF STUDY AND DESCRIPTION OF THE EYN RURAL HEALTH PROGRAMME

Garkida, the headquarter of the EYN Rural Health Programme is situated in Gongola State on the Gongola-Borno states border (see maps 1 and 2). The programme's activities covered four LGAs each in Borno and Gongola states in 1986. CBM(nd,7) specifies that its area of operation is 350 x 200 square kilometres(70,000sq km) in both states. The LGAs covered in Borno state include Biu, Uba-Askira, Damboa and Gwoza, while those in Gongola state are Gombi, Michika, Song and Mubi. The major ethnic groups in the area of operation and LGAs in which they are predominantly found are as follows:-

(a) Bura, Hona, Kilba, Ga'anda and Lala (Gombi LGA).

(b) Higgi and Marghi (Michika, Uba-Askira and Gwoza LGAs).

(c) Babur and Tera (Biu and Damboa LGAs).

(d) Yungur, Bata and Mboi (Song LGA).

(e) Gude (Mubi LGA)

There are nomadic and sedentary Fulani and other immigrant ethnic groups who live among the major ethnic groups. The participating ethnic groups speak mutually unintelligible languages but there are linquistic similarities between the Marghi, Kilba, Bura and Babur languages.

As regards the economy, the predominant occupation is farming. Groundnut is the major cash crop, and assorted grains especially guinea corn, maize and millet are the major food crops. Other food crops grown include bambaranuts, beniseed, tigernuts, and vegetables by irrigation during the dry season. Livestock, especially sheep, goats, pigs, poultry, and on a much smaller scale cattle are raised by the indigenes. Although groundnut is a cash crop, it is a major food seasoning and snack among the Gude, Kilba

and Hona who use it in preparing a variety of foods including soup and drinks in addition to eating it raw, boiled, fried or roasted.

Site of Study:

The area of operation of the programme studied consists of Gombi, Song, Mubi and Michika LGAs as they existed in 1986 when the sampling was done (see map 3). Since then, Gombi and Mubi LGAs have each been split into two to form Gombi and Hong; Mubi and Maiha LGAs respectively. For the purpose of this study, the 1986 administrative divisions are maintained because data collection had been completed before the split was made.

The geographical spread of the area is approximately from 10°N;12°30'E to 11°N;12°30'E. This proceeds eastwards to the Cameroun border (see map 2). In fact the programme has health posts in border villages such as Sahuda in Mubi LGA; and, Sina Whate and Kamale in Michika LGA. The population of the area is estimated to be 1,663,214 in 1990 based on the 1963 census figures[2].

The area is basically rural in nature. The settlements which could be categorised as small urban areas are mostly the LGA headquarters, namely Gombi, Song, Mubi and Michika. Except for Mubi, even the LGA headquarters were quite small in size before they were made headquarters in 1976, after which they expanded rapidly. Other large settlements include Dumne and Girei in Song LGA, Hong, Garkida, and Uba in Gombi; Bahuli, Maiha and Pakka in Mubi, Madagali, and Gulak in Michika LGA.

As regards Christian religious activities, the Sudan United Mission (S.U.M), now Lutheran Church of Christ in Nigeria (LCCN) and the Church of the Brethren Mission(CBM) now Eklessiyar Yan Uwa a Nigeria(EYN) were the pioneer missions in the area. They had established churches, and either primary schools or medical services in most of the large settlements

mentioned by the 1940s. The S.U.M general hospital was located in Numan (outside the area of study) but the Mission had dispensaries in Pella and Ga'anda (Gombi LGA) and in Dumne (Song LGA). The Sudan Interior Mission(SIM) and the Roman Catholic Mission(RCM) also worked in the area, establishing schools and rudimentary health services. In 1972, the then North-Eastern State Government took over all the Christian Missionery hospitals within its jurisdiction.

Origin and Organisation of the EYN Rural Health Programme:

The C.B.M., now translated into Hausa as Eklessiyar Yan Uwa a Nigeria (EYN) started rendering health services in Garkida and surrounding areas in the early part of this century. The mission established a leprosy treatment centre and an eighty-bed general hospital in 1929 and 1931 respectively in Garkida, while another general hospital was established in Lassa in 1938, on the present Gongola-Borno state border (Schram 1971; See Map 3). The three health institutions excelled in the provision of curative health services for leprosy and other diseases in the area currently covered by the EYN health programme.

At a stage the personnel realised from patients' records that many patients reported several times to the general hospitals with the same preventable diseases. In addition, it was found that most infant deaths were due to preventable diseases such as malaria, tetanus and malnutrition. To alleviate the problems, village dressing centres were established in 1956, but these were shortlived because there were neither supervision nor community involvement. They were replaced by four mobile health units, conducting underfives and antenatal clinics, but they were phased out because they were too expensive to run(CBM, nd).

When missionary hospitals were taken over by the state government in 1972, CBM embarked fully on the provision of primary health care for the rural communities which had been served by its former hospitals. The governing philosophy of this endeavour was spelt out as follows:

> Christian love and concern for one's fellow man and for his physical as well as spiritual conditions are the main motivations behind the development of this programme. Because of the fact that many villages are partly christian, partly muslims, and partly pagans, the decision to use the programme as sole christian programme was dropped. It was felt that to be successful and helpful, the rural health programme needed to be concerned about all people regardless of religion (CBM; nd; 2).

The programme's specific goals and objectives are as follows:

(a) To help as many communities as possible not reached by adequate basic medical care to get basic health services with the limited personnel and financial resources available.

(b) To train indigenous personnel to carry out preventive, curative and administrative medical services for the rural areas and to ensure adequate drug supply and drug control for medical programme activities.

(c) To help communities to see how they can control and prevent diseases through communal effort.

(d) To show people the importance of better health care through teaching of health education.

(e) To help people see the importance and obtain wholeness, both spiritual and physical.

(f) To provide working models of an innovative health care delivery system.

(g) To cooperate with government and other agencies to ensure the best use of available medical facilities (CBM, nd, 2).

The central activities of the programme include health promotion through health education, immunisation against communicable diseases especially measles, tuberculosis, diphteria, whooping cough and tetanus; and treatment of common diseases for which it ensures a regular supply of the essential drugs.

The organisational structure of the programme consists of its headquarter in Garkida where the Director, Assistant Director, Dispensary Supervisor and Medical consultant work. Within the premises of the headquarter is the Training School where the village health workers are trained. There is also a section of the EYN organisation which colaborates with the Rural Health Programme on rural water supply, helping village communities to dig wells.

The services rendered in dispensaries are primarily curative. Dispensaries are headed by community health supervisors. The workers here are employees of the programme. The village health workers, those who work in the health posts, are community volunteers who work under the auspices of the village health committee. Their main roles are the teaching of health education and treatment of minor ailments. Health workers are overseen by Community Health Assistants known as Health Post Supervisors.

The programme has a Board of Trustees on which are included, representatives of Ministries of Health of Gongola and Borno States, all involved LGAs' Health Departments, and all district communities in which it operates. The district community representatives are supposed to be well known and respected people in order to boost community acceptance and participation in the programme.

The villages which qualify for inclusion in the programme are those situated far away from sources of modern health services. They are usually identified and consulted by the Assistant Director of the programme,

but the programme obliges if a deserving community initiates request.

On meeting the village community, the Assistant Director mobilises and conscientizes the villagers about their health problems and how they can alleviate them through communal self-help. He then introduces them to the activities of the programme and assures them of the programme's willingness to assist them in their endeavours. The assistance offered include the training of personnel and the provision of a supervisor who conducts underfives and antenatal clinics in the community, working with the village health workers. The programme offers a loan to each of the participating villages which includes drugs and equipment worth ₦84.00 (in the 1970s) which are expected to be repaid within one year. These offers are effected however only if the village community can undertake to:

(a) Provide two locally resident indigenes, a male and a female, at least literate in Hausa, married and ages between 25 - 50 years (religion being no criteria for selection) to be trained in rudimentary health care in the Programme's Training School.

(b) Be responsible for the payment of the sum of ₦120.00 for the feeding of trainees during training.

(c) Be willing to build a two-room apartment, furnished with a bed, table, chairs, patients' seats, and dig a pit latrine in the premises.

(d) Assist the health workers on their farms and pay each the sum of at least ₦16.00 monthly as at 1981.

If the community accepts these stipulations, a Village Health COmmittee(VHC) is formed comprising of the village head, and if any, the village headmaster, pastor and imam. Each section of the village is represented by a permanent resident whose occupation is farming.

The committee sets to work immediately selecting candidates for training, collecting money required for their feeding and building the health post. In all, the Assistant Director makes eight visits to each village, each with specific objectives such as introducing the programme to communities and spelling out their responsibilities, examination and selection of health workers, announcement of date of completion of training and ascertaining how prepared the community is to have the health post opened.

During training the health workers are taught basic rules of hygiene, symptoms of endemic, epidemic and the common diseases in general, their causes, prevention and treatment. The teaching is mostly done through story-telling, after which the content is dramatised. The rationale for this method is that the same methods will be used in imparting health education to community members after training.

When the health workers start working, health education is expected to be taught at regular intervals interpersed by supervisory home visits. Curative services, underfives and antenatal clinics are paid for. The range of diseases treated are, however, limited and the health workers are not allowed to administer treatment by injections. Due to this, the programme has built dispensaries at strategic points to render mostly curative services and serving as referral centres for patients who need diagnoses and treatments beyond the competence of village health workers.

The drugs used by both dispensaries and health posts are bought from Christian Central Pharmacy(CCP) Jos. The CCP in turn makes purchasing arrangements with other voluntary agencies abroad who buy the drugs mostly under their generic names from manufacturers in Europe.

Drugs are obtained so cheaply through this channel that in the 1970s, some could be obtained at thirty times less than their Nigerian market prices. For example, a drug called levamisol, used for treating intestinal parasites, sold at six naira at CCP for a pack of one thousand tablets, while the same sold for one hundred and eighty naira at standard chemist shops in Jos. In this way drugs regularly reach consumers at much lower prices than can be obtained from commercial or private outlet.

The EYN Rural Health Programme as PHC:

The community - oriented approach, emphasis on health education, procurement of cheap essential drugs and the provision of maternal-child services embarked upon by the programme are integral components of PHC as declared in 1978. The programme's activities therefore, largely conform to WHO's specifications of pursuit of PHC, most especially that the targeted beneficiaries are rural dwellers who have the least access to modern health care. The undertaking made by such communities to organise and sustain the programme for themselves constitutes community participation.

The Assistant Director animates community participation, which recipient communities can sustain. The main tasks required of them are the building and furnishing of the health post, payment for training workers, assisting the health workers on the farm, and taking active part with health workers as performers, learners and implementors of health education. Communities therefore perform all that they can feasibly do like identifying health problems to be tackled, establishing and managing the health post, dissemination and implementation of health education.

CHAPTER FIVE

METHODOLOGY AND DATA COLLECTION

Statement of Research Problem:

Our major problem of investigation is the extent to which communities can participate in the various components of PHC. This is investigated through a study of the Eklessiyar Yan Uwa a Nigeria Rural Health Programme's activities in providing PHC and people's responses to the demands on them to organise the programme's health services on communal basis.

Definition of Key Concepts:

In the text some terms are used which need to be defined either operationally or in the context within which they are used. These terms and their meanings are as follows:

(a) Village Health Worker: This is a community member, selected by the community, examined, accepted and trained by the programme for three months to work in the village health post. This word is shortened to "health worker" in the text.

(b) Village Health Post: THis refers to a building, usually a two-room apartment, built by the community members in which the village health workers work.

(c) Functional Health Post; refers to a health post in which the village health workers are still rendering, at least, the curative services regularly. This leads to maintenance of working relations with the programme through purchase of drugs and visits for maternal-child welfare services by the health post supervisor.

Kashim Ibrahim Library,
Ahmadu Bello University,
Zaria - Nigeria.

(d) Non-functional Health Post: This is the health post where the health workers are no longer working. The falling of a health post into this state can be seen as a failure of the programme in the village because other activities depend on the health post being functional.

(e) Dispensary: The programme's dispensaries are health care units which render mainly curative services although their staff educate clients about the causes and prevention of the diseases they present. Each dispensary is usually headed by a community Health Supervisor and may be equated with the Primary Health Care Clinic in the Nigerian PHC system.

(f) "Success of the programme" in a community is primarily defined as the maintenance of the health post in a functional state. There may be reservations about regarding the maintenance of a health post in a functional state as a sufficient measure of success of the programme, but the functions performed by the health posts once it is functioning make it appropriate to resort to this classification within certain limits. A functional health post provides the much desired curative services and maintains an avenue through which community members can be educated on individual basis when they come for treatment. In addition, the health post supervisors continue their supervisory visits and provision of maternal-child welfare clinics. Thus a functional health post connotes the availability of most components of PHC as contrasted with their absence when not functional. This exposition should not be construed as saying that success of the programme is solely dependent on the mere functioning of the health post. The true successful implementation of the programme in a community is operationalised in terms of the following actors' performance as follows:

(i) The health committee - its ability to organise the programme by maintaining the provision of curative services, mobilising community members to assist health workers and effect repairs on the health post, organising the delivery of health education and conducting home visits by health workers.

(ii) The village health workers - their willingness to continue working, providing curative services, health education, home visits and maternal and child health services. In the latter case, this is done when the health post supervisor visits.

(iii) The community - the willingness by members to assist health workers, participate as actors in presentation of health education, attendance of health education lessons and meetings of the entire community. A very significant component of this is the extent to which community members implement health lessons learnt on such matters like nutrition, refuse disposal, personal and environmental hygiene, improvement of quality of drinking water, the provision of pit latrines and other health lessons.

(iv) On the side of the programme, success depends on the continuation of supervisory visits to health posts, immunisation of expectant mothers and children, procurement of drugs and conduct of refresher courses for health workers. The real success of the programme therefore depends on the combined efforts of community members, health workers, health committees and the programme's headquarter.

g) Household: A household is defined in the context of this study as a residential unit made up of at least two people headed by a male or female adult. The normal authority structure of households among all the ethnic groups in the study area is that on marriage, the young couple becomes autonomous in dealing with its conjugal and nuclear familial responsibilities especially economic pursuits and routine health care.

Research Design:

Data collection was done by means of qualitative and quantitative methods. The qualitative data consisted of information on the various aspects of the programme like form and content of health education; the social situations of recipient communities in terms of their social composition, social cohesion, history of community projects and responses of identified interest groups to the programme. These were obtained mostly through interviews with health committees and health workers (Appendices II and III). In addition, leaders of women's organisations were interviewed in two purposively selected villages, while the researcher was opportuned to attend a village community meeting summoned by the head of one of the programme's dispensaries. Individual community members also volunteered to provide some information which could not have been obtained through the formal discussions. The data needed at headquarters and training school of the programme were gathered over a period of time on various aspects of the programme culminating in a structured interview with the Director (Appendix V). In addition, interviews were held with heads of six dispensaries belonging to the programme (Appendix IV).

As regards the quantitative data, these consisted of information obtained from household surveys in sampled villages(Appendix I), records of diseases reported at health posts and dispensaries and records of vaccinations administered. The household survey focused mainly on the socio-demographic characteristics of household members, vital events before and after establishment of the programme in the village; utilization of services rendered at the health post, adult members' attendance and implementation of health education lessons; adult members' assessment of the organisation of the programme with specific reference to the roles of the headquarter, the village health committee and the community's response.

Sampling:

The survey is confined to the Gongola state section of the programme because of the presence of more ethnic groups participating in Gongola state. It is also instructive to note that the large ethnic groups among which the programme operates in Borno state, the Bura and Marghi are also found in Gongola state.

The survey began with a pilot study in which fifty-five villages which had participated in the programme were visited. Out of these, twenty-one had functional health posts while thirty-four had non-functional health posts. The pilot survey was confined to Gombi, Mubi and Michika LGAs. After the pilot study, a stratified sample of ten villages were selected out of sixty-seven to represent their functional status, LGAs and the dominant ethnic groups (see sampling frame in Appendix VI). Selected villages are shown in Table 1 below:

Table 1: Characteristics of Selected Villages

Village	Local Govt. Area	Ethnic Group	Functional State
1. Gangrang	Gombi	Ga'anda	Not functioning
2. Sokoron	Song	Yungur	Not functioning
3. Lidle	Michika	Higgi	Functioning
4. Vilegwa	Michika	Higgi	Not functioning
5. Mayowandu	Michika	Higgi/Marghi	Functioning
6. Hurumda	Gombi	Hona	Not functioning
7. Zah	Gombi	Kilba	Functioning
8. Kwatau	Gombi	Kilba	Not functioning
9. Mbalwaha	Gombi	Kilba	Functioning
10. Sahuda	Mubi	Gude	Functioning

Due to their relatively small sizes, the selection of respondents was done through a single stage cluster sampling for seven villages; namely: Gangrang, Sokoron, Lidle, Hurumba, Zah, Kwatau and Mbalwaha.

All households in these villages were included in the survey, provided an adult member was present and willing to be interviewed, as it was not feasible to have group interviews with all adult houselhold members as initially planned. A satellite settlement was however ommitted in each of the following villages, Mbalwaha, Zah and Lidle, because of various reasons. For Mbalwaha, the village head had forgotten to tell the researcher about members who had migrated to another village but had maintained membership in the village, participating in all community activities including the health programme. In Lidle and Zah, the committees were of the opinion that one satellite village could each be omitted because of their marginal involvement in both organisation and utilization of the health services.

In the rest of the villages, Vilegwa, Sahuda, and Mayowandu, the selection of households was done through a two-stage cluster sampling in view of their larger sizes or social heterogeneity.

Vilegwa : This is an ethnically homogeneous Higgi village. The homesteads are interpersed by farmlands and forest reserves. There are six satellite villages from which three were randomly selected in addition to the main village. In view of the harrassment of citizens by armed robbers at the time of study, the researcher excluded one village to which the way passed through a forest reserve.

Mayowandu: The settlement pattern of this village is similar to Vilegwa, except that the central village is much larger and more nucleatedly settled but it is ethnically heterogeneous, with Fulanis, Marghis and Higgis living in clusters. Provision was made to include all the ethnic groups. In this village one satellite village was excluded on similar grounds as in Vilegwa.

Sahuda: THis is a relatively large lineally settled village on the Nigeria-Cameroun border. It is basically ethnically homogeneous but quite heterogeneous in terms of religion. Moslems and Christians are about the same in number with traditional worshippers who constitute a numerical minority. It became clear during the preliminary investigations that it was christians who formed the back bone of the support for the health post in the community and that there was a differential response to the health post by religious groups. Because the village is quite large, the resercher grouped the sections according to their religious composition and randomly selected one each where there was a preponderence of moslems, christians, and traditional worshippers. Because of the nature of the combinations required, only one section was selected at random, the other two were the only ones that fulfilled the criteria.

