WOMEN'S PARTICIPATION IN COMMUNICATING PRIMARY HEALTHCARE POLICY IN SELECTED LOCAL GOVERNMENT AREAS OF KEBBI STATE

BY

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BEING A DISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA. NIGERIA, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS DEGREE IN DEVELOPMENT COMMUNICATION

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DECLARATION

I, Mairiga Juliana hereby declare that this Dissertation entitled "The Role of Women in the Commmunication of Primary Health care Policy in Selected Local Government Areas of Kebbi State, has been written by me in the Department of Theatre and Performing Arts under the supervision of Dr. Emmanuel Jegede and Professor. M.I. Umar Buratai. The information derived from the literature has been duly acknowledged in the text and a list of reference provided. There is no part of this thesis that was previously presented for another degree.

..... **.....**

MAIRIGA Juliana **Date**

CERTIFICATION

This Dissertation titled "Women's Participation in Commmunicating Primary Health care Policy in Selected Local Government Areas of Kebbi State, was written by me, Mairiga Juliana in the Department of Theatre and Performing Arts meets the regulations governing the award of the degree of M.A(Development Communication) of Ahmadu Bello University, Zaria and it is approved for its contribution to knowledge and literary presentation.

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DEDICATION

To God Almighty for his endless love, protection, and divine provision throughout the period of this study.

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I thank God Almighty who is the reason for my existence and success and in whom is hidden all the treasures of wisdom and knowledge.

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ABSTRACT

This study set out to explore Women's Participation in Commmunicating Primary Health Care Policy in Zuru and Danko-Wasagu Local Government Areas of Kebbi State, with a view to assessing the extent of women's participation being that the extent of women's participation in Primary Health Care is however, unclear or seems to be lacking. The study is premised on its advocacy to engender policy makers see the necessity of involving women in active participation, communication and formulation of primary healthcare policy. The study employed the Participatory communication theory which advocates for peoples particpation in development interventions and as such giving voice to the voiceless. Methodology for data gathering included, Focus Group Discussions (FGD), Indepth-Interview (IDI) and Documentary Observation (DO). Furthermore, a total of 138 women and men were sampled using Purposive Sampling Technique to include 100 members of FGD and 38 interviewees. The findings of this research according to the FGD and IDI revealed that women's participation in formulation and communication of primary healthcare policy in Kebbi state is still at its lowest ebb. This is a challenge that has development implications. The study also uncovered factors responsible for women's participation to include conservative adherence to customs and traditional beliefs, high rate of illiteracy, as well as communication barrier between women and health workers/experts. The study recommended that for sustainable women participation in Kebbi State, women should take active role and be involved in Primary Health Care Formulation and Communication. Appropriate communication strategies should be intensified as well as geninue women's participation should be encouraged by health policy makers.

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CHAPTER ONE
GENERAL INTRODUCTION

1.0 Background to the Study

Since the evolution of the concept of development, participation has become a popular discourse in Development communication. Development experts have come to realise the need for the stakeholders to be associated with all phases of development intervention either directly or indirectly. This singular act has necessisated the quest for people to be active participants in development. People's participation is at the heart of achieving success in any development effort, either at the primary level or the secondary level. The incorporation of people's knowledge and perspectives into development research process could enhance relevance of development effort.

Over the decades, national and international agencies have developed and are still developing programmes to assist in effective communication and participation of people most especially that of women in development intervention. Frantic efforts at different levels have been made to address the marginalisation of women in development intervention; but unfortunately these efforts have yielded little or no result. Despite the efforts of many agencies and organizations, and numerous inspiring successful story on paper, the picture is still disheartening, as it will take the active participation of women in the decision making environment in health policy formulation and communication to bring about sustainable development.

Even though, the poor and marginalised have always been at the centre of development communication, they are however, most often the subject of communication rather than the originators. Women have poor access to communication and the channels of communication respectively rural women fit into this group.

Participation, for women, whether it is in agriculture, health, or politics serve immediate instrumental goals such as the identification of felt needs as well as the

mobilization of local resources to meet needs. It requires the direct face-to-face involvement of women in social development and ultimate control over decisions that affect their own welfare. The essence is to empower the disadvantaged to take active part in social and community process. Women are mostly the disadvantaged majority in most of the actions and inactions of the government. This is because there are obstacles that cut across institutional, socio-cultural, logistic and technical limitations that prohibit their participation (Botes and van Rensburg 2000:4).

In policy development, economic planning, and key political inter-governmental arrangements around the world, the role of women has been very minimal especially when compared with the exertions of men. The reason for this drawback hinges on both the socio-cultural and institutional obstacle that patriarchy has created over time and the obliviousness of women to tumble the status quo. However, international development occasioned by globalization has placed women in positions where they can sue for their own development and self-growth even though their development is still being hampered by the vaulting over of women in development process given mostly due to the deeply patriarchal system in Africa and indeed Nigeria. Primary Health Care system is a conscious strategy to meet the Millennium Development Goals, MDGs, 4, 5 and 6 targeted at women and children (Vanguard Newspaper, 2014). Goal 5 is—improve maternal mortality. The goal was arrived at in the pre-2015 discussions given that women die in large number following poor pre-natal, ante natal, and post-natal care. According to the United Nations (2013), only half of the pregnant women in developing countries receive the recommended minimum of four antenatal care visits.

In Nigeria as well as in Africa, women constitute about half of the population. Female population in Nigeria was measured at 49.36 in 2011(World Bank Data, 2011). They make an essential and largely unacknowledged contribution to economic life and play

a crucial role in all spheres of the society. Nonetheless, established restrictive practices and constraints have not allowed them to take advantage of their numbers and position in order to significantly influence the decision-making process of almost all the sectors in Nigeria. They are still recipients of hollow government's policies in different sectors of Nigeria's economic, political, and social life; one of which is primary health care. Evidently, development of primary healthcare policies can not be truly achieved without effective participation of women.

The intergration of women's perspectives and inputs in formulation and implementation of primary healthcare policies could enhance the relevance and acceptability of health communication policies by rural women. The incorporation of women's inputs and knowledge in health policies is steeped in participatory paradigm which requires a shift in the way individuals are considered, from passive recipients to active agents of development efforts. There are a number of reasons for this shift, a major one of which is presented by Ascroft and Masilela (1994;12), "If peasants do not control or share control of the processes of their own development, there can be no guarantee, that it is their best interest that is being served". The cardinal objective of participation is, to empower communities, groups or individuals to determine their own directions, objectives, options for change, make well-informed decisions, take collective action to achieve their goals and monitor and evaluate the initiative if they are making progress (Van de Fliert 2007). This study is therefore, justified on the premise that involvement of women in primary health care policy formulation and communication is critical to success of any health policy research.