In all 731 households were included in the study. Husbands and wives were both available and jointly interviewed in 262 households, men were interviewed alone in 395 and women alone in 74 households respectively. As a rule only families who had resided in the village for at least one year when the village health post was functional were interviewed.

The primary sampling units are therefore villages and the secondary units are households. As regards analysis, the salient issues which determined the success or failure of the programme in each sample village are presented village by village while analyses of implementation of health education and utilization of health services are based on households.

Methods of Data Collection: Village Surveys:

The researcher had established rapport at the headquarter of the programme with the Director and staff during the pilot study(1984-85) and they were all pleased to learn that the study was continuing to a Ph.D. level. The Director willingly granted permission for the village/household survey which took place from September 1986 to July, 1988.

In addition, he wrote a letter of introduction for the researcher to show whosoever was to be approached for the study, informing such people that he had permitted the researcher to conduct the study and asked them to assist him.

The researcher resided in the villages during the household surveys. He went to the villages before hand to notify and explain to the village head, the Chairman of the village health committee and the health workers about the study. As a rule they were shown the researcher's student identity card and two letters of introduction, one from the Department where he studied and the one written by the Director. On such visits arrangements were made in consultation with the Chairman of the village health committee to select a suitable field assistant among secondary school leavers and teachers' college graduates from the village. These were obtained as requested except in Vilegwa where the person selected had left secondary school in form four and Lidle where the assistant was a Diploma graduate.

Training Field Assistants for Household Surveys:

The nature of the study was first explained to the field assistants after which the household interview schedule (Appendix I) was given to them to study overnight. We then discussed each item in terms of how it should be translated and how answers should be recorded. After this, the researcher and the assistant went from house to house beginning with those who understand Hausa (Hausa is the language used in interviewing most of the respondents because most of them do not speak English but Hausa and their respective languages, the researcher on the other hand can speak Hausa and the Kilba languages). The researcher conducted the first interviews to help the assistant learn more. After this he asked the assistant to conduct some interviews in Hausa, then some other cases with

people who understand Hausa but the interview being conducted in the local language. The responses would then be interpreted to the researcher. When these yielded reasonably valid answers, the assistant was allowed to conduct interviews with those who did not understand Hausa as well as with those for whom it was more convenient to conduct the interview by him than the researcher. However, the researcher was around most of the time such interviews were conducted, and often consulted on how certain responses should be recorded.

Problems Encountered During Data Collection:

Among the major problems encountered during data collection was the inaccessibility of the villages since most of the study was conducted during the peak of the rainy season. All of the ten villages are off the main road, but three of them, Mayowandu, Vilegwa and Sahuda have all season untarred motorable roads. The rest have only seasonally motorable roads. In fact on one occasion, the researcher and his motorcycle were carried across a twenty-five metre wide flooded stream.

Besides this, there were other personal security risks. The entire area covered by the study was infested by armed robbers during the study period. There were tales of recent robberies of grains, livestock and attacks on people in many of the sample villages. It was therefore risky for a person to ply the roads alone as the researcher did and equally dangerous was the possibility of his being suspected of being a spy for the robbers. However, he was never attacked, but robbers raided a village during his sojourn there.

There was also a problem caused by people's misconception of the researchers' professional role. Although he told all people approached that he was a sociology student and explained the difference between

studying medical sociology and the medical profession, many people still considered him as either a medical student, medical personnel, environmental sanitation worker or staff of the EYN programme. Community members most of whom did not know of social research, therefore often requested for medical examinations or treatment for diseases.

It was, therefore, necessary to explain the nature of social science research and also likening the researcher's situation to a student on teaching practice whose teaching capabilities would be assessed by a tutor. It was further explained that in the case of this researcher, his teacher had seen the questions and would assess him after he had compiled the answers. These details were necessary for portraying the researcher as a neutral person who was neither in position to influence action in any direction nor speak for the programme.

Another misconception was that some people took the researcher for a government official sent to the village to identify the social amenities such as schools, medical services, water supply and roads that were lacking in the villages so that the government can provide them. On the contrary, other people feared that the researcher was assessing their assets for taxation. The researcher always rectified all misconceptions and reiterated the purpose of his study.

Access to respondents:

Meeting respondents at home was a problem because most of the interviews were conducted during the farming season, May - November, when most people spend the whole day on the farms. Surprisingly, most people were also unavailable most of the time for interviews during the dry season because they went out to perform one task or the other.

Another precaution needed was to avoid interviewing people who were under the influence of alcohol which was observed to be heavily consumed in the villages.

Community secrets:

In some villages, disagreements in community transactions are well guarded secrets. There were occasions when interviewing health Committees or individuals, when the researcher was told that the gaps in the information were confidential. On some occasions such information were disclosed in confidence or after the interview by those who felt that the researcher should know the truth. Some people who were hurt in the process of organising the programme also supplied such information to portray how they had been unjustly treated.

Vital statistics:

Problems were encountered by some respondents especially the elderly ones in recalling the dates vital events such as when marriages, births and deaths of children occurred and also their own ages. Many respondents tended to mention only wives with whom they had surviving children and to count only living children.

Limitations of the Study:

This study was unable to establish empirically the impact of the programme on people's health due to methological problems. The data on implementation of health education acquired for instance are self-reported and progress made could be under-reported or exagerated. It is also methodologically significant to note that the programme did not collect baseline data on indicators of the communities' health status such as morbidity, mortality and nutritional status which could have

enabled us make a comparison with what obtained after the establishment of the programme. Thus we have relied principally on self-reports from households and the health workers' assessments of improvements made by people. We have however, done a time series analysis of diseases reported and treated at the health posts and dispensaries in the text.

With regards to community participation in the organisation of the programme in the villages, the health workers, health committees and household heads often rendered conflicting reports about each other's willingness to play their roles in the organisation of the health post, assistance rendered to health workers, delivery and attendance of health education. Consequently, the degree of community support for and participation in the programme is assessed from a synthesis of the information given by the health workers, health Committees, household survey informants and responses to probes for factual information from field assistants and other community members. These notwithstanding, findings of both theoretical and practical importance have been made.

CHAPTER SIX

SOCIAL CHARACTERISTICS OF RESPONDENTS, ESTABLISHMENT AND MAINTENANCE OF HEALTH POSTS

The social characteristics of household heads with regards to age, marital status, occupation, religion and educational attainment will be discussed in this chapter. The establishment and maintenance of health posts will also be discussed using various health posts as case studies.

Age and Marital Status:

Table 2 shows the age distribution of household heads, their villages and functional states of their health posts.

Table 2: Age of Household Heads by Village of Residence

Village	Functional State	17-29		30-50		51-60		61+Yrs.		Total	
		N	%	N	%	N	%	N	%	N	%
Gangrang	NF	28	26.9	57	54.8	15	14.4	4	3.8	104	14.2
Hurumda	NF	3	12.5	15	62.5	4	16.7	2	8.3	24	3.3
Sokoron	NF	26	32.1	42	51.9	8	9.9	5	6.2	81	11.1
Vilegwa	NF	7	13.2	26	49.1	4	7.5	16	30.2	53	7.3
Kwatau	NF	4	6.9	31	53.4	9	15.5	14	24.1	58	7.9
Mbalwaha	F	6	7.8	59	76.6	10	13.0	2	2.6	77	10.5
Zah	F	11	13.9	50	63.3	5	6.3	13	16.5	79	10.8
Sahuda	F	8	9.4	54	63.5	9	10.6	14	16.5	85	11.6
Mayowandu	F	11	9.5	63	54.3	21	18.1	21	18.1	116	15.9
Lidle	F	7	13.0	28	51.9	7	13.0	12	22.2	54	7.9
Total		111	15.2	425	58.1	92	12.6	103	14.1	731	100.0

NF is for Non-functional health post

F is for functional health post.

From a total population of 731 household heads, 536(73.3%) are fifty years old or younger. Most of the households have women of child-bearing age.

With regards to marital status, 696(95%) of household heads were married, 35(5%) were widowed or divorced. Of those married 426(61%) were monogamous and 270(39%) were polygamous.

Occupation:

As expected for rural communities, the main occupation of the bread winners for households, 684(94%), is farming, while 47(6%) are mainly teaching, civil service or receiving pension. Invariably, this group of people engaged in farming as part time occupation.

Among the full time farmers, 180(26%) have secondary occupations such as trading, tailoring, blacksmithing and other crafts. There were a few traders who had substantial quantities of merchandise, the majority being petty traders. The secondary occupations were, therefore, assessed as not yielding much material returns. Thus, out of the 180 farmers who have such occupations, fifty reported that they realise substantial material benefits from them, while the bulk said they realised little.

Part of farm work in the villages include the raising of livestock, especially sheep, goats and poultry and to a lesser extent cows and pigs. The economic importance of the small livestock are that they come in handy during emergencies such as illness, unexpected visitors who have to be entertained and meeting familial material obligations, like marriage and funeral celebrations.

Table 3 shows the distribution of goats, sheep and pigs combined per household. Their monetary values ranged from one hundred and fifty to three hundred naira for the average sized animal during the time of study.

Table 3: Distribution of Goats, Sheep and Pigs per Household

No. of Goats, Sheep and Pigs	Functional State of Health Post					
	Non-functional		Functional		Total	
	N	%	N	%	N	%
None	82	25.6	113	27.5	195	26.7
1-4	78	24.4	154	37.5	232	31.7
5-9	79	24.7	96	23.3	175	24.0
10 or more	81	25.3	48	11.7	129	17.6
Total	320	44.0	411	56.0	731	100.0

The distribution shows that, 195(27%) of households in all the villages do not raise any of the three animals, while 129(18%) have ten or more of them. The rest of the households, 407(56%) have between one and nine animals each. Thus most households raise only a few animals. However, it should be noted that a higher proportion of households in communities with defunct health posts raise larger numbers of animals in this category which actually gives them an edge in solvency over those whose health posts are functional in cases of exigencies.

The raising of poultry, although much less demanding than the larger animals is practised in fewer households. It was found that 421(58%) of all households had poultry with 320 of them having ten birds or less, eighty had eleven to twenty, while twenty-one households had more than twenty.

Cows are raised in eighty-five households, most of which had only a pair, used in ploughing farms, others had as many as eighteen head of cattle.

Judging by the occupations and sources of cash income of respondents, the communities are generally subsistence farmers and can adequately help on health workers' farms. In fact, most of their members said that the crops they grow, such as guinea corn, maize, millet, groundnuts, beans,

cassava, beniseed and bambara nuts are mainly for consumption, and that, sales of any part of the produce are done to meet obligations such as payment of school fees, taxes and purchase of clothes and other indispensable items. It should be noted that the only officially recognised cash crop grown in the area covered by the study is groundnuts, which is also an important food item. The extent and motive for its cultivation however, differ across the ethnic groups. Among the Kilba, where it is most extensively cultivated and marketed, it is also most consumed as food. Most of the other ethnic groups cultivate just a little for consumption and hardly sell. Their main sources of cash were reported as sales of grains, beans and livestock. Some household heads especially among the Higgi and Ga'anda resort to seasonal labour migration to acquire cash to meet their financial obligations. Thus, the availability of cash varies from season to season, and is at its lowest ebb in the rainy season when malaria and malnutrition are at their peaks of prevalence.

Religion:

Table 4 shows the religious affiliation of respondents.

Table 4: Religious Affiliation of Respondents by Functional State of Health Posts

Functional State	Religion							
	Traditional:		Christianity:		Islam:		Total	
	N	%	N	%	N	%	N	%
Non-functional	48	15.2	252	79.7	16	5.1	316	43.6
Functional	50	12.2	310	75.8	49	12.0	409	56.4
Total	98	13.5	562	77.5	65	9.0	725	100.0

X^2 = 11.5 2df sig at .001 level

Missing cases = 6

As can be seen in table 4, most, 561(77%) of all the respondents are christians. They, however, belong to various denominations such as the Eklesiyar Yan Uwa a Nigeria(E.Y.N), the Lutheran Church of Christ in Nigeria(L.C.C.N), Roman Catholic Mission(R.C.M), the Sacred Order of the Cherubim and Seraphim(C & S) and other "African" churches. As can be seen from the table, there are moslems and traditional worshipers. Thus religious difference is a potential source of serious rifts for cooperation in the communities.

Education:

Formal educational attainment by household heads is very low with barely 30 percent having any formal schooling. Table 5 shows the distribution of educational attainment by functional states of health posts.

Table 5: Western Educational Attainment by Functional State of Health Posts

Functional State	Education									
	Not literate		Literate in Hausa, no sch.*		Some/full Prim.Sch.		Some/full Sec.Sch. & above		Total	
	N	%	N	%	N	%	N	%	N	%
Non Functional	182	57.8	20	6.3	65	20.6	48	15.2	315	43.6
Functional	234	57.3	74	18.1	78	19.1	22	5.4	408	56.4
Total	416	57.5	94	13.0	143	19.8	70	9.7	723	100.0

X^2 = 37.0 3df sig. at .001 level.

Missing cases = 8

*no sch. means no formal education.

It is possible that those who have received formal education reside and work away from the villages and were, therefore, not included in the study. The bulk, 416 of the respondents are, however, non-literate. Based on the criteria that health workers must be literate, none of these qualifies to serve as health worker.

Those who are literate in Hausa but without any other formal schooling mostly attended adult education classes organised by churches. This category of people is similar in social status to the non-literate because they are barely literate in Hausa which does not help them much to get employment in formal sectors. They are, therefore, generally permanently resident in their villages. They therefore, form the ideal category of people from which the health workers and executive officers of the health committees can be drawn. Indeed, people from this category prove to be the most reliable health workers because all those who ran the health posts single-handedly or with the help of relatives belong here. Numerically, this group is small, being only 13.0 percent of household heads surveyed. Considering the inequitable distribution of people in this category among the villages and that personality factors are taken into account when selecting workers, situations do occur when a suitable candidate is not got in a village. When such a situation occurs, the workers may either be invited from another village or literate members who have migrated may be called back.

The crucial role played by those who attained literacy without formal schooling in maintaining health posts functional is statistically demonstrated by their being present in much higher proportions in villages with functional health posts than those with defunct ones. Thus while this category constitutes 6.3 percent of household heads in communities with defunct health posts, they constitute 18.1 percent for those with functional health posts.

It is significant to note that the proportions constituted by those who have not had any formal schooling and those who have had some or full primary education are about the same for the two groups being 58 and 57 percent; and 21 and 19 percent for functional and non-functional health post communities respectively.

The people who have secondary education or above on the other hand, are not expected to work in the health posts because they often do not live in the villages permanently. Consequently, the researcher found only one worker who had gone beyond primary school, but who resigned after working for three months. It should be noted, however, that there are proportionately more household heads with secondary education in villages whose health posts are defunct than in those whose health posts are functional. This rather anomalous situation is explained by the practice of early marriage by males in Sokoron and Gangrang villages both of whose health posts are defunct. The presence of those who have acquired secondary education or higher in the villages, whether married or not, did not show any qualitatively discernible impact on the organisation of the health posts. Discussions with some of them revealed that they did not participate in the organisation of the health posts in their respective communities. Community members who have attained post primary levels of education are, therefore, less likely to participate in running the programme with other members.

Community Mobilisation and Support for the Programme:

This section presents data on the ways in which the mobilisation of community members to participate is responded to. The data presented inlude information obtained during the pilot survey of fifty-five village health posts in order to portray basic facts about other health posts from which the sample is drawn.

Usually, the village communities respond favourably to the programme when approached for the establishment of a health post. The entire community, the health committee members and village health worker candidates are reported to turn up promptly when visits are fixed for the negotiations. Consequently, the arrangements are usually completed within a short period. This enthusiasm and support is maintained in most communities up to the time of the official opening of the health post[3]. The problems of community support usually set in after work has commenced in the health posts, when members are asked to assist the workers on their farms, make additional contributions or participate in the various activities of the health post.

However, in their enthusiasm to avail themselves of the opportunity of having a health facility, some communities cover up certain facts about themselves relating to the laid down conditions, especially non-availability of suitable candidates for the post of health workers. Other communities conceal the facts that some of their members would not contribute money for training workers and building the health post.

Communities which wish to cover the shortcomings either recruit health workers from other communities, call back their eligible members who have migrated, solicit for cooperation with neighbouring communities who have suitable candidates or ask a few individuals who are known to be compatible to finance the training of workers and building of the health post. The latter evidently created an impression that the health post belonged to the financiers with the result that community members did not respond when called upon to help after the establishment of the health post.

Generally, villages which violate the regulations that health workers be permanent residents of the villages and that the community as a whole contributes labour and money for establishing the health post usually

incur insurmountable problems in running them. In villages where workers are recruited from elsewhere, the expectations for rewards by such workers are high. When such expectations are not met, the frustration felt is greater than those of permanent resident workers. With little or no other stakes in the communities such people have low tolerance thresholds, they often resign and leave the villages. It should, however, be noted that the nature of villages which employ the services of this category of people could be very demanding on the health workers because they are mainly far away from the main road where drugs have to be collected while their health committees are less organised and knowledgeable about formal procedures.

Selection of health workers who fulfil the specified conditions does not, however, necessarily ensure continued functioning of health posts. There are cases where the health posts got defunct inspite of the selection of permanently resident workers. Their advantage over the outsiders or marginally integrated ones is that many of them continued to render services with neither payment nor community support when their health committees get dormant.

Differences in Programme Objectives and Community Expectations:

An important discrepancy between the programme's objectives and community expectations is on the type of treatment provided at the health posts. Most communities expected more elaborate medication than the programme allowed the health workers to provide. Thus when asked what they expected health workers to learn during the training, 599(82%) mentioned treatment of all diseases affecting people in the village and that they should know how to administer injection. Only seventeen(2%) of the household heads expressed expectations within the limits specified

by the programme, while 106(15%) pleaded ignorance of what to expect.

Furthermore, when asked about their major concerns about their health posts, 265(36%) asked the researcher for advice on what the community can do to have the health post upgraded to a dispensary; thirty-three(5%) suggested that the government should establish a higher level curative health facility, while ten of the respondents asked the researcher to advise them about or treat them for diseases which had not responded to treatment at the health post or other sources of care. One hundred and twenty-one(17%) raised a wide-range of issues on the implementation of health education like water scarcity, lack of proper educational background, weaknesses of health committees, poverty and the indomitability of disease vectors. The rest, 31%, said they had nothing to say.

Despite the diverse nature of the concerns, the one most frequently expressed is the establishment of more elaborate treatment facilities. As for the upgrading of health posts to dispensaries, some communities devised strategies to convince the programme of their eligibility by either exhorting members to patronise all activities of the health posts or imposing levies on members to exagerate the true revenue generating capacity of the health posts. In two known cases, the communities had each raised as much as two thousand naira when they applied for upgrading which were both turned down due to low prospects of economic viability. Thereafter, one stopped fund raising activities, while the other pulled out of the programme altogether. Such communities' initial conformity are, therefore, instruments for having their health posts upgraded and not indications of willingness to run the programme, because there is less demand on communities in running dispensaries than health posts.

The programme itself became aware of the lack of concordance in her objectives and the priorities of the recipient communities. On realising this, the Assistant Director visited villages which had problem. This exercise culminated in the organisation of workshops in zones to enable all health workers and committees to attend in 1987/88. During the workshops, each health committee recounted its experiences which were discussed by all. After this the tasks and responsibilities of health committees were reviewed within the context of the problems experienced. In this way, some health posts which had got defunct were reactivated and weak ones strengthened.

Relationship between date established, accessibility and functional state of health posts:

Of the 55 health posts included in the pilot study, thirty-four had became defunct, while twenty one were functional. A higher proportion of health posts established earlier continued to function than those established later as shown in Table 6.

Table 6: Year of Establishment and Current Functional State of Health Posts

Year	Functional State					
	Functional		Non-Functional		Total	
	N	%	N	%	N	%
1973-1975	6	46.0	7	54.0	13	26.0
1976-1978	5	33.0	10	67.0	15	30.0
1979-1981	4	28.0	10	72.0	14	28.0
1982 and after	3	38.0	5	62.0	8	16.0
Total	18	36.0	32	64.0	50	100.0

Missing cases = 5

Of the thirteen health posts founded within the first three years of the programme, 1973-1975, 46.0 percent were still functioning as contrasted with 33%; 28% and 38% for those founded in the periods 1976-78, 1979-81 and 1982 and after respectively. While it is plausible to explain this in terms of the programme's success in identifying the needy villages and success in making such communities imbibe the tenets of organising the programme in its earlier years, it is also true that distance of the defunct health posts are on the average further away from the main road as shown in Table 7.

Table 7: Functional State of Health Posts by Distance from Main Road*

Distance	Functional State					
	Functional		Non-functional		Total	
	N	%	N	%	N	%
0 - 5	6	60.0	4	40.0	10	18.2
6 - 10	8	53.0	7	46.7	15	27.3
11 - 15	5	50.0	5	50.0	10	18.2
16 - 20	1	16.7	5	83.3	6	10.9
21 - 25	-	-	2	100.0	2	3.6
26 - 30	1	25.0	3	75.0	4	7.3
31+	-	-	8	100.0	8	14.5
Total	21	38.2	34	61.8	55	100.0

$\bar{x}$ = 9.0km $\bar{x}$ = 18.5km

*It is assumed that the mid-point of those health posts which are more than 30km from the road is 35km.

As can be seen in table 7, the closer the health post to the main road, the more likely it is to be in a functional state. The direct effects of distance from the main road on the running of the health posts are in relationship to the supervisory visits, abilities of clients to go to other

institutions when referred and the monthly collection of drugs by health workers at rendez-vous along the main road. These can, therefore, affect the performance of routine procedures by supervisors, health workers and patients. This, however, does not account fully for the poor performance in far off villages. It is clear, therefore, that neither the objective nor even the subjective health needs of communities necessarily determine their responses to the health programme. Instead, the form of community organisation plays a crucial role in the collective maintenance of health posts as discussed below.

Collective Maintenance of Health Posts:

This section illustrates how health posts are maintained through the laid down collective effort and the alternative arrangements made when this fails. In doing this, the villages cited as case studies are discussed in some detail to facilitate the understanding of the contexts of the behaviours exhibited.

As regards the successful ones, Mbalwaha and Lidle villages are the best in fulfilling the requirements of community support. Their village health committees function quite well. The results are that community members are often mobilised to assist the health workers, repair health posts, be prepared for home visits, stage public health teaching and turn up for maternal and child welfare clinics.

Mbalwaha, a Kilba village, is situated about thirteen kilometres off the Gombi-Mubi main road. The majority of its residents are consanguineal relatives. The community is closely-knit which enables it to execute community projects. For instance during the period of field work, the community was building a block of two classrooms in the village primary school in addition to one they had earlier constructed.

It is, therefore, a reflection of this group cohesion that since the inception of the health post, it has neither become bankrupt nor defunct.

Although the workers are paid regularly, community assistance on health workers' forms had been poor. The committee decided that instead of going to work on the health workers' farms, community members should contribute a specified quantity of grains at harvest for the two workers. Women, on the other hand, contribute dried vegetables and other food items for the female health worker, which are normally supplied by women according to gender division of labour. An annual festival is also organised during which donations are made by community members for the upkeep of the health post.

By 1985, the health committee applied for upgrading the health post to dispensary. This was turned down in favour of Mijili, a village six kilometres away from Mbalwaha, because of Mijili's central location for the catchment area. This annoyed Mbalwaha community so much that all respondents complained during the interview. Revenue generation declined after 1986, but health education, maternal and child welfare clinics went on normally. The community leaders pointed out that despite their disappointment, they would continue to run the programme as planned.

Similarly, Lidle, a Higgi village, situated seven kilometres from Michika, its LGA headquarter, maintained its health post through community support. The community was spurred to do this because of it's awareness of being deprived of governmental social services. The health workers are assisted and paid. Home visits and health education are conducted regularly due to the efficiency of the health committee.

The physical layout of the settlement facilitates communication and community organisation. The village is encircled by hills, with most houses within earshot of each other and farms located in the central part of the valley. Members meet more often than in villages where farmlands

are far away from home and in different directions.

The third factor is the male health worker himself. He had come to the village as an evangelist thirty-five years prior to the study. He got integrated into the community and decided to remain in the village after he had trained the indigenes. When the negotiations were concluded for establishing the health post, he volunteered to be a health worker. He has been working since the establishment of the health post whereas two female health workers have left in succession.

The health post had some set backs though. It was plundered by thieves on three occasions, during two of which drugs and equipment were stolen. The thieves dismantled the roof and carried away the roofing sheets during the third episode. Thus, although the health post had never got defunct, it had only about ₦300.00 at the time of study.

It is interesting to note that an informant had a discrepant view about the organisation of the health post and claimed that it was run by a clique whose members want to dominate the village affairs. Despite the conflicts, people were generally appreciative of the health post as meeting their basic medical needs, and were proud that clients came from Michika, the LGA headquarter, to the health post for services.

Let us now look at two cases of health posts which were functional but marginally supported by the community of which Zah and Mayowandu are cited as cases in point. Community support fluctuated so much in these villages that the health posts were maintained by only the health workers at some points in time.

Zah, a Kilba village, is situated about fifteen kilometres off the Gombi-Garkida main road. The community is ethnically homogeneous, made up of seven lineages whose representatives govern the village through hereditary offices ascribed to each lineage.

The health post has been functional since it was founded in 1979, but is financially weak, with only ₦87.50 during the time of study. Due to its remoteness from the main road, visitors are usually people who come to perform specific tasks like the teams which came to dig earth dams and tsetse fly control in the 1970s.

The insularity of the community helps it to depend on its members who can easily be called to compliance. This also minimises diversity of interest and facilitates eliciting the necessary community support in pursuit of objectives. These observations are borne out by the activities of two voluntary organisations in the village, although such mass support is not demonstrated for the health post.

The first of the voluntary organisations is Zah Progressive Club. Its objectives include the pursuit for progress of Zah indigenes in such endeavours as business, formal education and provision of social amenities like roads and water rupply. The club's remarkable achievements are the successful sinking of a well, construction of a four-classroom block for the village primary school and exhorting parents to send children to school which has accounted for 100% attendance for school age children.

The second Association is the Zah Youth Club. The membership is mostly teenagers and those in their early twenties. The main health objective of the club is to modernise the village through environmental sanitation. The members therefore, clean the streets, school and health post premises on regular basis. They had also embarked on latrine digging programme, whereby all married members must dig one for their families and everyone must dig one for their parents if they had none. Aged childless people are assisted by members of the club. The club also requested and got authority from the village head to have all piggeries built on the outskirts of the village, with members assisting parents and aged members.

These public health measures were taken due to what members observed as high prevalence of diarrhoea, dysentry, worms, odours and nauseating sights of human and pig faeces. Paradoxically, these were not done as part of the health post's educational and preventive activities. Inspite of the apparent state of harmony, therefore, community support for the health post is weak.

Frustrated by failure to pay their monthly entitlements and facilitated by failure on the part of the treasurer to collect money realised from sales, two successive male health workers have engaged in financial mismanagement and their appointments terminated. At the time of study, therefore, only the female health worker was working. She complained about poor patronage of her services, and non-assistance on her farm. She said she had kept on working because her family had been recalled to the village as she was the most appropriate female member of the village to be health worker.

The rather poor patronage of the health post can however be attributed to the high prevalence of skepticism about the competence of the health workers. Some women in fact reported that they go elsewhere for maternal and child welfare clinics. A few extreme cases reported that they go to Garkida, 38 kilometres away, for all their medical needs, including antenatal and underfives clinics.

In the case of Mayowandu village in Michika LGA, it is located about ten kilometres from the main road. The village is a dispersed settlement, extending for about seven kilometres. Its health post kept on functioning inspite of the absence of community support for some years because of the female health worker's effort and a large clientele which patronised its services.

It is evident from the case studies therefore that while some health posts are administered and maintained through communal efforts, others are maintained by the health workers and their families. One of the characteristics of villages in which health posts function without active community support is that they have a relatively large clientele which generates enough funds to keep the posts functional. In addition, the socio-economic statuses of the health workers' families are high enough to enable them provide money when the posts get bankrupt.

We shall now cite the cases of villages whose health posts are non-functional. Of the five villages which fall into this category, three, Hurumda, Gangrang and Sokoron are thirty or more kilometre away from the main road, Vilegwa and Kwatau are five and ten kilometres away respectively.

In the case of Vilegwa, it was evident from the survey that most of the members had accesss to other sources of health services as 57 percent reported that pregnant women in their households attended antenatal clinics elsewhere other than the health post in contrast to 38 percent for the entire sample. In fact only six percent of respondents said that members of their households relied solely on the health post for antenatal care and children's clinics as contrasted with 26 percent of all the respondents.

The health post was first built near the erstwhile village head's house, one and half kilometres from the main village where both the health workers live. The death of the village head coincided with the collapse of the health post building, after which the site for rendering services was transferred to the main village. The successor of the deceased village head lived six kilometres away from the main village, which made it impracticable to build and operate the health post near his house like his predecessor's.

The committee also became dormant. The health post operated in a borrowed building for several years after which it was claimed back and demoslished by the owner.

The case of Kwatau village portrays distrust among community members. Both workers in this village were related to the village head and chairman of the village health committee. Some community members accused the village head of nepotism despite the fact that it was the health committee which selected the workers to sit for the examination which determined their selection. Daunted by the accusation, the Chairman did not want to organise community assistance for the workers. Moreover when the health post was blown off by a wind storm, it was not rebuilt and work stopped.

The effects of poor inter-community relations is best illustrated by Hurumda, a Hona village, which has several neighbouring Ga'anda villages which did not have modern health services. However, the Ga'anda villages were neither involved in the negotiations for, nor patronised the health post on the grounds that the communities have different origins. The health post therefore had a small clientele and poor community support for the workers. Moreover, both workers had been recalled from where they had migrated to, they resigned and went back when community support was not forthcoming as agreed.

The fourth defunct health post in Gangrang village illustrates the disadvantage of passing responsibilities of maintaining the health post to the health workers. Founded in 1978, both workers resigned in 1980 due to poor community support. A new set was trained, but the male worker resigned shortly after. The health committee became dormant, but the female worker continued working with the assistance of her brother inlaw who went to collect the drugs for her.

When he was transferred out of the village, work stopped. After several years of being defunct, the health committee was reconstituted and headed by a new chairman which selected a male worker for training who brought a consignment of drugs to reopen the health post. When he went for the second consignment he defected for several months and told the health committee on return that he had resigned and retained the money he had been given for drugs for himself as he had neither been paid nor assisted on his farm.

This village therefore, illustrates the lack of continuity when individuals who maintain the health posts can no longer do so. It also portrays the legalistic implications of communities' and health committees' failing to keep to their terms of agreement with health workers.

In general, many health posts became defunct or functioned marginally due to intersectional conflict between community members as illustrated below.

Intersectional conflicts :

The common segregating factors highlighted by informants include religion, clan, ethnicity, area of residence, political affiliation and personal rivalries. The subjective perception of social heterogeneity based on these factors by members of the same community was so real that it created social boundaries which hindered intergroup cooperation. An instance is the health post which two communities had agreed to own jointly but could not agree on where to build it. Because of the stalemate, the female health worker's husband asked her to resign. The male health worker also resigned, so the health post could not effectively take off as the health committee did not appoint another set of workers.

In several cases, when the post of the overall village heads became vacant, several candidates from eligible clans vied for it, thereby engendering jealousy and distrust. In some cases, this affected the health workers directly leading to their resignation and collapse of the health post. In others, the effects were indirect and insidious as when aggrieved losers withheld support from the winner who assumes chairmanship of the health post, or abrupt, as in the case of the clan head who demanded for the refund of his members' contributions.

With regards to religion, it was common in some communities for non-christians to point out that they regarded the health post as part of church organisation. In extreme cases, they expressed the fear that making the organisation and services of the health posts open to all community members are ploys by the programme to win converts to christianity.

With respect to social heterogeneity, some of the large villages are made up of people from different social backgrounds with some groups having conflicting interests which hinder voluntary cooperation in pursuit of a common goal. This assertion can be substantiated by Mayowandu and Sahuda villages whose health posts are functional and Kala'a village (not included in the sample) whose health post is non-functional.

Mayowandu is a large dispersely settled village. It is ethnically and religiously heterogeneous, being composed of Higgi, Marghi, Fulani and other ethnic groups. The religions are christianity, islam and the traditional religions of the various ethnic groups. Being cognizant of the devisive effects of ethnic and religious differences, the health committee, had, at the inception of the health post selected a Higgi christian female and a Fulani muslim male as health workers. The male worker died after a few years and was replaced by a non-muslim Higgi, which made some Fulani feel marginalised. The new male worker was shortly dismissed for misconduct while his successor resigned soon after commencement of work due to poor community

response to his welfare.

After the last male worker's resignation, the roof of the health post was blown off. The long serving popular Higgi village head(a traditional worshipper) and chairman of the village health committee was compulsorily retired and replaced in both capacities by a muslim Marghi. This act apparently weakened the health committee. For instance, it took five years to rebuild the health post during which period the female health worker rendered services at her home, while no other male worker was appointed until the one who resigned decided to take up the job again after the health post was rebuilt.

In the case of Sahuda village, it is ethnically homogeneous, except for Federal Government workers in the border barracks. The indigenes are however polarised on religious and political affiliations. When the idea and conditions of establishing a health post was first presented, therefore, some members rejected it, arguing that no organisation was so altruistic and apolitical to provide such services to people. It was therefore mainly christians and other sympathisers who later worked as a group to establish the health post.

Kala'a is a large ethnically and religiously heterogeneous village. It was approaching an urban status in social heterogeneity in 1974 when the health post was established, because a road construction company had built its camp in the village which attracted people from all parts of the country. The health post functioned for one year and closed down as no group took it upon itself to run it.

Social heterogeneity and intersectional conflicts are, therefore, forces to reckon with in eliciting cooperation in communities. The presence of identifiably distinct groups, tends to lessen overall community support for the programme. This finding proves hypothesis (c) which states that community support is a function of social composition, with religion, lineage organisation and differential intergroup values, having negative effects on the maintenance of health posts.

CHAPTER SEVEN

NATURE AND IMPACT OF SERVICES RENDERED BY THE EYN HEALTH PROGRAMME

In this chapter, the PHC services rendered, communities' responses to them in terms of utilization, implementation of knowledge acquired and the impact of the services on the communities will be presented. The major services rendered in the villages are health education; antenatal care and child welfare clinics, which pregnant and nursing mothers are exhorted to attend, and treatment of diseases. The key issues to be discussed therefore are:

(a) Health Education

(b) Implementation of Health Education acquired.

(c) Morbidity patterns and health seeking behaviour.

Health Education:

The teaching of health education to communities is a stated core objective of the programme. This is delivered in four different locations to ensure adequate coverage of members and follow ups of implementation. The first of these is aimed at the entire village community as audience. The community assembles at a convenient location where the health workers either give health talks, relate health stories adapted to sound like folk tales or perform plays on health issues with other community members as actors. The stories and plays are usually about characters who contracted the diseases/health problems which the workers want the community to know about during the lesson. Usually, two characters are key actors, with one behaving in accordance to the laws of hygiene and medical care, while the other contravenes both. The non-conformist or members of family contract the disease and experience hardship due to improper care, while the conformist does not.

The conformist eventually discovers the tribulations of the non-conformist and gives advice on where to get medical help and how to prevent recurrence of such illness.

Other variants portray people who refuse to seek for appropriate treatment when sick until a more enlightened person tells them the right thing to do. The plays or stories usually end with either the ignorant person getting enlightened and adopting appropriate preventive habits and treatment measures or rejecting the counsel given and continuing to suffer. This mobilization through cultural medium had been used in the past within the communities as a socialization technique for imparting wisdom, incisiveness and appropriate behaviour in various situations especially for children.

Health education is also taught to people who report for treatment or antenatal and child welfare clinics at the health post. For the sick, the workers after diagnosis, explain the causes and prevention of the disease the patient is presenting and suggest what the particular patient should do to prevent further occurrence. As for the pregnant and nursing mothers, the teachings are done directly on such topics as nutrition, birth spacing, immunization and oral rehydration therapy(ORT).

Home visits, during which workers and health committee members inspect the implementation of health teaching with regards to, drinking water, wells, latrines, cooking utensils, care of children and general cleanliness of the house are also used to teach those who did not attend public teaching or had forgotten what were taught. On some occasions, especially at women's organisations' meetings, the workers also give health talks to the members.

These are, therefore, the standard ways of imparting health knowledge to the communities. It was evident from the investigations however, that

public health teaching and home visits were rarely done because of difficulties in getting community members to take part in plays or to assemble to be taught. The daily attendance at health posts are usually too few(sometimes as low as two patients), while the antenatal and underfive clinic days are too busy for teaching for the following reasons. The supervisor visits more than one health post on such days and is usually in a hurry, while the women and children within the village come to the post only after the supervisor has arrived. Similarly, home visits are rarely done because members of the health committees usually do not turn up to lead such visits. The most common practice is to teach education during the first few months of operation, after which it is reinforced to those who come for curative services to the health posts.

Community Members' Implementation of Health Knowledge:

Although the teaching of health education is not done monthly as stipulated by the programme, 607(83%) of respondents reported that they had attended lessons on health education on digging of latrines, environmental sanitation and immunisation.[4] The rest 124(17%) reported that they had been briefed on what were taught for purposes of implementation by neighbours or other members of the family. In order to identify the aspects of health lessons communities implemented, the interviewees were asked to list what they did in adherence to the health education received. The responses are shown in Table 8.