Women, arguably, cannot be said to have had a reasonable participation in communicating or developing Primary Health Care (PHC) Policy in Nigeria (Ojobo, 2012) World Health Organization,WHO (1978) and United Nations International Children's

Education Fund, UNICEF (1998) defined Primary Health Care as the essential healthcare based on practical, scientifically sound, and socially acceptable method and technology; universally acceptable to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination, PHC policy in Nigeria have not effectively reflected the spirits of its international description and standard as many community women are still estranged from achieving the'full participatory status'. For example allowing women to be part of drating documents, that can inform make health policies, be actively involved in Formulation, implementation, Monitoring and Evaluation of Primary Health Policies.

The above is ironical because national and international aid, agencies, governments, international organisations are putting in funds to enhance women's participation in development which does not seem to yield required results. Development workers have the responsibility of incorporating women and improving the living standards of the people. The ample opportunity of the role of women in meeting the challenges of Primary Health Care communication is quite dorminant and prominent. Their relevance and significance therefore, cannot be overemphasised. The various contributions of women in health communication in Nigeria have been variously described in literatures but their role in the decision-making process with regards to primary health care has not been widely explored or at best, remains minimal.

Research findings in health, environment and agriculture reveal the participatory gap in the whole development process. From programme conception to evaluation stage, the people who are meant to benefit from such programmes do not participate actively. Often times development experts assume that women (mostly rural) are incapable of representing themselves. This assumption is made more in action than in words. Women have often been relegated to the background, even when development efforts and

communication strategies are targeted at them (Anifowose 1999:40). On the contrary, these women are not faceless and have the capacity to represent themselves by their voices, opinions, views and actions. MacDonald and Hearle have correctly observed that,

> It is sometimes assumed that rural women are not very clever and have to be told what to do all the time.The fact is really rather different,women survived for centuries generally living in harmony with the environment and successfully conducting their own affairs. (MacDonald and Hearle 2000:72)

MacDonald and Hearle's submissions might not be entirely true, given that it is not all rural women that are in this category of not knowing what to do. In certain circumstances they might not want to prove or show they know what to do, but allow themselves to be told what to do, or probably they have not be consulted on issues based on the assumption, that they are not clever.

Therefore, for development efforts targeted at people to succeed, those for whom it is meant to benefit must be consulted. There must be appropriate communication strategies and channels that will create conducive atmosphere for women and community members to freely express themselves. MacDonald and Hearle (2000) also argued strongly that,

> Failure to consult the local population and stakeholders cause great resentment, hostility and suspicion. Also from a psychological point of view people need to be involved in the planning of their lives and activities (MacDonald and Hearle 2000:72)

The above statement to a large extent has been the weakness of many development programmes. One may have excellent ideas, but putting it across inappropriately mars the intention. The implication of this weakness for development programmes is that if effective communication strategies and better participation concepts are thoroughly integrated into the whole process of development, it will help to enhance the well-being of the people it is meant for.

A situation in which people are consulted, heard and listened to, gives room for free flow of information. Women's participation coupled with adequate and effective communication is a sine-qua-non for sustainable women development in Nigeria. For the purpose of this study, participation/participatory communication is viewed from the angle of an approach based on dialogue, which allows the sharing of information, perceptions and opinions among the various stakeholders thereby facilitating their liberation, especially for those who are most vulnerable and marginalized (World Bank,2009).

Empowering women to be active participants in primary health policy formulation and communication is a very important and necessary step to take, and bring to barest minimum the adverse health challenges that women face. The unlocking of women potentials by bridging all participation and communication gaps in health communication, thereby given ample opportunity for women to fully participate in the sector. Accordingly, with necessary resources and the right information in place, issues of women's passive participation will be gradually reduced to the barest minimum in the country and bring about sustainable development in health communication. Therefore, planning message, designing, and media choice should target women, and be made participatory because communication is only effective when the message is well understood and utilised for positive productivity; This is largerly possible when the people participate all the way. Therefore, involving women in all aspects of primary healthcare policy formulation and communication will go a long way in improving women's participation in health communication. Another reason for advocating women involvement in health development process is that women are more aware of their health problems than outsiders (development health policy planners) and hence are in a better position to determine issues to be included in health policy.

Though there have been attempts in recent years to address the gulf of women's indepth participation that has been created most times by traditions and ineffective communication strategies in development, there still remains much to be desired. The struggle for women participation in development agenda in many societies across the world is gaining international recognition with the Beijing Declaration on women's right in 1998 as well as the Convention for the Elimination of all Discrimination Against Women-CEDAW of Beijin (1995) and the resolutions canvassing for women's active participation in achieving sustainable development produced by the United Nations in 2003. Yet, most strategies presently used for consultation in development intervention are prepared in far away offices or most times not suitable for the people, as development experts in many developing countries including Nigeria regard themselves as the only experts who know it all and who have all the answers, thereby making geninue participation a "yet to be achieved goal".

Against the backdrop of the arguments above, this study seeks to assess the role of women's in communication of primary healthcare policy in selected local government areas of Kebbi state, and further analyze the communication approaches and make relevant recommendations.

1.1 Statement of the Research Problem

Although, the importance of women's participation in development has been communicated to people since the inception of development communication and participatory communication in Nigeria and the world at large, agitations on inadequate and passive women's participation in development still abounds, especially in Northern Nigeria and in rural areas.

With the United Nations(U.N) Millennium declaration of goal 5 which is to improve maternal health, several government non-governmental organisations, women

associations and individuals have been involved in programmes to improve the health and nutritional status of women, and promote active women participation at all levels. Despite all these efforts, there have been rising cases of discrimination, marginalization, oppression and exclusion of women from active participation in sustainable development, which the primary health sector is not an exception. Perhaps this suggests a participatory gap in the application of participatory communication concept and strategy in the programmes by various agencies and organisations.

The strategy remains basically top-bottom approach, and women basically remain passive receptors of health policies, which may not necessarily meet their needs, while their involvement and participation in formulation and communication of primary health care policies remain low. Effective communication strategy which includes women active participation in all the processes of communication formulation, implementation, monitoring, and evaluation is a prequisite for any sustainable development. Women play a significant role in health development but they are hardly given prominence in the decision making in primary health communication. The role of women cannot be overemphasised in participatory development and communication. However, such prominence in decision making process in health development initiatives has not been widely explored in Nigeria, and most especially Northern Nigeria. Most health messages targeted at women emphasise their passive role, which is mostly anchored on persuasion and top-down bottom approach, which is mainly a take and use syndrome for the women.