Table 8: Self-identified Modified Health Habits in Households since inception of Programme

Health Practices	Functional State					
	Non Functional		Functional		Total	
	N	%	N	%	N	%
a) Little or no modification	67	20.9	81	19.7	148	20.2
b) Environmental sanitation	73	22.8	106	25.8	179	24.5
c) Dug latrines	10	3.1	60	14.6	70	9.6
d) Personal hygiene and nutrition	61	19.1	76	18.5	137	18.7
e) At least two of b, c & d*	109	34.1	88	21.4	197	27.0
Total	320	43.8	411	56.2	731	100

* The responses are not mutually exclusive.

Gamma = -0.12

From Table 8 it can be seen that little or nothing had been done in adherence to health educationin only148,(20%) of the households. Paradoxically, a higher proportion of respondents in communities with non-functional health posts reported having effected changes in more items taught than those in communitfes with functional health posts. Thus there is a negative correlation, albeit a negligible one (gamma = -0.12) between the functional state of health posts and self-assessed adherence to teaching. The finding is plausible in view of the fact that being generally less educated, more members of communities with defunct health posts actually acquire more new ideas from health workers than those with functional ones

some of who already know the lessons. Thus the numerous modifications reported do not mean that communities with defunct health posts adhere qualitatively better to health education than those with functional ones. On the other hand, some health practices have been so much internalised by some respondents that they saw them as part of everyday life. The digging of latrines for instance, had been done in 307 households in all the villages after the inception of the programme in contrast to 70 who reported it as the only lesson implemented. All the latrines were pits, over which logs of wood and grass were placed and covered with soil, leaving a circular opening. In most cases they were surrounded with grass matting for privacy, but without roofs. There are no vents like in ventilated improved pit latrines. This, coupled with none or improperly fitting covers resulted in offensive odours and the proliferation of flies and mosquitoes which partially explain why 50 percent of the households did not have latrines. The provision of latrines is however more common in more densely settled than dispersely settled areas as seen in Table 9.

Table 9: Availability of Pit Latrine in the House by Settlement type

Settlement Type	Availability of latrine					
	None		Available		Total	
	N	%	N	%	N	%
Dispersed	153	72.5	58	27.5	211	28.9
Small nucleated	109	67.3	53	32.7	162	22.2
Large, nucleated or linear	101	28.3	256	71.7	357	48.9
Total	363	49.7	367	50.3	730	100.0

X^2 = 129; 2 df. sig. at .001 level

Gamma = +0.62

Missing case = 1

As for the more densely settled and larger villages, it was clear during the survey that their satellite villages had proportionately fewer latrines than the main villages. It is clear therefore, that population density is positively associated with the provision of toilet facilities in the communities.

Invariably, health workers emphasize the digging of latrines because they consider human faeces to be posing very serious health and esthetic problems in villages. Some household heads also considered it the most important preventive measure and either congratulated or reproved themselves depending on whether they had dug one or not for their families.

Despite the concordance of ideas on the need for latrines, some health workers noticed during home visits that proper disposal of faeces was rarely observed. Thus while health workers teach that all members of the family use the latrine, some community members believe that what matters most is for adults to defaecate where they are properly shielded from the views of others. Thus if done at night, the intercompound farmlands are convenient places. Children's faeces are considered harmless by others so that children defaecate in open designated places in the compounds. A substantial number of people who had not dug latrines, therefore, pointed out that their houses were on the outskirts of the village, while others simply pointed to natural landscapes such as erosion gullies or large stone boulders which they said provided adequate covers for defaecation. Such members' perceptions therefore indicate that latrines are dug for convenience rather than for health measures.

The rest of this section is devoted to discussing how other items of health education such as environmental sanitation, water supply, food and personal hygiene are perceived and implemented.

Environmental Sanitation:

Keeping the environment clean is taught as sweeping the compound and the frontage as well as weeding them during the rainy season. The communities are asked to refrain from planting crops within the household enclosures and to bury disused receptacles. The lesson on the digging of latrines is also taught as part of environmental sanitation as the role of latrines in alleviating what health workers refer to as "a nauseating sight created by defaecation in open places" is emphasized. It is therefore mostly on the performance of these measures that the implementation of environmental sanitation is assessed. It is significant that the interhouse spaces which are either left fallow, used as farms or rubbish dumps are not usually considered as part of the immediate environment to be kept clean.

Drinking Water Supply:

One of the items emphasized in health education is the procurement of safe drinking water. The communal digging of wells in particular is encouraged because of the availability of well-digging section of the EYN organisation, and the fact that water scarcity is a common problem in the villages during the dry season. To alleviate the water problem, two villages, Mayowandu and Zah had invited the well-digging section to assist them dig the wells which met most of the communities' water requirements at the time of study. Members of Sahuda community also reported that they had applied for such assistance but had not got a reply.

Gangrang community had a borehole operated by a hand pump, sunk by the UNICEF in the central village. The borehole however, is used only by residents of the main village which is composed of about forty households.

Despite the small number of users, it does not satisfy the water requirements of all the families during the dry season when it almost dries up.

Vilegwa village community has a single tap in the central village. Similarly, only those people whose houses are close to the tap make use of it. The settlement pattern of the villages being the dispersed type, only thirteen households reported that their families fetch water from the tap. In fact, those whose houses were about one kilometre away from the tap reported that their families fetch water for consumption and domestic use in a stagnant pond half a kilometre away.

Seven of the villages, Sahuda, Lidle, Mbalwaha, Vilegwa, Mayowandu, Grangrang and Zah have at least one well sunk by the government, but most of them dry up during the dry season. Three villages, Hurumda, Kwatau and Sokoron had neither government sunk well nor any private one which has water perennially. Most of the inhabitants of these villages, therefore, rely on ponds and streams for water supply. Table 10 shows the sources of water supply for all the respondents' households.

Table 10: Main Sources of Water Supply

Source	N	%
Personal well (perennial)	63	8.6
Tap/Borehole	51	7.0
Personal, and public wells(not perennial)	518	70.9
Streams and pools (perennial)	99	13.5
Total	731	100.0

As can be seen in Table 10, public and private wells are the reported sources of water supply for most people. In practice, however, most of the people obtain water from sources other than wells during the dry season. The only households which could possibly be obtaining water from the same source perennially,are the sixty three who reported that their private wells yield water perennially. Members of such households are also likely to be the only ones who can enforce hygienic ways of making use of the water. Thus relatively few households have adequate and safe water supply inspite of efforts made by many household heads to dig wells for their members. This can be seen from the fact that prior to the introduction of the health posts, only thirty-three(5%) of households had private wells, while seventy-six(10%) reported that they dug wells to facilitate implementation of health teaching.

The scarcity of water therefore, poses a serious problem for effective implementation of healthy habits and hygiene taught in health education. This relates to both quantity and quality of water. As for quality, purification is a tedious and expensive task even when one employs appropriate technology. If for instance boiling is resorted to, large quantity of firewood will be required, the procurement of which will add to the already disproportionately higher share of women's household chores. It may also hasten deforestation. Similarly, unless the fast, but less perfect method of using a cloth filter is employed, it takes a long time to filter enough water for large families. The use of chemicals, on the other hand, may not be feasible due to its non-availability, high prices or even ignorance of usage. Consequently, no family had formed the habit of purifying drinking water. This probably contributes to the high prevalence of dysenteryand diarrhoeal diseases among the population studied.

Food preparation and Kitchen Sanitation:

This item refers to food preparation and care of utensils. The improvements observed in these respects include boiling meat long enough to kill the disease agents and not boiling vegetables too long in order to preserve their nutritional values. It also includes covering of foods both for sale and private consumption to prevent exposure to insects, dust or germs. Although the fly has always been regarded as a dirty insect, a detailed information about the specific diseases it carries led to further persuasions to diligently cover food. The health workers, therefore, observed that these hygienic measures, coupled with implementation of lessons on balanced diet led to improvement in nutritional status as evidenced by drastic reduction in the number of malnourished children brought to the health post a few months after commencement of teaching.

Personal hygiene:

Personal hygiene was taught as regular bathing, laundry, trimming finger nails, and washing of hands before eating. Getting rid of pests like lice and bed bugs are also integral part of these lessons. Health workers observed that although there were attempts to attain these aspects of health measures, success were beset by poverty with regards to inability to purchase soap during rainy season and unavailability of water during dry season. The consequences of these are; high prevalence of bed bugs, head and body lice about which some people asked the researcher for remedies. Scabies had also become endemic in two of the villages affecting children and adults at all seasons, while it occurred sporadically in four other villages. Due to water scarcity, those communites which have stagnant pools of water usually use them for domestic and other purposes, especially bathing, hence the endemicity of schistosomiasis in most of the villages.

Maternal - Child health

Maternal - child health services provided by the programme include antenatal care for mothers and children's clinics at which children are immunised and weighed for monitoring their growth.

With regards to occurrence of pregnancy and child-birth, 565 households reported between one and nine births since the inception of the health posts whose durations vary from village to village, while 166 reported that there had been no pregnancy within the period. In all, there were 1,953 deliveries, an average of 3.46 deliveries per household for the 565 which had any. When broken down according to the functional states of the health posts, the result is as shown in Table 11.

Table 11: Functional Status of Health Posts by incidence of Delivery

State of Health Post	No. of delivery: None		at least one		Total	
	N	%	N	%	N	%
Non-functional	44	13.8	276	86.2	320	43.8
Functional	122	30.0	289	70.0	411	56.2
Total	166	23.0	565	77.0	731	100.0

Yules q = -0.45

Table 11 shows that a higher proportion of households in villages whose health posts are non-functional than in those whose health posts are functional reported more cases of delivery of babies per household since the inception of the programme. Using the occurrence of pregnancy, birth and presence of children who need child welfare services as objective indicators of health care needs, this finding disproves hypothesis(a) which states that

communities with higher health needs are more likely to keep their health posts functional.

It is significant that some mothers do not attend the maternal-child services even when the health posts in their villages are functioning as shown in Table 12.

Table 12: Sources of Maternal-Child Health Care for Respondent's Families since the establishment of Health Post

Functional State	Sources: None		Health post only		Health post & others		Others only		Total	
	N	%	N	%	N	%	N	%	N	%
Functional	21	6.7	93	29.8	160	57.3	38	12.2	312	56.5
Non functional	49	20.4	50	20.8	110	45.8	31	12.9	240	43.5
Total	70	12.7	143	25.9	270	48.9	69	12.5	552	100.0

Missing cases = 179. All the 166 cases which did not have babies are excluded.

Table 12 also shows that members of the same community differ substantially in their sources of maternal-child services. It was pointed out in cases of those women who made use of both the health posts and other institutions that they went to maternities for antenatal care in order to make themselves more acceptable to such institutions if they went to them for delivery. Most of those who made use of only other sources pointed out that they had been patronising the other institutions before the inception of the programme, while others expressed skepticism about the health worker's competence in dealing with pregnancy and delivery.

For some pregnant mothers who did not attend any antenatal services, it was explained that they had been having babies safely at home so that there was no need for antenatal care.

Others pointed out that they did not have the money to pay for the services.

It can be seen from Table 12, however, that 20.4 percent of households whose health posts are no longer functioning as contrasted with only 6.7 percent in those whose health posts are functioning reported that pregnant women did not go for antenatal care. This clearly demonstrates that the presence of a functional health post is a motivating factor in utilization of antenatal services.

As regards the place of delivery, inspite of the argument presented by some informants that pregnant women attend antenatal services elsewhere to facilitate their acceptance at such maternities for delivery, the bulk of deliveries took place at home assisted by traditional birth attendants as shown in Table 13.

Table 13: Place of Delivery for Respondent's Household Members by Functional State of Health Post

Functional State	At home assisted by TBA		*At home Assisted by Health worker		At Maternity		Total	
	N	%	N	%	N	%	N	%
Functional	78	27.0	58	20.1	153	52.9	289	51.1
Non-functional	184	66.7	35	12.7	57	20.7	276	48.9
Total	262	46.4	93	16.5	210	37.1	565	100.0

Missing cases = 166, households in which no deliveries occurred.

*Even when health posts are defunct, former female health workers can be called to assist during delivery.

It is significant to note that 262,(46 percent) of households out of a total of 565 reported that pregnant women within them were delivered by TBAs as compared to 37 percent who had their babies in a maternity setting.

However, a larger proportion of those whose health posts are no longer functioning delivered at home assisted by TBAs than those whose health posts are functional. These differences notwithstanding, the utilization of modern obstetric facilities is generally poor as only 37 percent of all households reported that their mothers had babies in maternities, while 46 percent relied solely on TBAs and 17 percent on the female health workers for assistance during delivery.

Inspite of the apparent lapses in the utilization of maternal-child health services, improvements were reported in maternal-child health. Some health workers pointed out that they had identified mothers who were likely to have difficult deliveries and asked them to go to maternities for delivery while the immunisation of children were observed to have reduced incidence and prevalence of childhood diseases in comparison to what the situation was before the inception of the programme. As regards children's feeding, some health workers pointed out that they had succeeded in discouraging bottle-feeding in their communities which had become a fad among nursing mothers. Other remarkable areas of observed improvements include the discouragement of forced-feeding and cultural deprivation of certain foods such as eggs and meat from being consumed by pregnant women and children. In some communities, new diets and their preparation, especially of groundnut porridge for children were taught by health workers and adopted by the community.

In fact some of the health workers observed that their teachings on balanced diets made some men to start buying and bringing meat home to be eaten by all members of the household. Such men used to buy either roast or cooked meat for only themselves at the market.

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Child Mortality

In all, the death of at least one child was reported in 362(50%) of households since the establishment of the health posts in their respective communities. Table 14 shows the number of deaths per household.

Table 14: Number of Deaths of Children Under Five per Household since establishment of the Health Post by Functional State

Functional State	No. of deaths per household									
	None		1 - 2		3 - 4		5+		Total	
	N	%	N	%	N	%	N	%	N	%
Non-functional	134	42.0	99	30.7	37	11.6	50	15.7	320	43.8
Functional	235	57.2	95	23.1	43	10.5	38	9.2	411	56.2
Total	369	50.5	193	26.4	81	11.1	88	12.0	731	100.0

X^2 = 18.5 3df sig. at .001 level

Table 14 shows that communities with defunct health posts reported proportionately higher number of deaths per household than those whose health posts are functional. Thus while 58 percent of households in communities with defunct health posts reported death of at least one child, only 43 percent did so in communities with functional health posts. It should be recalled (see table 11) that there were also proportionately more births in communities with defunct health posts than those with functional ones within the period these deaths occurred. Thus the trend is that both birth and death rates are higher in communities whose health posts are defunct than those with functional ones. Since family planning is not an integral part of services rendered at health posts, it is inferred that availability of health posts abets child survival which results in longer child spacing and fewer births.

If the figures in Table 14 are broken down according to villages, the result shows that the villages having the highest number of children's deaths per household are Vilegwa, Hurumda, Lidle and Kwatau, all of which have unsafe drinking water supply. Mayowandu, Mbalwaha and Gangrang villages which excell in safe water supply have the lowest number of deaths per household. It can therefore be concluded that safe water supply is correlated to child survival in the survey villages.

Morbidity Patterns: Diseases Reported and Treat at Dispensaries and Health Posts.

The records of diseases treated at dispensaries and health posts show that the most frequently reported are the infectious and parasitic ones, prominent among which are; malaria, amoebic dysentery diarrhoea, filariasis, schistosomiasis, pneumonia and other respiratory diseases, measles, intestinal parasites and a host of others. Malnutrition is also significantly high especially at the dispensaries. The intensity of the diseases may differ from village to village, but all health workers and dispensary leaders reported them as endemic in their areas. The endemicity and indomitable nature of the diseases within the socio-economic context of the rural populations studied result in high patronage of curative services at both dispensaries and health posts. The records of diseases reported and treated at the institutions are presented in Tables 15 and 16 respectively. We shall deduce from the figures whether there are discernible reduction in prevalence of diseases over the years. In doing this, we take cognizance of the facts that reports for some months were either missing, or as the researcher was told, merged with other months. There were some new health posts established while some got defunct over the years for which records are not available. These anomalies notwithstanding, the figures depict considerably true pictures of the situations especially if we consider the proportions constituted by any disease from year to year.

A time series analyses of the data in Tables 15 and 16 show that there is no observable pattern of reduction in prevalence or proportion constituted by any disease over the years. The trend in fact shows that the cases of the most prevalent diseases like malaria, diarrhoea, amoebic dysentery intestinal parasites and schistosomiasis remained stable in both proportions and magnitude as from 1980-83 at the dispensaries. The preventive roles of both the health posts and dispensaries are, therefore, yet to be reflected in the patterns of occurrence of the most common diseases.

Table 15: Cases of all Diseases Reported at all Dispensaries belonging to the Programme in Gongola and Borno States 1978-1983

Disease	1978	1979	1980	1981	1982	1983	Total
Malaria	12377	24106	27627	27968	30129	27054	149261
	22.4	17.2	11.6	16.2	16.6	14.7	15.5
Amoebic Dysentery	4464	21078	19365	16996	18037	25467	105407
	9.2	15.1	8.1	9.9	9.9	13.9	10.9
Filariasis	2999	15751	17375	14432	18966	20125	896448
	6.2	11.3	7.3	8.4	10.4	11.0	9.3
Diarrhoea	1757	14037	18390	16079	14290	13016	77569
	3.7	10.0	7.7	9.3	7.9	7.0	8.0
Intestinal parasites	4869	14080	13015	10562	13727	18332	74585
	10.0	10.1	5.5	6.1	7.6	10.0	7.7
Schistosomiasis	2518	12789	9068	14942	15669	18923	73909
	5.1	9.1	3.8	8.7	8.6	10.4	7.7
Malnutrition	835	9071	9711	12344	14899	11097	57975
	2.0	6.5	4.1	7.2	8.2	6.1	6.0
Ulcers	3075	8070	8289	7003	8821	10926	46184
	6.3	5.8	3.5	4.1	4.9	6.0	4.8
Pneumonia	1477	6658	5477	8564	11843	11898	45917
	3.0	4.8	2.3	5.0	6.5	6.5	4.8
Measles	1000	1470	8120	8289	5277	4655	28811
	2.1	1.1	3.4	4.8	2.9	2.5	3.0
Cold/Cough	2283	1315	1908	2886	3685	4831	16908
	4.7	0.9	0.1	1.7	2.0	2.6	1.8
Whooping cough	174	84	129	104	64	75	630
	0.4	0.1	0.9	0,1	0.0	0.1	0.1
Others+	10699	11380	99605	32010	26340	17111	197145
	21.9	8.1	41.8	18.6	14.5	9.3	20.5
Total	48545	139889	238079	172179	181747	183510	963949
	5.0	14.5	24.7	17.9	18.9	19.0	100.00

+Others: include cerebro-spinal meningitis, neonatal tetanus, gengivitis, mumps, otitis media, ringworm, mastitis, scabies, conjuctivitis and unclassified dysentery

Source: Compiled from the Programme's Records of Reported Diseases at Dispensaries 1978 - 1983.

Table 16: Cases of Diseases Reported at all Health Posts in Gombi and Michika Local Government Areas of Gongola State, 1976 - 1981

Disease	1976	1977	1978	1979	1980	1981	Total
Malaria	4228	2990	3761	2580	5891	4352	23002
	27.2	21.7	27.0	26.6	29.7	36.2	28.0
Intestinal Parasites	2349	1997	1894	1416	1680	840	10176
	15.1	14.5	13.6	14.6	8.5	7.0	12.0
Diarrhoea	1984	1623	970	1225	2142	1010	8954
	12.8	11.8	7.0	12.6	10.8	8.4	10.6
Cold/Cough	2484	831	769	977	1429	768	7256
	16.0	6.0	5.5	10.1	7.2	6.4	8.6
Amoebic Dysentery	91	324	429	339	2449	1154	4786
	0.6	2.4	3.1	3.5	12.3	9.6	5.6
Ulcers	906	1338	741	447	415	190	3037
	5.8	9.7	5.3	4.6	2.1	1.6	4.8
Filariasis	659	207	324	384	1344	842	3760
	4.3	1.5	2.3	4.0	6.8	7.0	4.4
Pneumonia	253	545	589	460	945	672	3464
	1.6	4.0	4.2	4.7	4.8	5.6	4.1
Schistoso-miasis	180	270	350	123	487	284	1694
	1.2	2.0	2.5	1.3	2.5	2.4	2.0
Measles	156	321	720	96	93	240	1626
	1.0	2.3	5.2	1.0	0.5	2.0	1.9
Malnutrition	116	144	141	88	210	66	765
	0.7	1.0	1.0	0.9	1.1	0.6	0.9
Whooping Cough	11	64	39	28	101	16	259
	0.1	0.5	0.3	0.3	0.5	0.1	0.3
Others	2109	3103	3208	1545	2659	1592	14216
	13.6	22.6	23.0	15.9	13.4	13.2	16.8
Total	15524	13757	13935	9708	19845	12026	84795
	18.3	16.2	16.4	11.4	23.4	14.2	100.0

+"Others" include cerebro-spinal meningitis, neonatal tetanus, mumps, gengivitis, otitis media, ringworm, mastitis, scabies, conjunctivitis and unclassified dysentery.

Source: Compiled from the Programme's Records of Reported Diseases at Health Posts 1976 - 1981.

The tenacity of most prevalent diseases in this study such as malaria, filariasis, schistosomiasis, diarrhoea, dysenteryand intestinal parasites are due to environmental and social factors which have defied control by individual members in the communities. The major problem militating against the reduction of these diseases is the fact that their vectors, the mosquito; the black fly; the housefly and the water snail are difficult to control. Finally, human faeces are not properly disposed of either because of lack of latrines, improper or non-usage of available ones.

In comparing the prevalence of diseases reported at dispensaries and health posts, it can be observed from Tables 15 and 16 that there is a marked difference between the relative magnitudes of the same diseases reported at these institutions. The ranks of the diseases are indicated for the years in Table 17.

Table 17: Differential Reporting of eleven Common Diseases at Health Posts and Dispensaries

Disease	Ranks in magnitude at: Dispensaries	Health Posts
Malaria	1	1
Amoebic dysentery	2	5
Filariasis	3	7
Diarrhoea	4	3
Intestinal Parasites	5	2
Schistosomiasis	6	9
Malnutrition	7	11
Ulcers	8	6
Pneumonia	9	8
Measles	10	10
Colds/cough	11	4

Spearman's rho(rs) = 0.48

From Table 17, it can be seen that except for malaria and measles whose magnitudes rank the same at both health posts and dispensaries, the rest rank differently. This can be attributed to the differences in methods and scope of treating diseases at dispensaries and health posts. Village health workers are allowed to administer only external treatments and orally taken drugs, and are categorically forbidden to treat schistosomiasis, cerebro-spinal meningitis, tetanus and a large number of other diseases, which they are expected to diagnose and refer to dispensaries. This arrangement has resulted in a number of consequences for attendance at health posts. Some people bypass them, going to dispensaries directly with diseases which they personally assess as being too severe or out of the range allowed for health workers to treat.[5] Others go directly to the dispensaries on the grounds that the patient can have better medical examination there than at health posts which in fact do not have medical examination facilities. This, therefore, explains the preponderance of diseases which are culturally considered non-threatening like colds, cough, intestinal parasites and diarrhoea at health posts. A significant deviation from this trend however, is the case of malaria which constitutes a much higher proportion at the health posts than dispensaries. The health post supervisors with whom the researcher discussed these discrepancies pointed out that in the case of malaria and malnutrition, there might have been substantial cases of misdiagnoses by the health workers. They said that there was a tendency for health workers to diagnose all feverish conditions as malaria and to fail to look for signs of malnutrition in such children.

The comparatively low esteem in which health posts are held with respect to curative services can further be inferred from a comparison of quest for treatment and preventive services for the period 1978-1981 as shown in Table 18.

Table 18: Utilization of Various Medical Services at all Health Posts in Gombi, Michika and Song LGAs, 1978 - 1981

Services	Year				
	1978	1979	1980	1981	Total
Treatment	21669	17482	15961	10832	65944
Underfive clinics	7751	10555	9085	9290	36681
Antenatal care	3046	2655	2811	2121	10633
Vaccines	6237	6348	7092	8785	28462
Total	38708	37040	34949	31028	141720

Source: Compiled from Monthly Reports to the Programme's Headquarters in Garkida.

Thus, while there is increase in the number of children being brought for underfives clinics, there is a marked decline in number of people reporting for treatment in the same health posts over the same period of time. This can be interpreted as a reduction in incidence of diseases needing treatment, but when we recall the large number reporting at dispensaries for treatment during the same period, the assumption fails to be tenable. A more plausible interpretation is that people in health post catchment areas make use of the preventive services there, but very often, go to dispensaries when sick. This assumption was corroborated by health workers and dispensers. While the former reported that they knew a number of people in their villages who go directly to the dispensaries, the latter said they do get such patients, but often send them back to the health posts if their problems could be dealt with by the health workers to discourage such practices.

It is necessary to point out however, that in some villages, the health workers and health posts are held in such a high esteem that all cases are reported to the health posts first. Health workers in such villages as exemplified by Mbalwaha and Lidle expressed satisfaction with their work, and generally had a low staff turn over.

As for health workers in communities which look down upon the health posts, they are accused of imcompetence instead of blaming the organisational structure which limits the curative roles of workers. The perceived ineptitude of workers is operationalised as inability to treat diseases by injection. Some of the health workers respond to such social pressures by resorting to illegal treatment of patients with injections. These are usually discovered and penalised by termination of appointment.

The foregoing analyses of responses to the programme's services have been done in view of expectations that there would be observable reduction in diseases reported over the years at health posts and dispensaries on account of the health education delivered to communities. This, however, turned out to be indiscernible. Perhaps the trend will be manifested when the numbers and catchment areas of health posts and dispensaries are stabilised. What is clearly established, however, is that large number of people go to the institutions for both curative and preventive medicines.

CHAPTER EIGHT

ANALYSIS OF QUALITATIVE FINDINGS: EFFECTS OF CHANGES IN SOCIAL ORGANISATION ON COMMUNITY PARTICIPATION IN THE EYN HEALTH PROGRAMME

This chapter presents and analyses the qualitative aspects of the findings, focusing on changes in the structures of social organisation and the acquisition of new values. These result in the redefinition of who constitute one's moral community and therefore those with whom to carry out joint activities.

Changes in Social Organisation:

The social set ups for which the programme was designed at its inception in the early 1970s have since then undergone some changes. New interest groups have emerged ranging from those which constitute deviant subcultures to those which hold rigid religious beliefs. However, many of such groups have not been incorporated into the village health committees. In addition, women are growing more aware of their marginalisation in their communities.

The programme bases its community mobilization on the assumption that villages are made up of primary groups among which exist high levels of social cohesion and reciprocal relations. Thus the programme invariably uses the analogy of thatching a hut, a task which used to be done by all in the recipients' communities, whereby everyone in the neighbourhood helped in lifting the thatched roof from the ground on to the wall, when soliciting for communities' acceptance. With regards to the services rendered, the programme also assumes that the communities have imbibed the principles of "prevention being better than cure", while in reality many people feel that the diseases are unpreventable, although amenable to treatment.

With regards to community organisation, there are several factors which have been introduced which have divisive effects. These include immigration of people from other ethnic groups or other clans into communities which initially considered themselves corporate groups. The adoption of Islam and Christianity by members of the same corporate groups has also weakened their solidarity. The commercialization of hitherto reciprocally exchanged assistance and services has considerably eroded the bases for rendering assistance for each other and by implication, assistance on the health workers' farms. Each of these factors will be elaborated on below.

The growth in sizes, population, clans, religions and other forms of social hetorogeneity has resulted in competition over scarce resources, especially land in many of the villages in which the programme operates. Land tenure system has changed from the practice, whereby one abandons a farmland when its fertility is exhausted to permanent holdings, signified by the planting of perennial economic trees and fencing. A few people in some of the villages have in fact fenced up farmlands and residential areas that could have served several families. Consequent upon the pursuit of personal interests at the expense of others, there have been land disputes and court cases among residents of the same villages, including relatives. Such disputes over what used to be commonlly owned are indicators of redifinition of what constitutes a community. This has disasterous consequences for achieving the programme's aim of mobilising the entire community, as the formation of cliques with conflicting interests become the order of the day. This, for instance, explains why Christians predominate in running the programme in Sahuda, Mayowandu and Gangrang, and why a group of people who were considered compatible were asked by the community to finance the establishment of the health post in Sokoron instead of the whole community doing so.

Hurumda's case, where very close neighbouring village communities kept away from the health post before and after its establishment is also a case in point.

With regards to technology and economic production, the traditional technology and social organisation of work necessitated interdependence among residents of the same village even if they were not relatives. Thus thatching a hut, clearing a new farmland and threshing grains were routine tasks for which an individual could invite any fellow villager for assistance. Failure to ask for assistance or to assist when asked were both considered deviant as only people who are ostracised for habitual deviance would so behave or be treated. Such a high degree of obligatory interdependence among individuals created a high sense of belonging and motivation for corporate responsibilities for community's common interests.

The use of modern technological devices and commercialisation of labour has altered the social cohesion created by the predominantly reciprocal economic relations. Tractors and ox ploughs and farm labourers are now acquired or paid for to perform such tasks like clearing new farmlands, ploughing, weeding, harvesting and any other task which the farmer wishes others to perform. Similarly, most people buy metal sheets and pay carpenters to roof their houses. Besides, occupation and sources of income in villages are now diversified although most people are primarily farmers. Some rich farmers however, rely a great deal on paid labour and do little or no farming by themselves. These developments constitute indices of increasing degree of social defferentiation which make the rendering of communal assistance on the health workers' farm an unpopular task. Some communities, therefore, decide to assist health workers by giving them farm produce at harvest or pay them as much as fifty naira each per month in lieu of assistance on their farms.

Another area of controversy in communities' response to the programme is the professional status of health workers. It is clear from the interviews that communities value the curative more than the preventive services. Moreover, the type of treatment most preferred is by injection. These expectations and preferences still held despite the exclusion of treatment by injection being explained before the establishment of the health posts. There is, therefore, a lag between the programme's emphasis on health education and preventive measures and communities' strong desires for high level curative services. Hence some community members interpret the primarily educative roles of health workers as indices of incompetence. Such people look unto either the dispensaries, private clinics, chemists or itinerant drug sellers to make up for the perceived professional weakness of the workers. This partially explains the large number of people reporting for treatment at dispensaries.

Another factor which jeopardised the zeal of some communities for organising the programme is the implementation of the National Basic Health Service Scheme promulgated in 1975, which started reaching some of the villages in the late 1970s and early 1980s which also coincided with the civilian regime in 1979-1983. Various categories of governmental health institutions ranging from Primary Health Care Centres to very small units called Dressing Centres were established in villages, in some of which the programme was operating. The governmental health institutions were initially well stocked with drugs, did not charge patients for treatment and made no demands on communities for maintenance. These made some communities abandon the programme.

The most adverse effect of the governmental health facilities on the operations of the programme in the villages was inadvertently inflicted in Gombi LGA in 1982.

The Health Department had reasoned that since the Dressing Centres could adequately be manned by personnel of village health workers' status, it was decided, in due consultation with the programme that the health posts be used as Dressing Centres wherever they existed. The arrangement was that such health posts would continue to be governed and supervised by the programme, while the LGA Health Department supplied drugs and grants for other necessities. Most of the village health committees misunderstood this as government take over of health posts and abandoned their responsibilities in maintaining the health posts. The arrangement worked for a few months after which the assistance from the Health Department ceased. Some communities reverted to the initial arrangements, but others could no longer do so because of bankruptcy and other problems. The worst affected by this is Ga'anda District in which only one out of the sixteen health posts continued to function after the LGA intervention and withdrawal.

The Marginalisation of Women:

Although children brought by women and women themselves are reported to form the bulk of clients at health posts, the administration of the health posts is basically a male affair as virtually all committee members are men. The exclusion of women from decision-making position, therefore, made the researcher interview a purposively selected group of women, which included leaders of women organistions in two purposively selected villages out of those included in the sample. The villages are Mbalwaha with a very active health post and Gangrang with a defunct one. In addition to these, the researcher was opportuned to attend the meeting of a dispensary official with community members of one of the survey villages which will also be reported.

In Gangrang, the women attributed the closure of the health post to lack of cooperation among male household heads and poor administration by the health committee.

They pointed out that men refused to pay for the treatment of their wives and children, while most women could not pay because of reasons to be explained below. Thus lack of concordance in role obligations by couples was identified as cause of poor patronage of services in the village. The failure of the health post, can therefore, be better explained within the context of economic organisation in the village.

According to the women, wives work for three years on the same farms with their husbands after marriage, then they acquire their personal farmlands. Some women, waive this right and continue working with their husbands who control the proceeds. Women who acquire personal farmlands, are, however, expected to clothe themselves and their children as well as feed the family from harvest to weeding period (approximately November to June). By the crucial period of rainy season, when malaria, undernutrition and other diseases are most prevalent, women who have independent farms would have depleted their resources, thus the expectations for men to pay.

The women also singled out the impatience of the three male workers, all of whom resigned shortly after they started work, pointing out that they were more interested in material gains than serving the community. Due to their disatisfaction with the health committee and male workers, the women reported that the health post can be better organised by women if given the opportunity. They argued that unlike men, they have an existing organisation, the Zumuntan Mata, which they believe can support the health workers. The aspect of the health organisation which they felt could not be performed by women is the monthly collection of drugs at the rendez-vous which is more than thirty kilometres away. Being a dirt road with villages far apart along it, there have been many cases of armed robbery on it, thus the fear.

In Mbalwaha, although the health post is functional, the women expressed concern about their immense contribution in its maintenance and marginalization from its organisation. They pointed out that women contribute more than men during fund raising and render more help to health workers. As for health education, the women reported that except for the health committee members who attend to oversee what is going on, women are the sole actors and audience during health dramas, story-telling and other forms of health teaching.

Like in Gangrang, the women complained that most husbands do not pay the medical bills of their wives and children, leaving the burden to the women, which they executive successfully. The economic organisation here is that a wife works on the same farm with her husband for the first year of marriage after which she acquires her private plot whose proceeds she controls. She is also expected to feed the family from November to June.

The women in this community are very conscious of societal problems which affect them. They, for instance, expressed a strong desire for family planning, arguing that they wanted fewer children since men have left most of the burdens of child up-bringing to them. They complained about men's non-usage of condoms, the only contraceptive made available to health workers. The women had already staged a drama directed against premarital sex and pregnancy and were preparing to stage another one, all under the auspices of the health post, directed against men's heavy drinking habit and shirking of their domestic responsibilities like payment of children's school fees, feeding and clothing children.

It is, therefore, clear from the foregoing that the women look up to the Rural Health Programme for solutions to their societal problems.

As regards the opportunity the researcher had of attending a meeting of the entire village community, this took place in Kwatau which has a defunct health post. It happened that the officer incharge of the Rural Health Programme's Dispensary in Mijili, (seven kilometres from Kwatau) was touring his catchment area to meet with the communities. He came to Kwatau on a Sunday when the researcher was in the village. About sixty adults attended the meeting, most of them females. The highlights of the messages relayed by the officer were the need for children and pregnant women to attend clinics; avoidance of delay in seeking care at the dispensary and lack of proper follow-up of prescriptions. They were also encouraged to go to the dispensary on the days of the medical consultant's monthly visits.

During this meeting, the women were more active than men in the discussions. They expressed a strong desire to rebuild the health post, exhorting the health committee to do so. They complained about the problems they encounter when taking children to the dispensary. As there is no other village on the way, it was feared that robbers could easily attack people. Consequently, people make the journey in groups and women had to have male escorts who were not easy to acquire. Another problem they raised was premarital pregnancy. They argued that although pregnant unmarried girls were equally susceptible to complications of pregnancy, they did not go for antenatal care. The officer was, therefore, called upon to declare the official position of his dispensary with regards to accessibility to antenatal care to unmarried mothers and also their babies. He clarified that they were not discriminated against.

The women further complained that they were not usually informed about the day of the consultant's visit; the officer promised that henceforth, he would devise a means of informing all villages in the dispensary's catchment area.

It should be pointed out that despite the women's contributions at this meeting, they were opportuned to attend it because it took place on a Sunday afternoon. Most of them could have been too busy to attend especially during the evening hours when they normally prepare meals and perform other household chores.

In concluding the role of women, we shall highlight the variations in their economic power across ethnic groups, which is related to the performance of health posts in such communities. The Director of the programme has observed for instance, that the programme is most successful in Kilba District. Since it is women who patronise it most, it is our opinion that this success is brought about by women's efforts as explained below.

Based on the organisation of production within families and the types of crops grown, Kilba women are in better positions to pay for services by themselves. They have their own farms and livestock whose proceeds they control. They however, have some obligatory contributions to make to the upkeep of the family. This notwithstanding, a hard-working Kilba woman can get as rich as most men in their communities. This explains the women's prominent contributions to the upkeep of the health post in Mbalwaha and the degree of concern shown by women in Kwatau, both of which are Kilba villages.

Among other ethnic groups where women own their farms such as the Hona, Yungur, Cude and Ga'anda, the main emphasis is on growth of food crops with little cash crops, both of which are exhausted during the period allocated to the women to cater for the household. This probably explains Gangrang(Ga'anda village) women's awareness of their potential powers but

apparent powerlessness in running their health post.