Most formulators of Primary health care policy are unenthusiastic to go into communities to work with the community women to get authentic information which will help inform policies. They rely heavily on foot-dragging local government's officials and external sources which do not reflect the ideas of members of community. Hence, what is imported as Primary health care becomes extra-terrestrial to the women in the communities

because they were not part of the process that birthed the idea. By being removed from the process, they are disempowered as knowledge and self-help effort is denied them. Development efforts that ignore local circumstances, local technologies and local systems of knowledge have often wasted time and resources

Women's participation in development is imperative, when the people are secluded their participation is limited, as such little or no meaningful success in development strides is achieved. This research seeks to identify and contribute to the global realisation that despite enormous efforts put in by well meaning agencies and development partners in programmes targeted at women, there are rising cases of marginilisation, exclusion and discrimination of women from relevant participation in development, most especially Northern Nigeria where women traditionally enjoy little or no independent decision making in individual, family, and community issues.

As long as there are continued rising cases of passive participation, deprivation and marginalization of women in the approaches and processes of communication, the people who are meant to benefit from such programmes are alienated, indifferent and cold towards such initiatives. At best, they mostly concern themselves with immediate and gratifying gains like money.

The implication of this is that knowledge, behaviour, and attitudes are not changed or positively affected for long term purposes, thereby making women participation and sustainable development more of a myth than a reality.

1.2 Aim of the Study

The aim of this study is to explore the crucial importance of active women's participation as a way forward in achieving and sustaining effective Primary Health Care policy communication and delivery in Nigeria.

1.3 Objectives of the Study

The study attempts to achieve this aim through the following objectives.

i) To identify and examine the role women play in formulation and communication of primary healthcare policy in selected local government areas of Kebbi state.

ii) To evaluate the factors that limit women's active role in the formulation and communication of primary health care policy within the local government areas under study.

iii) To critically assess how primary health care policy is communicated to women in the local governments of study in Kebbi State.

iv) To suggest how women's greater participation in health policy formulation and communication in Kebbi state can be achieved and sustained.

1.4 Research Questions

Owing to the foregoing, this work seeks to ask the following questions.

i) Do women participate in formulation and communication of primary healthcare policy at all?

ii) To what extent do women participate in formulation and communication of primary healthcare policies in Kebbi state?

iii) What factors are accountable for the passive participation of women in formulation and communication of primary healthcare policy?

iv) How primary health care policy are communicated to women in Kebbi state?

Providing answers to these questions is important to identify the gap in the quest for women's greater participation in primary health care formulation and communication.

1.5 Significance of the Study

This research contributes to knowledge by examining the role of women in the communication of health policy particularly in Kebbi. This research identify the gap inherent in processes of development, critique and offer reccommendations that can enhance women's greater participation in health policy making.

Thus, it has become relevant to assess women's participation side by side with the development of primary health care policy in Nigeria.

Hence this research is justified to the extent of exploring the importance of women's participation in development and health communication. It shall therefore, fill this obvious gap in the continuum of search for active women's participation in achieving sustainable development.

The research is justified by the need to recognise the importance of women's active participation in effective participatory communication because women consitute part of development that cannot be sidelined or ignored. Also, the research shall contribute to knowledge about participatory communication practice and its effective use in obtaining sustainable results around the world and specifically within the Nigerian context.

Although, this is essentially an academic activity, it is hoped that the information and knowledge from the research can be used by policymakers, development planners, decision makers, donor agencies, governmental and non-governmental organizations to set policies and designs for genuine participation and for sustainable development for women in Northern Nigeria and generally in Nigeria at large

1.6 Scope of the Study

Women participation in development is a global project as well as a national project in Nigeria. It is being carried out in all the nooks and crannies of Nigeria. But this study is limited to Kebbi State in northern Nigeria.

The study focuses on Women's Participation in Communicating primary Health Care Policy in selected Local Government areas of Zuru and Danko-Wasagu areas of Kebbi State, because of its highest maternal and child mortality rate. The activities of Primary Health Care cover different communities in Kebbi State. It is, therefore, not possible for the study to capture all the different communities and health programmes in the state at once. In view of this, the researcher streamlined and focused on the selected communities for accessibility and easy manageability of data.

1.7 Definition of Terms

Participation

The conscious and deliberate coming together of a group of people, with equal opportunities to actively contribute and chart a course towards making their lives better than what it use to be.

Communication

Communication is the basis for all human interactions and provides the means for individual or group of people to relate reciprocally and hence enable groups to function. According to Rogers et al. (1981), communication is a process that involves the exchange of ideas between two or more individuals in an attempt to arrive at convergence in meaning.

Empowerment

This can be seen as the means of supporting an individual or group of people to be independent, without having to always depend on someone .

Primary Healthcare (PHC)

Primary Health Care is an essential healthcare based on practical, scientifically sound, socially acceptable method of technology made universally acceptable to individuals and families in the community through their full participation and at a low cost that the community and country can afford to maintain at every stage of their development (W.H.O. 1987)

CHAPTER TWO
REVIEW OF RELATED LITERATURE

2.0 Introduction

The emphasis by development planners and initiators to always involve people in development initiatives or systems that can bring the desired result of sustainable development is paramount, as scholarly literature seek to understand reasons behind low/passive women participation especially in Health communication development.

Over the last couple of decades, development communication and health communication have witnessed an unprecedented change in the trail of events. Women have been confronted with the challenges of improving their lives and welfare of their entire being, together with the trends of globalisation and development.

Research findings by scholars (Anifowose, 2004, Enejere, 1991, Bamidele, 2004 and Enemuo, 1999) have all strongly advocated the necessity of active participation of women in health development and discourse, as this can help in addressing the challenges of low women participation in development as a whole.

2.1 Development and Communication

Communication is the basis for creating awareness, consensus building, making informed decisions, resolving conflicts, and generating participation in processes of development. Communication occurs within and between formal and informal units of people. At the most simple level, communication takes place intra-personally, that is within an individual as a stream of conscious dialogue. Communication between two or more people referred to as interpersonal. This interpersonal communication can take place between or among individuals and small groups; local, regional, national and international networks or organisation (Rose, 2000)

Traditionally, communication efforts have tended to fufill three main roles in development practice. First to inform and persuade people to adopt practices and behaviours that are deemed beneficial to them; to enhance the image and credibility of development organisation involved in the efforts; and to enable community consultation on specific initiatives (Gray-Felder, 1999). The focus in more recent years has shifted to providing a forom or platform for dialogue, debate and participation for all sectors of society, especially those that have been underrepresented hence, the need for communication that is geared towards development and sustainable change.