In contrast, Higgi and Marghi women work on their husband's farms. They are thus dependent on their husbands for cash, some of who are said to be relunctant to give out. This lowers the overall attendance of such women at the health posts.

Given the crucial roles played by women in the sustenance of families, delivery and implementation of health lessons and their keen interest in having functional health posts, community participation is incomplete without their being fully involved in organising the programme in the villages. This really is generally the case because out of the ten villages surveyed, only four village health committees had a female member each.

Concordance Between Daily Routines And Health Education Delivery:

One of the key objectives of the programme is to provide health education to recipient communities through indigenous and western forms of communication such as songs, folktales and other parables, anecdotes, didactic methods, and drama. When asked which of the forms appealed to them most, a majority said that it was the didactic teaching on health, diseases and nutrition rather than songs, stories and plays. It was found, however, that the less popular forms were rarely employed due to the difficulties in organising and presenting them, while the didactic form could easily be delivered either when patients assemble or on individual basis during consultation. It is, therefore, necessary to discuss why these forms of health education which are supposed to be staged or received by community members as utilitarian forms of recreation and entertainment are less popular.

Interviews with village health workers revealed that plays, stories and songs were rarely employed due to inability to get enough volunteers to perform them. Moreover, the audience usually became very small after the formal opening of the health posts.

It should be noted that these forms are mainly meant to appeal as recreations to the audience, thus we must delve into the current recreational patterns and seasonal work cycles for possible explanations of why these forms of health education are not convenient for most community members.

The major problem posed by the methods is that none of them is currently a popular form of recreation among the communities. Besides, even in the traditional era story-telling, parables and anecdotes were mainly used as means of socialising children, told by adults and not primarily for other adults. In some of the societies, the stories had to be told at night and tabooed in the day time. Thus adoption of this method of teaching to inculcate knowledge of proper health care is inappropriate for adults and day-time recreations. Similarly, drama is problematic because of the long time it takes to prepare and the difficulties in getting volunteers to practise and stage them. The increasing social differentiations within community members, discussed elsewhere in this thesis also militates against mass response. Another problem in using drama is the extent to which the health workers, whose responsibilities it is to create the plays, can make them attractive to the audience.

With regards to the use of songs, the traditional situations at which such songs could be imparted like grinding corn by females, threshing corn by males, dances, initiation and second burial ceremonies are now rendered obsolete. The tasks which used to be done in groups are now either done by technological devices or hired labour. In the case of the dances and ritual ceremonies, the religions of islam and christianity, to which most community members belong, view them as pagan practices and forbid their members from participating. Thus the most common forms of entertainment in the villages are religious celebrations, marriages and village youth days, none of which is used for health education purposes. Activities of religious groups include evening prayers and lessons groups, Boys Brigade, the choir and Women's Fellowship (Zumuntan Mata).

The choir and Boys Brigade are mainly composed of literate youths some of who are secondary school graduates. They usually meet two or three times a week for practice. By the nature of their composition, these groups are most suitable for the performance of health drama, songs and other activities like helping health workers because of their intelectual capabilities and ease of mobilisation. Despite these potentials none of the village health committees had involved any of these organisations as a group in performing the required tasks for the health post. The Zumuntan Mata on the other hand has established working relations with the health posts in some villages by inviting health workers to deliver health lessons during meetings.

Another activity which takes up most of the time of some people in the villages is heavy drinking. Lager beer and locally brewed alcohol are always available for sale in the villages. Some people are, therefore, perpetually under the influence of alcohol and cannot meaningfully participate as actors or audience in disseminating health education or other activities. Even this group can, however, help in running the health post if properly approached by the health committee. An appeal to them for instance, to help on health workers' farms may elicit a favourable response especially if the traditional form of entertainment for work parties, alcohol, is provided.

While the foregoing militating factors for community participation are based on people's personal interests in committing their time to specific causes, it is true that the time needed for performing one's responsibilities is very demanding even during the dry season which is considered a period of rest for peasant farmers. It was noted during the study by the researcher that farm work, house fencing, roof and granary repairs took substantial part of community members' time. The typical yearly work cycle of most respondents is as follows:

November - December: Both men and women harvest guinea corn, millet and late groundnuts. Men cut grass and collect other materials for roofing and fencing. Women dry and store vegetables for use during dry season.

January - February: Threshing guinea corn and millet, weaving grass for roofing, fencing perennial crops like cassava, orchards and sugar cane. Women harvest bambara nuts and tiger nuts.

March - April: Men thatch and mend roofs, some go fishing. Women gather firewood for use during rainy season. This is the period when water is most scarce, so fetching water takes substantial part of women's time. They also forage for fresh edible wild vegetables to make soup. Both men and women prepare farmlands for planting.

May - October: The rainy season when all farmers are preoccupied with farming.

It can, therefore, be seen that people are generally busy enough during both the rainy and dry seasons to participate regularly in disseminating health education or assemble as audience. When we consider the fact that the health workers perform the tasks for themselves in the absence of community help, staging public health teaching tantamounts to serious sacrifices and is easily abandoned especially when attendance is poor.

Summary of Findings:

The major findings of this study is that even though communities accept responsibilities to manage the health services made available to them, they are unable to perform them as agreed. Altogether, thirty four, (62%) of fifty-five health posts established in the four Local Government Areas studied had become defunct by 1986.

Their closure was due to lack of community support as evidenced by turnover of staff and inability to effect repairs of premises.

Weak community support is usually blamed on the health committees by the health workers, which are accused of not mobilising people to act. In fact, even in the communities where health posts are functional, some health committees do very little for the health posts as they are sustained single-handedly by the workers. Most health committees could not devise income generating activities. In such cases the health posts operate on meagre funds which run out during refresher courses and when patients fail to pay for treatment. In the absence of other sources of income, health posts with large clientele such as Mayowandu are likely to have better finances.

In contrast to the weaknesses exhibited by health committees is a large number of health workers who take it upon themselves to keep the health posts functioning through personal efforts and sacrifices like financing the work in addition to foregoing assistance and monthly stipends from the community. Such individuals are mostly permanent residents of local communities who are materially well off. Non-permanent resident workers have low tolerance for these failures which are quite common in the communities which employ them. Thus, only one non-permanent resident worker, that is, one who was either invited from another village or called back to the village after emigrating, has worked for more than two years in any of the health posts; and this was because her husband had decided to remain permanently in the village when the family was recalled.

With regards to the services rendered, the communities expressed more preferences for the curative than the preventive and promotive services. This is empirically reflected from the infrequent public delivery of health education for which various community members act as performers and audience.

In a substantial number of cases, the public teaching is staged within the first few months after which dissemination of health education is limited to those who come to the post for other services. This has the disadvantage of low coverage of people who need to be educated as well as limiting what is taught to problems presented by individuals. In a few villages however, the teaching and home visits are done regularly although the audience is predominantly female. The aspects of health education directed at men may not therefore be implemented. Thus while only 50 percent of households have functional latrines, the provision of which is men's task, between 43-70 percent of them in all the villages reported improvements in one or more of women's tasks such as environmental sanitation food preparation, maintenance of utensils and children's feeding.

However, most respondents complained about inability to comply fully with requirements of health education received because of water scarcity in particular, time constraints and lack of money to buy the necessary materials needed to implement knowledge acquired. Inability to implement first lessons may therefore, be responsible for loss of interest in subsequent ones. The poor implementation of health lessons is clearly indicated by the high morbidity patterns over the years as observed from records of diseases reported and treated at dispensaries and health posts in Tables 15 and 16.

Paradoxically, the persistence of diseases is attributed to the low professional status of workers which is seen as making them unable to administer effective treatment. This makes some community members look down upon health workers. Some members also found referrals to dispensaries inadequate and expressed desires to have their health posts upgraded to dispensaries. Despite the presence of a functional health post, therefore, some people patronise chemists and private clinics in towns where they receive treatment in the form usually preferred, by injection.

As regards the dispensaries, they are so popular that as many as a hundred patients attend daily and very often as much as four hundred naira is realised from sales of drugs and payment for services a day. Thus, no dispensary has ever been closed down since the establishment of the programme due to poor patronage. Lack of money per se may not therefore be the sole cause of poor patronage of health posts, the limited curative services plays a significant role.

Focusing the Findings on the Hypotheses:

The quantitative aspect of the findings will be summarised in this section as they relate to the hypotheses put up on page 21.

The first hypothesis which assumes that the zeal of community members for maintaining their health posts is determined by their health needs is not borne out by the findings. Instead, it is found that communities which have higher frequencies of births and child mortality, problems which are largely adequately taken care of by village health workers, are those whose health posts, have in fact become defunct. Moreover, it was specifically found that communities are most enthusiastic about organising the health post mainly only at its inception and when they wish to have it upgraded to dispensary. The health post is, therefore, perceived as a stepping stone to a higher level of health care, and that this preoccupation strongly determines the degree of community support.

The second hypothesis which states that the programme will be better accepted and run in communities with large number of western educated members is not also wholly borne out by the findings, because, while health posts in communities with very few or no western educated members have high failure rate, it was also found that individuals who acquired higher levels of western education, secondary school and above, are less likely to live in the villages and even if they do, they hardly get involved in organising the health post. It is, therefore, primary school leavers who are permanently resident in the villages and those who acquired literacy

through non-formal education who occupy the strategic posts which need literacy like secretary, treasurer and the health workers.

The third hypothesis which states that intra-community conflicts hinder the effective organisation of the health posts is found to be largely supported by the findings because it was found that the primary reasons for the closure of health posts are disagreements or suspicion among members of the community. This results in the refusal by some sections to carry out tasks to sustain the health post.

Finally, the hypothesis that being located far away from other sources of health care makes communities value and maintain the health post more effectively is not borne out by the findings. Instead, the trend is a curvelinear relationship between distance from and accessibility to other sources of medical care and the successful maintenance of the health post. Thus, villages which are closest or most accessible to other sources of modern health services and those which are furthest from, or least accessible to them, have the poorest performance in sustaining their health posts, while those in between have the best performance.

The generalisations which can be made from the findings therefore are that:

(a) Communities which already have modern medical services close by are not likely to take up the task of organising PHC services seriously. Similarly, those which do not have access to modern health services are not likely to be enthusiastic in organising health services for themselves.

(b) Communities need to attain a certain level of "modernisation" which generates modern health care needs and also the awareness of deprivation of such health services in order to be motivated to organise health care services for themselves.

With regards to social organisation, the adoption of christianity and islam in addition to traditional religion have segmented most communities into three mutually exclusive moral communities, who as groups, prefer to avoid each other in their dealings. Thus, even such important social events like funerals and naming ceremonies are prerogatives of co-religionists to decide on and execute instead of involving all kinsmen and neighbours.

Besides religious differences, succession to village-headship is a serious problem for the maintenance of health posts in communities where the post is contestable. The contestants who lose displace their anger on the organisation of the health post by withholding support since the winner becomes chairman of the health committee, or at least, assumes a significant role to play on the health post. In contrast, village headship and other posts are hereditary in Zah and Mbalwaha. In fact, the power structure in these villages is ascriptive so that there is no inter-lineage competition for posts and therefore, no one feels threatened. In Mbalwaha for instance, the overall village head who lives outside the village delegates his assistant to perform routine tasks while the chairmanship of the health committee is assigned to one of his sectional heads. While village heads of both Mbalwaha and Zah had died after the establishment of their health posts, the offices had been passed to their sons through primogeniture; health worker's appointments have been terminated in both villages due to one offence or the other, yet none of these resulted in discontinuity or upheaval in the organisation of the health posts. In contrast to these are villages like Mayowandu and Vilegwa where change of villageheads resulted in upheavals in the activities of the health committees. Moreover, the villageheads clung to the chairmanship of the committees even when it was evident that they could not meet up to the demands of the post.

Uncontested transfer of power which is more often obtainable in communities with ascribed positions is therefore, associated with high degree of success of health posts when success is defined as the ability to maintain and nurture the health post. For instance, Fadama Reke, Kwakwa'ah and Mijili all of them Kilba villages, whose health posts have been upgraded to dispensaries have ascribed leadership positions.

Having analysed the factors creating problems at the community level, we shall now discuss issues emanating from the Nigerian health system itself. The Nigerian medical policy having given priority to curative services resulted in turning the citizens' attention to cure rather than the prevention of diseases. Moreover, the missionary organisation running the programme had attained fame as provider of curative medical services for the people in the area being studied from the late 1920s to 1972 when its general and specialist hospitals were taken over by the state government. Consequently, most members of the present generation of people and in particular, the middle aged and elderly ones who are leaders in organising the health posts had been born and grown within the curative health culture. Such experience reinforce the preference for treatment rather than prevention. In this regard the laxed government policy on drugs enables a large number of categories of drug dealers to meet the demands for "cure" at the expense of attaining the programme's objective.

The time of inception of the programme in 1973 however, coincided with a turning point in the history of medical services in the northern states of Nigeria when Voluntary Agency Hospitals were taken over by the state governments. In addition, the BHSS was introduced in 1975 whose principles are still being implemented under the current Primary Health Care. This therefore, meant that there was an increase in governmental health services in the area served by the programme. Since the government services were free, communities preferred them to the programme's services which in addition to charging fees, required communites to maintain the health posts, pay and assist health workers. Consequently, health posts became

defunct in communities where governmental health services were established. It is therefore, plausible to argue that since health posts which were founded before the BHSS clinics had higher survival rate, the establishment of governmental health institutions created a dilemma for such communities on whether to maintain the programme or solicit for clinics.

CHAPTER NINE

C O N C L U S I O N

Theoretical Implications of Findings:

Our interest in conducting the study had been motivated by the novel idea of the World Health Organisation and health workers who have worked with underprivileged people, especially, King(1966), Newell(1975), Djukanovic and Mach(1977), Werner(1980) and Werner and Bower(1986), among others that community members can organise their own health services with specific emphasis on prevention of diseases, promotion of health and rudimentary curative services. This study has found that the rural communities which a voluntary agency is helping to be so self-supporting generally have a preconceived idea of the type of medical services they want, which is the conventional curative type. Consequently, responses to community participation are generally poor as 62 percent of all the health posts established in the demarcated area of study had got defunct due to community members' inability to either maintain the physical structure of the health post, raise money when bankrupt or remunerate health workers mainly through communal labour. This clearly indicates the effects of the professional restriction on the health workers which prohibits them to treat serious illness and treatment by injection. Thus the rendering of services by the programme has been affected by the values of medical professional hierarchy as discussed by Freidson(1976), Navarro(1974), Waitzkin and Waterman(1974) and Illich(1976) whereby the medical professionvalues expertise, specialisation and excellence in its practice to the detriment of basic services for all. The findings show that the population studied subscribed to this practice in some ways because some members look down upon the professional status of the health workers, while maintaining high regards for the community health assistants who act as health post supervisors, community

health supervisors who man the dispensaries and the medical consultant, a medical doctor who visits the dispensaries monthly. The awareness of the existence of such a hierarchy of medical personnel in the organisational structure of the programme may in fact make community members conscious of their low positions in the hierarchy, thereby losing confidence in taking initiatives to modify the organisation of the programme to suit their conditions. There is also some false expectations raised on the side of the community because in practice, community members' roles are confined to community mobilisation for work, delivery of health education and maintenance of the health post. All aspects of medication are decided upon by the programme. In fact the programme is so much concerned about the types of medicines to be used at both dispensaries and health posts that it insists that all drugs must be procured from the headquarters. A breach of this regulation has resulted in the closure of some health posts.

With respect to poor organisation at the community level, this can be attributed to erosion of unifying factors, such as communal recreational activities, obligatory reciprocal relations and poor group exchange of labour. Incidentally, these have been caused by indices of modernisation such as the acceptance of the religions of islam and christianity, availability of farm labourers and the employment of technological devices like ox drawn ploughs, tractors and grinding mills to perform tasks that used to be performed in groups for one another or for oneself. The paradox is that whereas the programme wants to use the indigenous system of economic organisation, recreational patterns and other ways of life to run the health care services in the villages, such indigenous institutions have been very much weakened. Contemporary communities in the villages are in general unable to reconstruct and apply the elements of communal living required to keep the programme functioning as desired by the programme in the villages.

With regards to the liberating role of health workers as propounded by Werner(1980, 1981), Kadt(1983), Werner and Bower(1986), this study has identified some specific ways in which the programme's activities have raised self-consciousness among underprivileged groups which have made demands in subtle and even rebelious ways for justice. Some privileged people have also conceded their privileges in a number of respects. Specifically, these changes have been observed within family organisation and gender roles in marriage. The programme's teaching on nutritional status of women and children have made some men form the habit of supplying meat more regularly for family consumption and abandoning the former practice of consuming these food items outside the home.

The drama performed under the auspices of the health post has been used by women to satirise men who abandon their roles in various respects, while taking to drinking and other social vices whose pursuits affect the families' economic well being. Of special importance are also the criticisms women levy against men's poor handling of the health post affairs. Thus, the programme has created some form of conscientization among women. This notwithstanding, it is also true that other groups of people, especially associations have not been coopted into the organisation of the health posts because they had neither requested to, nor invited by the health committees to assist.

From the modernisation point of view, it can be observed that the abrupt call on communities to organise the health services is ahead of their system of thought. Conventionally, the people would be expected to hold unto the programme and adjust to the demand, but this is not generally the case as many people are discouraged by the limited curative services provided at the health posts. This has contributed to the closure of 62 percent of health posts established in the four LGAs studied.

Policy Implications: Towards a Model PHC Programme:

With regards to policy, the findings of this study cast serious doubts on achieving successful community participation in organising their health services. The limited material resources available for promoting health, non-cooperation among people, the upbringing of the present generation in a scarce curative-oriented modern medical culture and the difficulties in implementing preventive measures within the socio-economic setting of recipients militate against communities imbibing the tenets of PHC. As far as the programme is concerned, these problems may be alleviated in the following ways:

(a) A strategy should be devised to demonstrate the benefits of preventive measures over a period of time so that communities can link improvements in health status to the adoption of specific health measures. This can be done by making the first year of contact with all prospective recipient communities a probationary period during which baseline data on vital events and morbidity should be collected for the previous year from all households by the health workers. The entire community should be informed about the findings. Similar health information should be collected for subsequent years for comparison.

The probationary year should also be used to study the structure and social cohesion of the community. This will facilitate the final selection of a representative health committee and sensitize all actors in performing their roles. Successful communal revenue generation and implementation of health lessons during the year should be made part of the conditions for establishment of permanent health posts.