Historically, development communication is said to have its origins in post-World War II. Worsley (1984) states that the history of development is as old as human history, however, the current conception of international development is usually traced back to soon after World War 11. It was President Truman's January 1949 inaugural speech that marked the beginning of modern birth of development (Esteva 1992), and it synthesized the emerging vision of the world divided between richer and poorer countries.

Since then, the issue of development has been highly debated, a debate with many different angles and voices, broadly classified until recently into two camps. In one camp, there were those who viewed development as struggle and a mission under the survillence of more powerful and richer countries, to defeat poverty and ignorance, and to rise above their"underdeveloped"condition.This angle became the dorminant position in development.

In the other camp, there were those who viewed development from the angle of a critical approach, where they viewed development as an attempt by rich countries to maintain the status quo over developing countries, through constantly ignoring local realities, needs and knowledge in the underdeveloped countries. This camp gives greater prefrence to participation which is a veritable tool in achieving sustainable development in any given society. It observed that development communication is a purposeful

communication effort geared towards realisation of human potentials and transformation from a bad situation to a good one.

Beginning in the late 1970s and 1980s, a critical or alternative approach to development was proposed. This approach stressed the need to listen and involve those people (Men and Women) in development process for whom the project is implemented. FAO (1984) indicated that "people oriented and sustainable development can only realise its full potentials if rural people are motivated and if information and knowledge are shared". Sharing is not a one- way transfer of information, it implies rather an exchange between communications equals. On one hand, technical experts/specialists (outsiders) learn about people's needs; on the other hand, the people (insiders) learn about the techniques and proposals of the specialists. This means that developmental effort with rural community should begin with development planners and technical specialists listening to them which goes beyond a simple appraisal of needs.

Owing to the above arguments, it suggests that development communication is "empowerment of marginalised individuals, groups, and organisations. They viewed communication as a "dialogic process", through which community members learn "self management". It can be deduced therefore that development communication is people oriented and a process of giving stakeholders prominence in developmental strides. It is a special case of delegation, in which the surbodinate gains greater control, greater freedom of choice, with respect to his own responsibilities.

2.2 The Concept of Participation

The search for a different and better vision of development practices continued until the emergence of participatory paradigm. Participation is a concept that has been gaining increasing recognition in the development discourse and practices it has become an essential part of the vocabulary used in project proposals; while the quest for

participation in development programmes and projects has existed for a long time, in recent years, the concept of participation has received increasing support from development partners and organisations, thereby gaining a louder and stronger concern globally.

Now most experts agree that there is hardly a development challenge that can be met succesfully without the people's participation. Participation, in development context, is a process through which all members of a community or organisation are involved in and have influence on decisions related to development activities that can affect them. People initiate, discuss, conceptualize and plan activities they can all do as a community.

Participation requires a shift in the way individuals are considered, from passive recipients to active agents of development efforts. Ascroft and Masilela (1994) opine that if peasants do not control or share control of the processes of their own development, there can be no guarantee that their best interest that is served.

Participation is a catalyst in development with support from many different stakeholders; donors, ordinary, civil society, government and non-governmental organisations, it is mainly about people's mobilization for conscentization and the application of strategies that can be located at the grassroots where participation for development matters most. This implies that development projects will address those community or group needs on which members have chosen to focus, and that all phases of the development process will be characterized by active involvement of community or organization members.

As Moemeka (1981:56) notes that participation of people in development makes people appreciate the process because, the people can have a sense of belonging and feeling that they are the ones directly involved in developing themselves when they participate in the process of development. If decisions about a community's development are left in the hands of Professionals, the community is sidelined to the back seat, and is being

considered as secondary, they can remain at a distant level, thereby disconnected from the actual development. In Participation, stakeholders are more capable than experts because the community and the people know their situation and have a perspective on problems and needs, that no outsider can fully share. Therefore, participation in development must actively engage local communities in developing an understanding about their situations and in becoming confident about their abilities to change situation(Servaes 1999).

Evidence from research findings ranging from global development programmes suggests that participation has become a highly praised term, but a poorly adopted one. Participation has been incorporated mainly as the involvement of communities in programmes whose outcome and goals are mainly and largerly defined by international aid system.

Participation of people in development must employ studies that allow "the researched to do their own research, rather than rely on the findings of academics or change agencies. The principles of participation" believed in the knowledge and ability of ordinary people to reflect on their oppresive situation and change it.

Participation is both right and a practical necessity, hence the need for stakeholders to be fully involved. Khan (1998) views the whole essence of Participation as:

> ...an organised effort to increase control over resources and regulative institutions. It is people's involvement in decision making, implementation, benefit-sharing and in evaluation of programmes. It is also people's capacity to take initiative in development to become "subjects" rather than "objects"of their own destiny and this can only be achieved through a de-professionalization in all domains of life in order to make ordinary people responsible for their well-bieng. Participation involves a reversal of role playing. People should be the primary actors and government agencies and outsiders should participate in peoples activities.

Khan's submission prioritizes people's involvement as the bedrock of achieving sustainable development because power should remain with stakeholders in development

intervention, thereby allowing people set their own agendas and make them known in regard to political, economic and other spheres of life.

2.3 Typologies of Participatory Approaches

The reaction against modernization, and to some extent the realization of global structural imbalances, gave rise to various participatory approaches. They share the common intent of actively involving people who were the subjects of development in shaping the process, but in most cases, this is where similarity ends and a diversity of differences begin. People's participation became defined in many different ways, and in turn led to numerous unresolved disagreements.

According to White (1999), authentic participation of grassroots people may still be more of an ideal than a reality. Individuals and agencies actively engaged in development are conscientiously struggling to move beyond theorization to achieving this ideal. Based on White's observation and inquiry, there seems to be an ever increasing overt recognition of the need to involve oppressed and disadvantaged people in the flow of decision making and action required for decision development. But it is not as though that recognition will facilitate participation of the people and make it happen. It would not be appropriate for a development professional to talk about participation as being pretty simple. But to "walk the talk" with a commitment to make communication happen is not easy.

White (1994) points out different types of participation that can be found during projects which may include either development projects or health interventions projects; these include:

a) **Passive Participation**: People participate by being told what is going to happen or has already happened. It is a unilateral announcement by an administration or a project management without listening to people's responses. This has been the

usual approach of bringing development to the people. It is assumed they know what the people want. (White, 1994)

b) **Participation by Consultation**: People participate by being consulted, and external agents listen to views. These external agents define both problems and solutions, and may modify these in the light of people's responses. Such consultative process does not concede any share in decision making, and professionals are under no obligation to take on board people's views. (White, 1996).

c) **Participation for Material Benefit**: People participate by providing resources such as labour, in return for food, cash or oather material incentives. Much on farm research falls in this category, as farmers provide the fields but are not involved in experimentation or the process of learning. It is very common to refer to this as participation yet; people have no stake in prolonging activities when incentives end.

d) **Interactive Participation**: People participate in joint analysis, which leads to action and the formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple objectives and make use of systematic and structural processes. These groups take control/ownership over local decisions and so people have a stake in maintaining structures or practices.(White, 1996)

e) **Self-Mobilization**: People participate by taking initiative independent of external institutions to change systems. Such self-initiated mobilization and collective action may or may not challenge existing inequitable distribution of wealth and power.

f) **Functional Participation:** People participate by forming groups to meet predetermined objectives related to the project which can involve the development or promotion of external initiated social organization. Such involvement tends not to be at early stages of project cycles or planning, but rather after major decisions

have already been made. These institutions tend to be dependent on external initiators and facilitators, but may become self-dependent.

g) **Participation in Information Giving**: The information being shared belongs to the external professionals. People participate by answering questions posed by extractive research using questionnaires, surveys of such similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared nor checked for accuracy.

White's (1994), offers some insights into different interests at stake in various forms of participation as a way of working out how people make use of participation, it can be useful tool to identify conflicting ideas about why or how participation is being used at any particular stage in a process. Types of participation such as these can be read as implicitly suggesting a progression towards a more "genuine" type of participation. When these types of participation are contextualized, however, they become more ambiguous. Participation through information giving for example might limit more active engagement, although it could be argued that transparency over certain kinds of information opens up the possibility of collective action in monitoring the consistency of rhetoric with practice. But keeping a flow of information going is in itself important.

What people are participating in, conditions how their participation might be evaluated. Delegated power over choosing the kind of Primary health care structure in the name of "patient involvement"- in the absence of any involvement in decisions on what the Primary Health Care does, may count for little in genuine participation.

Different purposes, equally demand different types of engagement by different kinds of participants. A process that sought only the engagement of small group of

articulate elite community members is different to one in which community members delegate power to such group to engage with the authorities to receive information and be cosulted on key issues.

2.4 Participatory Communication

The Participatory approach to development communication sprang up as an alternative to difussion of innovations. The primary goal of participatory communication is to empower local communities to manage their own development. Participatory communication views communication as a people –oriented activity.

No generic definition exists for the concept of participatory communication, Several scholars tried to define it. Morris (2003) defines it as "Communication that empowers people to have greater control over decisions that affect them, and in this way... fosters social equity and democratic principles". Communication is a "horizontal process of information exchange and interaction". (Morris 2003: 30)

Nair and White (1993) believed that participatory communication is the "opening of dialogue, source and receiver interacting continously, thinking constructively about the situation, identifying development needs and problems, deciding what is needed to improve the situation and acting on it". (Nair &White: 1993: 60).

Morris (2003) who reviewed research in participatory communication, suggests direct involvement of local people in management and evaluation of development programmes, education about empowerment rather than technical know-how instructions, and learning by participation rather than passive processing of directions about innovations.

Servaes (1999) identified five concrete principles of participatory communication. First, ordinary people, rather than change agents or formal power structures, are the "key agents"of change. Communication is employed to encourage self-reliance and independence of local people from donor agencies.

Secondly, the principle of re-distribution of power from the elites to local communities (Servaes1999). In order to encourage changes, development communicators must support local communities in their efforts to resist the obstacles set by those in formal power who want to maintain status quo.

The third principle of participatory communication is the implementation of a new research tradition or"participatory research"(Servaes 1999). The effectiveness of empowerment cannot be measured in terms of empirical social science tradition. Participatory development communication must employ studies that allow the "researched to do their own research" rather than rely on the findings of academics or change agencies. Participatory research "believes in the knowledge and ability of ordinary people to reflect on their oppresive situation and change it (Servaes 1999: 50).

The fourth principle centered around development, education and activation of people towards self and community improvement; development means lifting up the spirits of local community to take pride in its own culture, intellect, and environment.

The fifth is the re-shifting of the focus from the nation state to local communities (servaes1999). Participation does not mean just one metropolitan center; true participation consists of "many local and regional poles of development with regional media, educational facilities, professional services, and cultural expressions" (White 2004: 60)

In participatory communication, participants must be free to call into question any proposal, to introduce any proposal, and to express any attitudes, wishes, and needs. Participation involves all levels of the public sphere from a village to a global-level.

In order to share information, needs, aspirations, common trust, and knowledge in development projects, participation is very crucial in any decision making process for development.This calls for knowledge, aspirations, needs and committment for overcoming stereotyped thinking, and to promote more understanding of plurality of people.

Development efforts should be anchored on faith in the people's capacity to discern what is best to be done as they seek their liberation, and how to participate actively in the task of transforming society. The people are intelligent and have centuries of experience, draw out their strength and listen to them" (Mbachaga 2014:15).

2.5 Health Communication

Health is an area where effective communication is particularly important. This is paramount because good communication contributes immensely to virtually all aspects of healthcare.

According to Berry (2007:36)

> There is now a substantial body of evidence to show that patients who are attended to by healthcare providers with good communication skills have better health outcomes". The converse or ineffective communication, whether at the individual health professional or wider public health level, can lead to patients not even engaging with the healthcare system or refusing to follow recommended advice as well as adhere to treatment regimens and failing to cope with the psychological consequences of their illness".

In view of the above, Healthy People (2010:68) define Health Communication "as the study that encompasses the use of communication strategies to inform and influence individual and community decisions that enhance health". This definition links the domains of communication and health together and shows clearly the necessity of the interrelationship which is an effort towards improving personal and public health. In addition, Rogers (1996:15) opines that Health Communication is "any type of human communication whose content is concerned with health". This obviousy infer a communication where the focus is on health related transactions and other factors that has direct bearing or influence on it.

The importance of effective health communication has become increasingly recognized, yet exposure to numerous examples of poor and inadequate health

communications abound. These occur as a result of personal dealings with healthcare providers of various sorts, or via the media and other similar channels. It is observed that the media also contribute to the information available for consumption. That is why it is rare for people to claim that they are not informed regularly about some new health issues, however, what transpire often times is that some of the information provided are misleading, confusing, or poorly presented to the public (Berry, 2007).