(b) In view of the low professional status of health workers and high prevalence of fatal diseases, their training period should be prolonged to enable them acquire more knowledge of health and treatment than they do during the three months training. While commending the practice of selecting community members as health workers, their professional credibility can be

enhanced if they meet the perceived medical needs of their clients. However, treatment by injection, which is the preoccupation of most communities should continue to be discouraged especially when this practice implies a high risk of transmitting the Acquired Immune Deficiency Sydrome (AIDS), through the sharing of injection needles. In fact, this practice should form a topic for community health education itself in view of the activities of itinerant and even sedentary drug dealers who treat their clients by injection.

(c) Women should not only be represented as a group on the health committee but should be granted autonomy in organising aspects of the health post which concern them most. Men and women should meet as groups to map out and share fairly, new tasks arising from health lessons between men and women. This will minimise the confusion in the gender division of labour in performing novel requirements as well as relieve women to whom most of these new tasks and responsibilities are passed.

(d) Much as the exclusion of religion from the organisation enables all members of a community to contribute to the programme, the fact remains that in Nigeria today, religious affiliation is a force to reckon with in all aspects of social organisation. Being a christian programme, the health posts can be run by the village churches in communities where religious difference is proved to be the cause of lack of cooperation. Village churches are endowed with such subgroups like the Boys Brigade, Girl's Guide, the Choir , Women's Fellowship and the whole congregation among which responsibilit for maintaining the health post can be shared. For, the organisation of christian health institutions have usually been on religious basis but its services open to all, irrespective of religious affiliation, and this policy should not be abandoned by christian bodies if members of other religions cannot cooperate. To ensure inter-religious cooperation however, dialogue should be held at high levels of the religious hierarchy and the agreements made availabe to villages. But, the problem is the fact that there are many

sects in both the christian and moslem religions whose lines of authority may be difficult to trace and meet with.

In conclusion, it should be noted that although the recommendations are specifically for the programme studied, the Nigerian PHC can benefit from the findings and recommendations. The institution studied is a Basic Primary Health Care programme which incorporates a large number of aspects of the current PHC which Nigeria has embarked upon. The programme is, however, ahead of the Nigerian mainstream PHC in community involvement in organising health services. Nigerian PHC can, therefore, learn from the programme's experiences, given the fact that the area studied is representative of many rural communities in Nigeria in respect of such important factors like morbidity patterns, ethnic heterogeneity, educational attainment, occupation, religion and a host of others.

One of the lessons to be learnt from the findings of this study, therefore, is that community participation in running PHC is difficult to attain even in rural areas, which supposedly due to their hitherto being deprived of medical services are expected to be better motivated for organising such services. This problem is, therefore, expected to be higher in urban areas where health services have already been established. The towns and other rural settings are also socially more heterogeneous than the rural communities studied, and therefore, less likely to elicit intergroup cooperation in pursuit of PHC.

Another lesson to be learnt is that in view of the high prevalence of diseases, people are more interested in curative than preventive services. It is, therefore, advisable that preventive and curative measures should be approached simultaneously and with equal priority for the common good of health consumers. In fact, it should not be otherwise as emphasis on prevention ignores the already affected who in turn increases the risk of getting others infected whatever the degree of preventive measures within poor socio-economic settings.

End Notes

1. This colonial Ten-year Development plan included welfare services like water supply, housing and good working conditions as health measures.

2. The figures are derived from the 1990 Gongola State Government Official Diary.

3. During the pilot study, it was found that health posts could not be opened in only four communities which had started working on them.

4. Some people attend the opening ceremonies during which health lessons are delivered out of curiosity and due to the novelty of the health post.

5. Malnutrition is a case in point here. The disease is usually considered to be mysteriously caused, but when it is associated with closely spaced pregnancies, it is regarded as a natural outcome. Thus the marked difference in the proportions constituted by the problem at the health posts and dispensaries.

6. These conjectures are informed by impressionistic circumstances like the Directors' owning up of possible lapses in presenting the programme in some villages. The researcher also had evidence of reification when he was requested by some community members to treat them for diseases as a "medical personnel" despite prior explanations that he is not one. It is also significant that the health posts are generally referred to as "asibiti" a Hausa word meaning "hospital" by the communities.

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APPENDICES

Appendix I: Interview Schedule for Household Survey

Name of village and Local Government Area----------

1. Age----------
2. Sex----------
3. Marital Status----------
4. If married duration of marriage:----------
5. Number of children ever born - if polygynous - wives

   numbers1---------2---------3---------4----------
6. Number of surviving children - wives

   numbers 1---------2---------3---------4---------
7. Educational attainment of Household Head----------
8. Ethnic group----------
9. Religion----------
10 a) Occupation: a) Main----------

   b) Subsidiary I------

   c) Subsidiary II ----

   b) Livestock: Owner: No:

   a)_____ _____ __

   b)_____ _____ ___

   c)_____ _____ ___

   d) _____ _____ ___
11. If farmer, what are the crops grown? (state in descending order of magnitude) 1------- 2---------- 3---------- 4--------
12. What are the main purposes of growing each crop?

	crop	sale	consumption
a)	---------	---------	----------
b)	---------	---------	----------
c)	---------	---------	----------
d)	---------	---------	----------

13. Which of the following do you have in your house?

(a) economic trees------ (b) a well------ (c) latrine-------

If you have a well:

14. When was it dug?----------

15. How deep is it?----------

16. Does it have water all the year round?---------

17. Is the water drunk?----------

18. If either of 16 or 17 is no, where do you obtain water for the following?

(a) drinking----------

(b) washing----------

(c) cooking----------

19. If you have a pit latrine: when was it dug?----------

20. How much deep is it?----------

21. How much do your household members use it?

	Children 4 years or less	5 - 13 years	adults
a) All the time	---------	----------	---------
b) Most of the time	------	----------	---------
c) Rarely	----------	----------	---------

22. What ailments do individuals in your household usually suffer from?

1----------2----------3----------4----------5--------

23. Which of the following do you do about the ailments?

a) Stock the medicine used in treating the ailment:
(probe for source, e.g. provider, location and frequency drugs are obtaine
----

b) Take patient to health post each time----------

c) Take patient to health institution other than village health post
(where?)----------

d) Others (specify)----------

24. Have you ever visited the health post?----------

25. If yes, what for?----------

26. Which of the services rendered or activities performed at the village health post do you consider most important to you?(Descending order)

1----------2----------3----------4----------

27. Which of the following activities of the health workers did you ever attend?

	Yes	No
a) Drama	-------	------
b) Story telling	-------	------
c) Direct teaching about health	--------	--------

28. Which of the items in question 27 would you say you benefited most from?

---

29. Has your household ever been visited by the health workers?----------

If yes what did they do during the visit?----------

30. What health-related habits would you say changed in your household due to what were learnt from the health workers?

1----------2----------3----------4----------

31. What other things do you think you should have changed but did not?

1----------2----------3----------4----------

32. Why is the failure to change in 31? 1---------2---------3-------4-------

33. Which of the following did you learn about from the health workers and what did you do to implement lessons learnt?

	Knowledge		Practice	
	Yes	No	good	bad
(a) bottle and breast feeding	----	----	---------	--------
(b) water bathing/drinking	----	----	---------	--------
(c) mosquitoes	----	----	---------	--------
(d) houseflies	----	-----	----------	--------
(e) cooking/roasting meat	----	-----	----------	--------
(f) walking barefoot	-----	-----	----------	--------
(g) "balanced diet"	-----	-----	----------	--------
(h) vaccination	-----	-----	----------	--------

Pregnancy and child birth

34. How many births have occurred within the household since the establishment of the health post?----------

35. (If any) Did the mothers attend antenatal clinics?----------

36. If yes - where?----------

37. Where were the babies delivered?

a) At home assisted by VHW----------

b) At home assisted by Traditional Birth Attendant(T.B.A.) or other women----------

c) At a maternity----------Where?----------

38. Were there any birth complications?----------

39. If yes, when?----------

40. What were the natures of complications and final outcome?------

41. Were babies delivered taken to underfive clinics?----------

42. If yes, where?----------

43. Has there been any death of children under five years in the household since the health post was established?----------

44. If yes, provide the following:-

a) How many?----------

b) When i----------ii----------iii----------

c) Perceived causes of death i----------ii----------iii----------

Assessment of programme

45. Having been in operation for------ years, in this village, which of the following activities/services/organisation of the health post do you think should be modified?

a) Range of diseases treated by village health workers(VHW) a---------

b) Payment of village health workers b---------

c) Home visits c---------

d) Health teaching d---------

e) Well digging programme e---------

f) Village health committee f----------

g) Payment for drug/treatment g----------

h) Community organisation and response to programme h----------

i) The role of supervisors and or organisation of routine clinic days i----------

j) The performance of VHWs j----------

k) The payment of VHWs k----------

l) Upgrading health post to dispensary l----------

m) Free treatment m----------

46. From your experience and what you have seen or heard, which of the following diseases have either, (a) remained the same, (b) increased, (c), reduced, or, (d) unheard of within the past-------years?

	A	B	C	D
Malaria	—	—	—	—
Dysentery	—	—	—	—
Diarrhoea	—	—	—	—
Intestinal worms	—	—	—	—
Schistosomiasis	—	—	—	—
Measles	—	—	—	—
Filariasis	—	—	—	—
T.B.	—	—	—	—
Others, specify				

47. Which of the following responsibilities do you think are difficult for the community to perform?

	why
a) The payment of village health workers	----------
b) The responsibilities of village health committee	----------
c) The assistance given to village health workers	----------
d) Supervision of village health workers	----------
e) Attendance of under five's and antenatal clinics	----------
f) Attending clinic for treatment	----------
g) Assembling for health teaching	----------

48. When VHWs went for course, what did you expect them to know during training?----------

49. Did they know as you expected?----------

50. Respondents were requested at the end of the interview to ask any questions or provide any further information (if they wished) about the interview and the programme.

Appendix II: Interview schedule for village health workers

Section A: Organisation of Village Health Posts

1. Name of village.....Date established.....

2. Local Government Area.....

3. Distance from the main road.....

4. Proximity to: a) a hospital.....km

b) a dispensary.....km

c) a primary health centre.....km

d) a comprehensive health centre.....km

e) other health institutions.....km

5. Estimated number of households in the village.....

6. Estimated number of people per household.....

7. What is the current financial situation of the health post .....

8. What financial problems has the health post faced so far?----------

(if any).....

9. Have you paid the drug loan?.....

10. How many village health workers man the post at present

Male.....Female.....

11. Is it the first set of village health workers that are running the health post ?.....

12(a) If question 11 is "no", how many sets of workers have so far manned the health post?.....

(b) When and what were the reasons for changes of village health workers?:

		Specify
VHWs set A	.....	A.....
VHWs set B	.....	B .....
VHWs set C	.....	C .....
VHWs set D	.....	D .....
VHWs set E	.....	E .....

13. If you are not the first set of village health workers:

    a) Did your predecessors attend all the refresher courses they were supposed to have attended?----------

    b) If not, specify how many they attended and how many they failed to attend----------

    c) Why did they fail to attend?----------

14. a) Did your set of workers attend all the refreshers courses you are supposed to have attended?----------

    b) If not, specify number of courses attended and not attended and reasons for failure to attend.----------

15. How often does the village health committee meet?----------

16. Comment on the adequacy of drugs you obtain in relation to the various complaints you receive----------

Section B: Epidemiology and Perceived Impact of Village Health Posts

17. a) Are there diseases endemic in this and other nearby villages?----------

    b) If yes specify villages and diseases

Village	Endemic Diseases
A----------	----------
B----------	----------
C----------	----------

18. Which of the diseases would you say have reduced in prevalence since the inception of the programme? a.----------b----------c----------

19. For which diseases are there no discernible changes?

    a----------b----------c----------

20. a) Name seven most common diseases reported at this health post.

    a)----------b)----------c)----------d)--------e)-------f)-------g)--------

    i) Sort out as follows:

    Adult diseases(women) a)----------b)----------c)----------

    ii) adult disease(men) a)---------- b)---------- c)----------

21. Which of the diseases mentioned in 20 were taught during your training? a)----------b)----------c)----------d)----------

22. Which of the diseases mentioned in 20 can be prevented using facilities and resources available in the village?
a)----------b)----------c)----------d)----------

23. Which of them are you allowed to treat? a)-----b)-----c)-----

24. a) What are the actual measures taken so far to prevent the diseases mentioned in 22?----------

b) Other information----------

25. Rank the frequency of visit paid by the following categories of people to the health post

	Rank
a) Underfives	-----
b) Children 5 - 12 years	-----
c) Children 13 - 19 years	-----
d) Male adults	-----
e) Female adults	-----

26. If any category of people seldom attend the health post, what are the special provisions(if any) made for their health education?----------

27. How often do people visit the health post for the following?

	very often,	rarely,	occasionally,	seldom
a) Sickness	----	---	---	---
b) Health education	----	---	---	---
c) Underfive clinic	----	---	---	---
d) Antenatal clinic	----	---	---	---

28. What changes have you observed in the following habits, events or practices in the village since you became village health worker?

a) child feeding

b) adult feeding

c) child mortality

d) maternal mortality

e) child morbidity

f) adult morbidity

g) disposal of excreta

h) disposal of refuse

i) care of cooking utensils

j) acquisition, purification and storage of drinking water

k) personal hygiene

l) housing sanitation

m) turning up for vaccines

29. a) Are there differences among social groups in the utilization of the health post? ---------- b) If yes specify----------

30. a) Are there differences among social groups in adhering to health teaching?----------

b) If yes specify----------

31. How often does the supervisor visit your post?----------

33. How often do you refer patients to other health institutions?--------

34. Which of the following other sources of health care services do people in the village make use of?

a) traditional healers

b) itinerant drug sellers

c) spiritual healing

35. If a drug seller of any sort----------

a) How often does he/they come?----------

b) What are the drugs sold?----------

c) Which of the drugs sold are you allowed to administer?----------

d) Which are you forbidden to admister?----------

Appendix III: Interview schedule for Village Health Committee(Group Interview)

1. Indices of Modernisation

A. Levels of formal educational attainment by community members.

i. Schools available and when they were established.

ii. Estimated response to school(attitudes of parents, pupils and prospective pupils - chronologically)----------

iii. Out migration of "enlightened" members----------

iv. Literacy levels of adult population resident in the village----------

v. Occupations and occupational mobility----------

vi. Ideal reference groups and criteria for prestige: e.g. charismatic, achieved or ascribed criteria:----------

B. Interaction with other groups and organisations

i. Existence of development projects in the area e.g. agriculture, road construction, camps etc.----------

ii. Nearest town and nature of relationship(economic, social, administrative, etc)----------

iii. Immigration and nature of immigrants----------

iv. Out migration and nature of emigrants----------

v. Seasonal migration and nature of(if any pattern exists)----

2. Felt health needs. (Before and after the establishment of Health Programme)

		Before	After
i.	Endemic diseases	------	-----
ii.	Preponderance of morbidity among specific demographic and social categories	-----	------
a)	Children(school age)	-----	------
b)	Women	-----	------
c)	Men	-----	------
d)	Underfives	-----	------

iii. Water; sources purity, and quantity ----- ---- -----

3. Notions of corporate responsibility and mutual aid.

i) Existence of community cooperative before the establishment of the programme----------

ii) The existence of community cooperative ventures after the establishment of the programme---------

iii) Existence and nature of mutual aid groups-------

iv) Composition of village community(whether mostly blood relatives, an aggregate of non-consanquineally related)----------
(whether ethnically homogeneous or heterogeneous.)--------

v) Instances when community got together to tackle a problem affecting a part or the whole community.----------

vi) Assistance rendered on village health workers' farms----------

vii) What actually transpired when the community was collecting money for training village health workers and building the health post?-------

viii) What actually transpired when the community was building the health post?----------

ix) How many villages contributed to the building of the health post?-----

x) How many community leaders(Jauros)* are there in the community that contributed to the building of the health post ?----------

xi) On what criteria was the health post sited where it is?---------

xii) Attitudes of community members(if ever) when the Health Post was in danger(e.g. VHW attrition, health post needing repairs etc)----

xiii) Roles of interest groups, e.g. (Religious organisations, clubs, youth organisations etc, in the affairs of the health post)---------

4. Self-perception and assessment of roles and responsibilities by the committee members (as a unit).

i) Which aspect of your responsibilities as Village Health Committee members would you say you perform best?----------

ii) Which of the following duties do you find difficult to perform?

a) Supervision of VHWs

---

*A jauro usually p[illegible] 50-100 households, he collects taxes and settles minor dis[illegible]

b) Keeping record of drug sales

c) Community Mobilization

d) Payment of the VHWs, etc.

iii) Which of the responsibilities in ii, would you be most unwilling to relinquish and why----------

iv) Composition of village health committee(i.e. members' social status, posts being held in the village and in the committee etc).

v) Attendance of various members at meetings.

Appendix iv: Interview Schedule for Dispensary Attendants

1. Name of Dispensary----------(location)
2. Local Government Area----------
3. Distance from LGA headquarter----------km
4. Take inventory of staff and facilities----------
5. Are there endemic diseases in the surrounding villages?----------

   If yes, specify diseases, villages, and their distance from the dispensary.

	Diseases	Village	Distance
a)	----------	---------	----------
b)	----------	---------	----------
c)	----------	---------	----------
d)	----------	---------	----------

6. What are the most commonly reported diseases at the dispensary

   a---------- to h.

7. What are the most commonly referred cases from the health posts?

	Health posts,	common cases	cases per month	distance
a	----------	----------	----------	--------
b	----------	----------	----------	---------
c	----------	----------	----------	---------

8. Which diseases do you refer to the medical consultant?

   a ----------h,

9. How often do you have the cases in question 8? a, to h.
10. For which diseases do you refer patients to hospitals? a, to h.
11. How often do you see the cases in question 10? a, to h.
12. For which diseases have you observed a decrease in:-

a Incidence	a, --------- to h.
b Prevalence	a, --------- to h.
c endemicity	a, --------- to h.
d severity	a, --------- to h.
e fatality	a, --------- to h.