Looking at patient-service provider bases, which falls under health communication, Payne & Horn in Berry (2007) acknowledge that there are difficult situations. For example situations such as during the delivery of bad news of diagnostic and prognostic information to people such as children, older people and those with learning difficulty. Here, communication behaviours need special attention and in view of this most health professionals now are required to undergo basic training in order to be able to effectively and proffesionaly handle these situations and of course, this is a crucial aspect of health coomunication which has been ongoing. This is why there can not be room for assumption that communication is well taught to health professionals at the training level but needs to be re-emphasied because this issue still forms some of the major reasons for dissatisfaction and complaints by patients using health services (Payne & Horn in Berry, 2007).

It is however, important as observed by Department of Health, (2004) that insights and evidences from health psychology, patients/families experiences as well as other feedbacks and complaints from relevant agencies should be incorporated to health policies and programmes in order to pave way for a meaningful improvement in health communication. This is useful in the course of disseminating basic and fundamental health information which is tatamount to making informed decisions and capable of leading to great gain in terms of seeking the right health assistance. However small or from whatever medium, it is pertinent to note that without information, there can be little or no meaningful

choice that can be made in terms of seeking health assistance and interventions. This is because information helps people to build knowledge and acquire the neceassry understanding about health challenges. In the case of patients, it gives them the power and confidence to function as partners with their health service providers for maximum efficiency (Department of Health, 2004).

Consequently, effective communication is now generally acknowledged to be central to effective healthcare. This to a large extent is crucial because, not all communication can be termed as effective. Some are considered ineffective. For this reason, effective communication is no longer seen as an add-on extra; rather it is recognized by many as being at the heart of patient care or health care generally. In other words, it plays a pivotal role and as such, cannot be over emphasised. Kreps et al. (1998) note that, for communication to be effective, that it requires calculative and purposive creation, gathering and sharing of health information to the right people and at the right time. This is central to enabling individual and collective adaptation to health risks at different levels (Kreps, 2003). Based on the crucial nature of the above assertion, an International Conference on Health Communication produced the 'Toronto Consensus Statement' on the relationship between communication practices and health outcomes (Simpson et al., 1991). The statement made eight points relevant to this study:

- Communication problems in medical practice are important and common.
- Patient anxiety and dissatisfaction are related to uncertainty and lack of information, explanation and feedback.
- Doctors often misperceive the amount and type of information that patients want to receive.
- Improved quality of clinical communication is related to positive health outcomes.

- Explaining and understanding patient concerns, even when they cannot be resolved, results in a fall in anxiety.
- Greater participation by the patient in the encounter improves satisfaction, compliance and treatment outcomes.
- The level of psychological distress in patients with serious illness is less when they perceive themselves to have received adequate information.
- Beneficial clinical communications is routinely possible in clinical practice and can be achieved during normal clinical encounters, without unduly prolonging them, provided that the clinician has learned the relevant techniques.

Consequently, there are indications that healthcare providers who communicate well with patients are more likely to secure positive outcomes for patients. Invariably, they are more likely to make more accurate and comprehensive diagnoses, even to detect emotional distress in patients and have patients who are more satisfied with their care. It is also stated that patients in this category exhibit less anxiety and tend to agree and adhere to instructions and advice given to them (Lloyd and Bor, 1996). In addition, patients who are caretered for by professionals with good communication skills have been shown to have improved (Davis and Fallowfield, 1994). This point further emphasises the essence of effective communication which is as vital as health itself. Schofield (2004) firmly asserts that "effective communication was a drug that could be prescribed". He is of the opinion that effective communication is as good as a good drug that is administered, that even a good drug administered with poor communication can be rendered ineffective and even harmful.

Indeed, it is pertinent to point out that in as much as effective health communication yield positive results, ineffective communication is harmful and can lead to a wide range of negative outcomes. These include, patients not engaging with the health service when they

should, refusing to follow recommended health behaviours and undergo necessary treatment, failing to adhere to treatment regimens, or failing to cope with their own or another's illness (Dulmen and Bensing, 2001). In extreme cases, poor communication can lead to psychological damage, physical harm, or at worst, death (MacDonald, 2004). In a nutshell, as noted by Pettigrew and Logan (1987), Communication promotes both health and illness in society, and makes the system run at optimal or marginal effectiveness. The emphasis must therefore be on effective communication, rather than on communication per se. It is important that people be imparted with the right information, in the right way, at the right time and the right place. It is not entirely efficient to simply provide bulk of information that does not get to the desired target as many might consider communication to be. Therefore, communication needs to be patient centred and informative and above all promote trust and confidence. As MacDonald (2004) noted, good communication between patients and medical staff is important from the very first encounter, because it forms the basis of all future transactions.

It is however necessary to also point out that effective communication is attainable when there are right policies and enabling environment in a given community, state or nation as a whole. Without the enabling environment, it can be difficult to ensure adequate health information to the people. In considering this aspect, the media, policy makers, government, non-governmental and donor agencies can play leading roles. This is because several health policies have been churn out especially for the developing countries aimed at tackling health challenges and many do not tackle the issue of effective health communication. Therefore, many have been found to fall short of the expected outcome.

In furtherance of the need to sustaining effective communication, some communication approaches have been used in health communication globally and even at the local levels.They include communication between different 'players' in the healthcare processes,

communicating with particular audiences and in difficult circumstances as well as communication on a Wider Scale

Ensuring communication between different ‘players’ in the healthcare processes was found necessary because communication extends beyond healthcare provider–patient relationships. It is also necessary in interactions between different healthcare providers, between health service administrators and patients, between healthcare providers and carers or family members, between patients and family members, and so on. The nexus of this various communication areas is to bring about quality result in terms of health care delivery at all levels. Also, communicating with particular audiences and in difficult circumstances is vital this is because the same type of communication skills and behaviours which best suits one situation might not be effective in another.

2.6 Primary Health Care

Primary healthcare is the basic healthcare services that is opened to people at all levels and often times is at the confines of the government to iniate various interventions and programmes in this direction so that a large majority of people can benefit. This is particularly important in rural or suburban areas where people are not financial buoyant to acquire expensive medical or health services. This is because basic health services abound and that is why it is refered to as primary healthcare. To further expantiate on this, Martens (2013) has given a robust insight into the development and constituents of primary healthcare. According to him, primary healthcare has emerged as the dorminant approach to address health communication and health related problems in the world, particularly in most developing countries. This development has stemmed from the realisation that the exisiting “hightech-oriented and hierarchial” health system has failed to provide, improve and extend services to vast majority of people particularly in the rural areas of developing countries.

Furthermore, it is pertinent to note that primary healthcare covers a wider scope but basically, it includes disease prevention, health promotion, health care policy, and the business of health care, as well as the enhancement of the quality of life and health of individuals within the community which may also include reproductive and sexual health concerns. Disease prevention is cheaper given the huge cost involved in obtaining quality health care which is almost non-existent especially in third world countries. Therefore, to realize disease prevention and health promotion it is important to know the behaviours and practices that mitigate healthy living and to do this it is imperative to involve such people since it is their lives at stake. This is where people's participation comes into play. If health communication is to be effective, it is important that the level of participation by stakeholders is complete and not forced.

Indeed, the World Health Organisation (1987) defined primary health care as essential healthcare based on practical, scientifically sound, socially acceptable method of technology made universally acceptable to individuals and families in the community through their full participation and at a low cost that the community and country can afford to maintain at every stage of their development, in the spirit of their development in the spirit of self reliance and self determination. The goal of the primary health care is promotive, protective, preventive, restorative and rehabilitative (UNDP, 2000).

Primary Healthcare forms an intergal part of the Nigerian social and economic development. It is the first level contact of the individual and community in the national health system, thus bringing healthcare as close as possible to where people live and work and contributes the first element of a continuing health care process (Akinsola,1993: 100).

In the same vein,W.H.O. (1987) specified the aims and objectives of Primary Healthcare

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1) To make health services accessible and available to everyone where ever they live and work.

2) To tackle health problems causing the highest mortality and morbidity at a cost that the community can afford.

3) To ensure that whatever technology is used must be within the ability of the community to use effectively and maintained.

4) To ensure in implementing health policies, the community must be fully involved in planning, delivery, and evaluation of the services in the spirit of self reliance. In essence, Primary healthcare is essentially aimed at promotion, prevention, curing and rehabilitation.

Improving health throughout the world is gigantic tasks requiring global cooperation.To facilitate this cooperation, WHO established an annual two-week meeting in Geneva. During this World Health assembly, representatives of member countries meet to exchange information, share experiences, consult about health issues, and devise global strategies. W.H.O understanding of how best to promote health throughout the world has continued to evolve.

The strategy for achieving the goal of "Health for All" emerged in 1978 at a historic conference in the former Soviet Union.The conference was sponsored by the United Nation Children's Fund (UNICEF) and W.H.O. Prior to the Conference; W.H.O had identified eight components common to nine successful health programmes. The code words "Primary Health Care" (PHC) were selected to describe the following eight components:

1. Education about common health problems and what can be done to prevent and control them.

2. Maternal and child health care.

3. Family planning; promotion of proper nutrition.

4. Immunization against major infectious diseases.

5. Adequate supply of safe water.

6. Basic sanitation.

7. Prevention and control of locally endemic diseases.

8. Appropriate treatment for common diseases and injuries.

Primary health care (PHC) stresses prevention rather than cure. It relies on home self-help, community participation, and technology that the people find acceptable, appropriate,and affordable. It combines modern scientific knowledge and feasible health technology with acceptable effective traditional healing practices. Of special importance for women is that the effectiveness of PHC should depend very much upon community acceptance of the primary health care policies, with the participation of the community.

Other basic concepts drawn from the study were summarized as follows: Primary health care should be shaped around the life patterns of the population; it should both meet the needs of the local community and be an integral part of the national health care system; preventive, promotional, and rehabilitative services for the individual, family and community need to be integrated; majority of health interventions should be undertaken as close to the community as possible by suitably trained workers; the balance among these services should vary according to the community needs and may well change over time; the local population should be involved in the formulation and communication of health care activities; decisions about the community's needs and solutions to its problems should be based on a continuing dialogue between the people and the health professionals who serve them.

These concepts were not new, but it was not until 1977 that they were put together as a comprehensive strategy. Furthermore, based on qualitative results from countries where the principles had been applied and found effective, primary health care was put

forward at a conference not as one alternative but as possibly the only alternative, and the world's top health authorities agreed.They adopted primary health care (PHC) as the strategy most likely to meet the health needs of the majority of the world's population.

Thus, at Alma-Ata previously accepted approaches to medicine were figuratively turned on their head.Curative medicine would in the future take second place to prevention. Representatives from all countries in attendance signed the "Declaration of Alma-Ata" and pledged to return home to start chaneling funds to primary health care and to shift from central control toward regional and district control. These were drastic changes that, if implemented, would begin to empower people to take charge of their own health care. Such a dramatic shift in thinking and action, however, would require something that was not always forthcoming: political will.

In all these discussions, value will be added if this work examines a few primary healthcare policies in Nigeria. According to CIA World Factbook (2004), in August 1987, the federal government launched its Primary Health Care plan (PHC), which President Ibrahim Babangida announced as the cornerstone of health policy. Intended to affect the entire national population, its main stated objectives included accelerated health care personnel development; improved collection and monitoring of health data; ensured availability of essential drugs in all areas of the country; implementation of an Expanded Programme on Immunization (EPI); improved nutrition throughout the country; promotion of health awareness; development of a national family health program; and widespread promotion of oral rehydration therapy for treatment of diarrheal disease in infants and children. Implementation of these programs was intended to take place mainly through collaboration between the Ministry of Health and participating local government councils, which received direct grants from the federal government.

Out of these objectives, the EPI (Expanded programme on immunization) was the most concrete and probably made the greatest progress initially.The immunization program focused on four major childhood diseases: pertussis, diphtheria, measles, and polio, and tetanus and tuberculosis. Its aim was to increase dramatically the proportion of immunized children younger than two from about 20 percent to 50 percent initially, and to 90 percent by the end of 1990. Launched in March 1988, the program by August 1989 was said to have been established in more than 300 of 449 LGAs (CIA World Factbook, 2004). Although the program was said to have made much progress, its goal of 90 percent coverage was probably excessively ambitious, especially in view of the economic strains of structural adjustment that permeated the Nigerian economy throughout the late 1980s.

The government's population control program also came partially under the PHC. By the late 1980s, the official policy was strongly to encourage women to have no more than four children, which would represent a substantial reduction from the estimated fertility rate of almost seven children per woman in 1987. No official sanctions were attached to the government's population policy, but birth control information and contraceptive supplies were available in many health facilities (Abdulraheem et al, 2012).

The federal government also sought to improve the availability of pharmaceutical drugs. Foreign exchange had to be released for essential drug imports, so the government attempted to encourage local drug manufacture; because raw materials for local drug manufacture had to be imported, however, costs were reduced only partially. For Nigeria both to limit its foreign exchange expenditures and simultaneously to implement massive expansion in primary health care, foreign assistance would probably be needed. Despite advances against many infectious diseases, Nigeria's population continued through the 1980s to be subject to several major diseases, some of which occurred in acute outbreaks causing hundreds or thousands of deaths, while others recurred chronically, causing large-

scale infection and debilitation (Abdulraheem et al, 2012). Among the former were cerebrospinal meningitis, yellow fever, Lassa fever and, most recently, AIDS; the latter included malaria, guinea worm, schistosomiasis (bilharzia), and onchocerciasis (river blindness). Malnutrition and its attendant diseases also continued to be a refractory problem among infants and children in many areas, despite the nation's economic and agricultural advances.