13. List the villages and their respective distances from which most of the patients come to the dispensary

	Villages	Distance
A.	---------	------km
to	---------	------km
H	---------	------km

14. What are the commonest problems reported by patients who come from places over 10 km away? a,------- to h.

15. What changes have you observed in the following events, habits and practices since the dispensary was established in this village?

a Child feeding

b Adult feeding

c Child mortality

d Maternal mortality

e Child morbidity

f Adult morbidity

g Disposal of human waste

h Disposal of refuse

i Care of cooking utensils

j Acquisition, purification and storage of drinking water

k Personal hygiene

l Housing sanitation

16. What are the major occupations of patients who come to the dispensary?----------

17. Comment freely on the occupation, ethnic group and financial position of your most regular clients----------

18. Any other comments and observations about the dispensary?----------

19. About how much money does the dispensary realise per day for charges on drugs and services?----------

20. How solvent are your patients generally?

Give details----------

Appendix v: Interview schedule for the Director of Programme:

Section A. Staff of the programme:

1. State the number, qualification and salary of staff in each category specified below.

Category	No. on post	No. on Establishment	Qualific.	Salary
Director	----------	----------	-------	-------
Asst. Director	----------	----------	-------	-------
Dispensary Supervisors	----------	----------	-------	-------
Teachers in the Training School	----------	----------	-------	-------
Supervisors of Health posts	----------	----------	-------	-------
Attendants of dispensaries	----------	----------	-------	------
Cleaners	-------	----------	-------	------
Drivers	-------	----------	-------	------
Clerical Staff	-------	----------	-------	-------
Cooks/stewards	-------	----------	-------	-------
Medical consultants	-------	----------	-------	-------
Technical/Maintenance Staff	-------	----------	-------	-------
Any other staff	-------	----------	-------	-------

(Provision to be made for more than one in each category)

2. Spell out the duties for each category of staff. a ----- h in q1.

3. Spell out the conditions of service for each category of staff a --- h in q1

4. Are there provisions for further education of staff members?----------

5. If q4 is yes, (a) for which categories of staff?----------

   b. What are the conditions for each category?----------

6. a. Has anyone been sent for further studies?----------

   b. If yes, i. which category of staff

      ii. How many in each category of staff----------

      iii. What courses did they undergo?----------

7. Enumerate cases of termination of all appointments of all categories of staff since the inception of the programme; where possible, give reasons for termination of appointment----------

Section B: Facilities of the Programme

8. Take inventory of the following, where possible/applicable, evaluate their adequacy for rendering the services.
   a. Drugs available
   b. Vehicles and their functional states.
   c. Motorcycles and their functional states.
   d. Microscopes and their functional states.
   e. Bicycles and their functional states.
   f. Classrooms
   g. Offices and No. of occupants
   h. Laboratories
   i. Other equipment and their functional states

9. How often are damages done to items(a) to (i) in question 8?
   a----- to i.

10. (Where applicable), who repairs the damages? a-------- to i.

11. About how long does it take to repair damages on items a --- i?
   (where applicable) a ------ i. Any other comments on repairs----------

12. List the dispensaries currently being operated
   ---------- ----------

13. State the categories and number of workers in each dispensary

Catetory	No.	Salary
----------	---	----------
----------	---	----------

Section C: Utilization of Services of the Programme

14. In how many LGAs does the programme operate? a----, b-------, to n.

15. How many dispensaries are there in the respective local government areas?----------

16. How many health posts are there in the respective Local Government Areas?----------

17. How many health posts are functioning in the respective local government areas?----------

18. How many health posts are defunct in the respective local government areas?----------

19. By your assessment, rank the LGAs in ascending order of enthusiasm with which they respond to the programme

    1---------- n ranks

20. a. By your own assessment comment on the enthusiasm with which various village communities responded to the programme.

    b. In your opinion, how well informed are village communities about the programme?

21. Are there specific ways in which communities assess the benefits of the programme to them over the years of operation?

    If yes, specify----------

Section D: Organisation of the Programme

22. Who is the proprietor of the Programme?----------

23. What is the highest decision making body of the programme?----------

24.a) Who are the members of the "Board of Directors" or its equivalent?--------

   b) State occupation, education, residence, institution or community represented by each member a--------n.

   c) What are the criteria for appointing Board members?----------

25. How well are Board meetings attended? (Probe for usual attendants and absentees).

26. How much involved are various members at such meetings?

    (probe for contributors, veto power etc).

27. What are the problems usually dealt with by the Board of Directors a----n.

Section F: Funding of programme

28. What are the means of generating revenue for the programme?----------

29. Is the programme self-sustaining now?----------

30. What are the means for generating revenue for up keep of health posts by the communities? a----------n.

31. If any: (of q 30)

    a. Do communities put them into practice?----------

    b. How profitable are these to the communities?----------

    c. Have the proceeds from such activities sustained any health post?------

    d. If yes, which ones?----------

32. Provide a breakdown of the programme's expenditures on the following:-

    a. Staff

    b. Drugs

    c. Buildings and their maintenance

    d. The Training School

    e. Administration/equipment

    f. Transportation.

Appendix VI: Sampling Frame and Selection of Health Posts

Functional Health Posts

Village	LGA	Dominant Ethnic Group	Selection
1. Mayowandu	Michika	Marghi/Higgi	Selected
2. Rugudum	"	"	
3. M. Vapura	"	"	
4. Sinakwande	"	"	
5. Lidle	"	"	Selected
6. Bakopi	Song	Unknown	
7. Kuma	"	"	
8. Bankam	"	"	
9. Livo	"	"	
10. Roma	"	"	
11. Kukta	"	"	
12. Sokoron	"	"	Selected
13. Shashau	Gombi	Kilba	
14. K/Tava	"	"	
15. Mbalwaha	"	"	Selected
16. Bangshika	"	"	
17. Zhedinyi	"	"	
18. Zah	"	"	Selected
19. Uding II	"	"	
20. Uding I	"	"	
21. Mayolope	"	Fulani, Nzanyi/Kilba	
22. Gashala Mgzl	"	Kilba	
23. Mbewa	"	Bura/Kilba	
24. Mtldaji	"	Kilba	

25. Betso	Mubi	Marghi/Higgi	
26. Sahuda	"	Gude	Selected
27. Muchalla	"	"	

Non-functional Health Posts

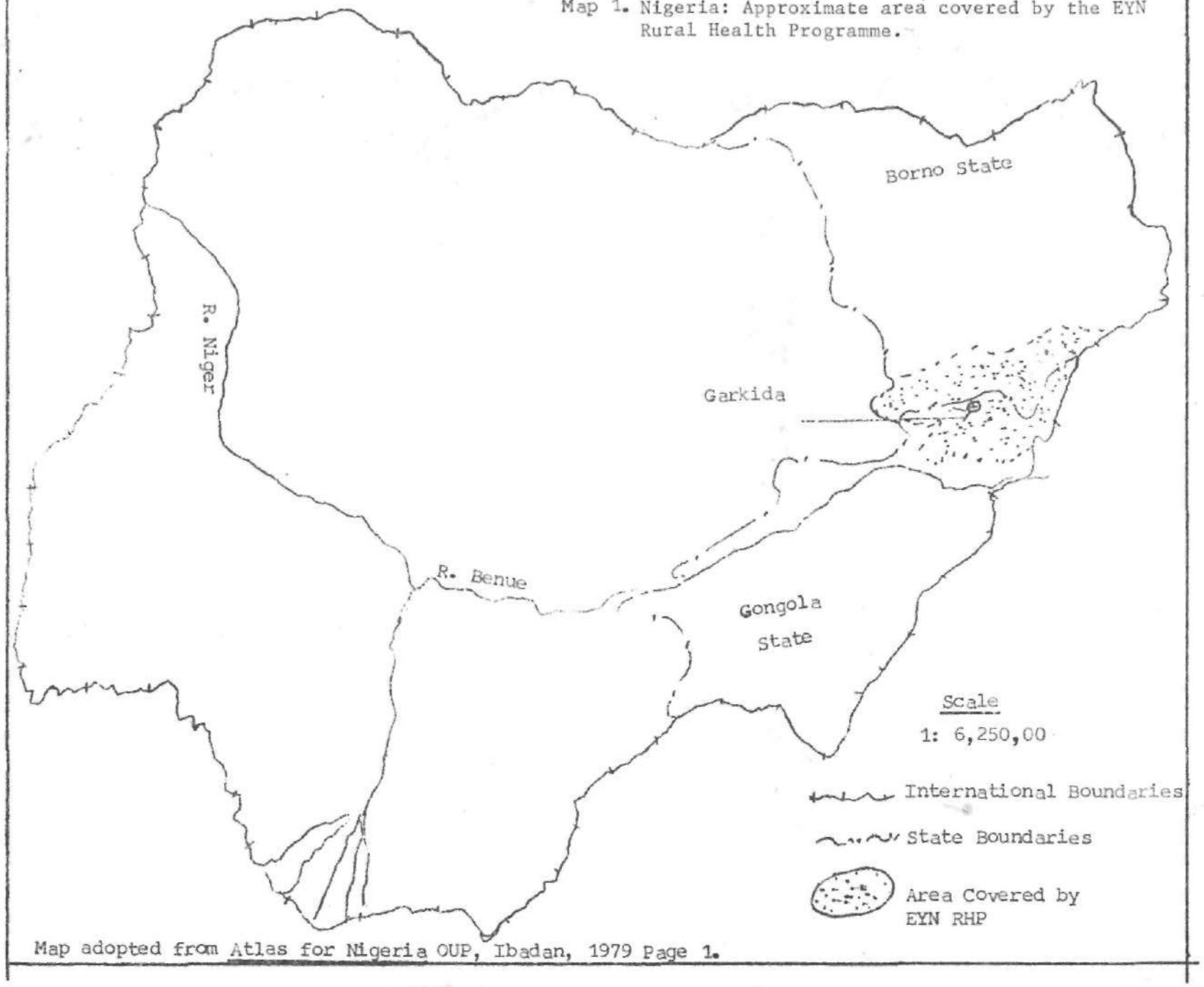
28. Ganjara	Gombi	Ga'anda/Fulani	
29. Duwa	"	Lala	
30. Boga	"	Ga'anda	
31. Dingai	"	Lala	
32. Zangra	"	"	
33. Leme	"	"	
34. Tena	"	"	
35. Hursama	"	Ga'anda/Bura	
36. Kwandasin	"	Lala/Ga'anda	
37. Bebe	"	Hona	
38. Wungilja	"	"	
39. Hurumda	"	"	Selected
40. Galga	"	"	
41. Hushbra	"	"	
42. Balhona	"	"	
43. Gangrang	"	Ga'anda	Selected
44. Dzangula Kilba	"	"	
45. Dzangula Yusufu	"	Hona/Bura/Kilba	
46. Kinging	"	Kilba	
47. Kwambola	"	"	
48. Dabna	"	"	
49. J/Gaya	"	"	
50. Chika	"	"	
51. Dilwachira	"	"	

52.	Gashala Kufom	Gombi	Kilba	
53.	Kwatau/Makera	"	"	Selected
54.	Kala'a	"	"	
55.	Mombil	"	"	
56.	Jalingo	"	Marghi/Kilba	
57.	Hildi	"	" "	
58.	Mukavacita	Michika	Highi	
59.	K/Shashau	"	Marghi/Higgi	
60.	Chumci	"	Higgi	
61.	S/Whate	"	"	
62.	Kamale	"	"	
63.	M/Shelmi	"	Marghi	
64.	Vilegwa	"	Higgi	Selected
65.	Palam	"	Marghi	
66.	Kirchiga	"	"	
67.	Kwajiti	"	Higgi	

Never took off

S/Gari	Michika	Highi)	
W/Jidel	"	")	excluded from selection.
B/Chukumu	"	")	

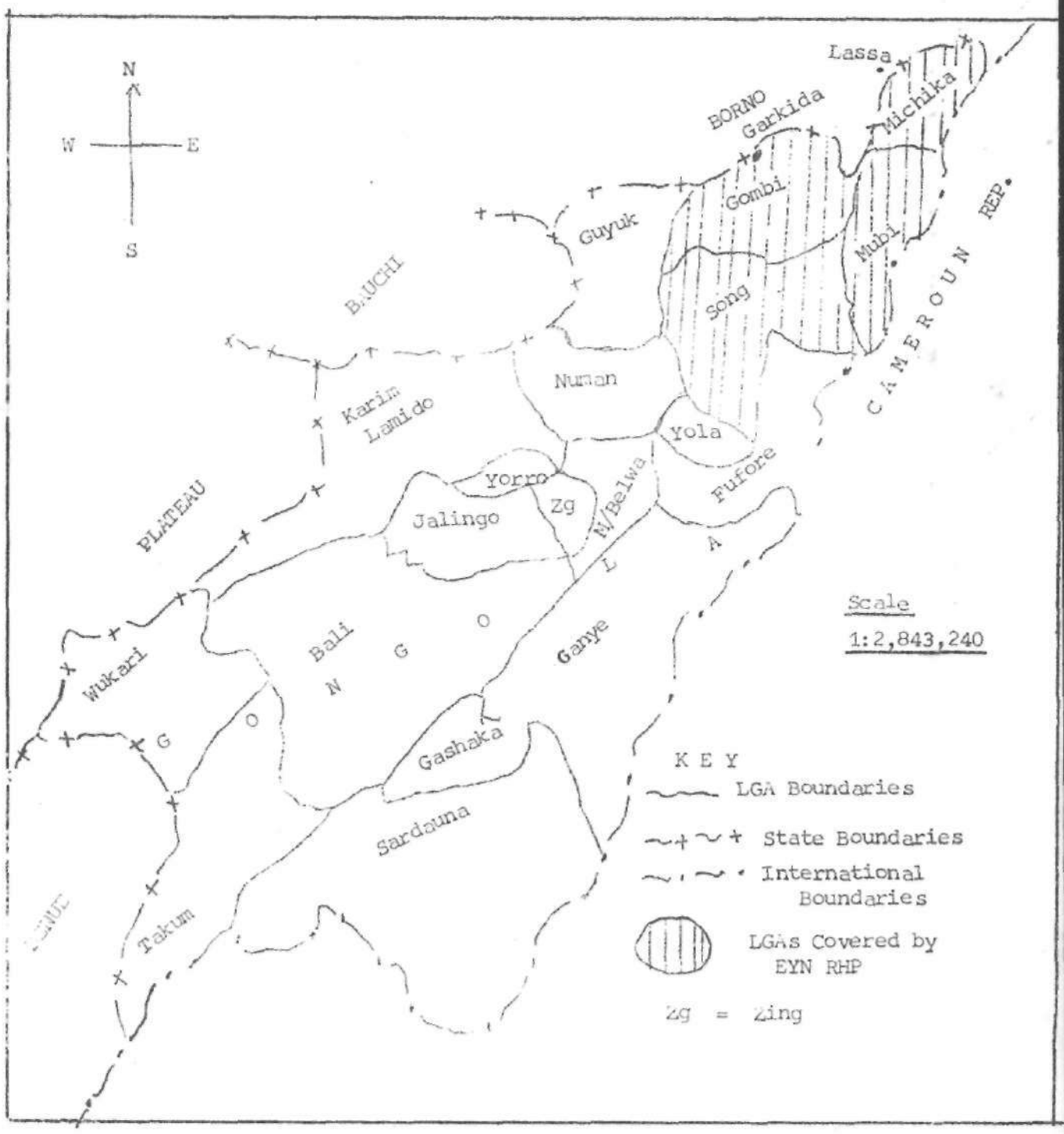
Map 1. Nigeria: Approximate area covered by the EYN Rural Health Programme.



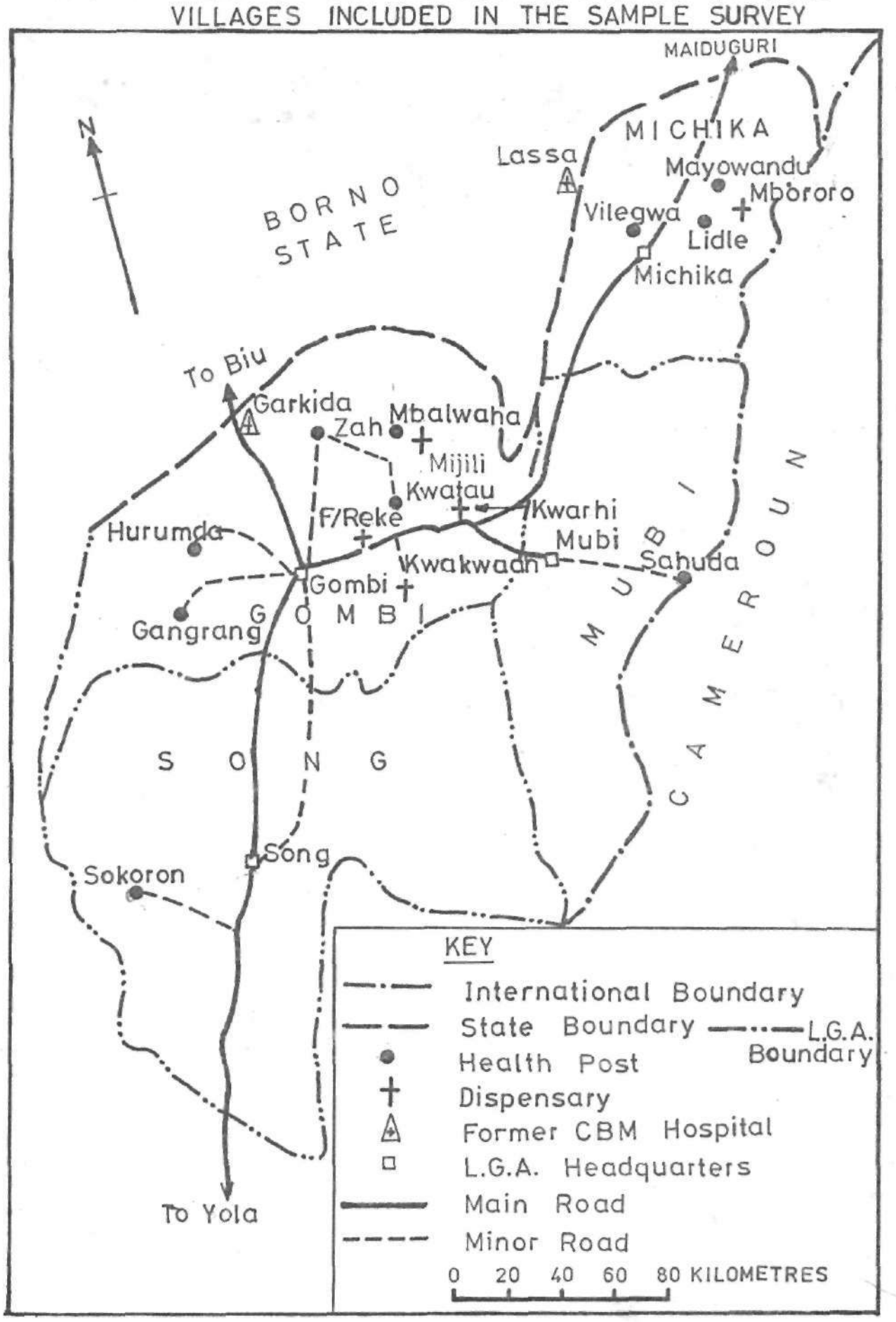
Map adopted from Atlas for Nigeria OUP, Ibadan, 1979 Page 1.

Map 2: Gongola State: Local Government Areas covered by the EYN Programme.

(Map adopted from 1990 Gongola State Diary).



MAP 3: AREA OF EYN PROGRAMME STUDIED SHOWING VILLAGES INCLUDED IN THE SAMPLE SURVEY



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