2.7 Women Participation in Development: A Global Overview

As a national and global concern, women's participation in development is gathering momentum in the world at large. This perhaps is due to the fact that the importance of women's participation in development has come to limelight. Before now, women were only viewed as mothers and housekeepers within development policies and programmes, their participation and contributions were ignored and sidelined, development planners and facilitators regarded women as passive participants, invisible and less receptive to development interventions, their voices were absent and so poor participation in development intervention. It is not suprising that since the Beijin 1995 declaration, different strategies have been mapped out to improve involvement of grassroot women in development process.

According to Olaitan (2001), "women are essentially disadvantaged in the society; it is almost axiomatic to remark about their lack of significant representation in important societal processes"

The disadvantages suffered by women are so pervasive and universal that the international system, especially through the United Nations...has had to specially focus on, and seek to address the problem. This is the sense in which there have been international conferences on women and their interests, particurarly the last one in Beijing in September 1995, to articulate issues of concern to women, and seek for ways of significantly involving

them in societal processes, while also significantly reducing their disadvantages and oppression (Olaitan, in Sesay and Odebiyi, 2001:73)

It is noteworthy however, inspite of all these international concerns and efforts, women remain overwhelmingly disadvantaged and insignificantly represented in many spheres of life.(Ojobo, 2001:56)

Women in development is a priority issue as observed by Prata (2010), because women perform both reproductive and productive roles, thus sustainable development has to be women centered, since in many countries, most women shoulder the burden of health implications. It should therefore be considered a development issue.

Increasing women's participation in primary health care policy formulation and communication will boost efficacy of health communication among grassroots women because they are directly involved, as well as bringing about sustainable development, and significantly reduce cases of women seclution in development worldwide (Delia, 1999).

For sustainable development to be achieved in economic, social and cultural sector, no fraction should be sidelined, ignored or given passive role in development process. It therefore, connotes that all necessary apparatus must be on ground for adequate participation of marginalised groups most especially (Women and Children, World Bank, 2009).

Women have been involved in various levels of development be it at the national, grassroot and international, but as Ojobo, (2004) rightly pointed out that women participation in development intervention is inadequate, and this situation has warranted several movements seeking for emancipation of women from inadequate participation. This uproar is not only predominant in developing countries but in the world at large. Particularly in Nigerian and other African countries women have participated in few stages of the country's development from the Colonial Period through the Post-Colonial Period.

However, it is important to state that majority of women demand for adequent represent and participation whether in politics; social-economic platforms can be summed up in the concept of Feminism and womanism.

In Nigeria, Feminism according to Adamu, (2006) has been a distant tool of intellectual discourse and political action to the majority of women scholars and activists in Sub-Saharan Africa. Today, this notion has changed dramatically because women in African have not only embraced the ideology of feminism but they have gone far ahead to transform it to meet the tenets of the African society. Various nomenclatures given to it, it is invariably obvious that they have divergent views and ideology.

In Nigeria, records of women's struggles to correct acts of discrimination and violence have been in existence since the 19th century. Nigerian women have been recognised to play significant roles in anti-colonial struggles. The struggles during the National Independence and social modernisation also resulted in the formation of women's movements. The colonial era revealed active participation of women in activities aimed to better their lot. The intervention of women in social and political landscape helped to improve their status at the grassroot, national and regional levels. In Nigeria, women have been involved in various movements and activities in their own ways even though such movements were not identified or labeled with any specific name.

At the early stages, feminism as a concept attracted negative connotations, and usually feminist women were usually associated and/or stigmatized as being, 'men haters', frustrated or divorced women with nothing better to do but 'cause trouble'. In view of this Feminism gained attention in Nigeria as a result of different attempts made by women to secure and sustain equal rights and opportunities for women. The prevalence of unequal power relation resulting in disproportionate distribution of rights and privileges to women

has been a great issue of concern leading to different interventions by individuals and women's groups to eradicate such concepts.

Feminism in Nigeria emerged out of the demands of women to improve women's status and eliminate debilitating factors that deprive women of enjoying their full human rights. Historically, women in Nigeria have faced a wide spectrum of experiences in navigating through several hindrances that have confronted them. The culture of patriarchy, male chauvinism and anarchy has undermined the rights of women and the outcome of this is the exploitation and marginalisation of women in the affairs of development both at the private and public spheres.

It is assumed that if women are given near equal opportunity in participation at all levels, that meaningful development would be achieved. From the emerging global issues, there are indications that women are playing participatory roles in global development today. At the regional level, especially in Africa, the anticipation of women's participation is fast being acknolwegde even at the level of governance and policy formulation, although many still believe that it is grossly inadequate especially in primary health care areas.

2.8 Women and Development of Primary Healthcare Policies in Nigeria

Women's participation in health communication is a sine-qua-non for sustainable development of health communication in Nigeria, and an opportunity to develop their individual capacities (Anifowose,1999)**.** Ideally, active participation of women in primary health care involves the decision that has to do with their lives. Women's participation in health communication involves activities such as involvement in drafting communicating strategies, being active from the stage of conception until the evaluation stage.

However, the pursuit of this essential principle in development, according to Khan (2004), shows that women are generally left behind. Most times the women are seen, but not heard in health issues. In the hierarchy of development strides, they are at the lower

ladder as a circumstance of either cultural or patrachial system associated with participation. They are seldom involved in national programmes, and even when they do, it is at the peripheral level. (Anifowose, 2004). The assumption that development planners make about women in society is almost never stated. This is obviously a challenge which no government can afford to ignore, more importantly, it has become increasingly clear that development or progress in people's welfare cannot be achieved where the needs and contribution of half of the world's population (women) are continually downgraded, marginalised or completely ignored (Bamidele:2000)

However, a cursory look at the pattern of women's involvement in health communication in Nigeria reveals abysmal low levels. Inspite of all the quest for their participation, the objectives and benefits, Nigerian women still suffer a lot of constraints which millitate against their personal and national development. The passive role assigned to women in development especially in developing countries, and Nigeria has been so entrenched that the growing concern with the plight of women has not been able to easily dislodge it.

According to Ojobo (2001:116), Women are less well informed about issues of development and less able to be exposed to health communication and less likely to be concerned with patricipation in development intervention because of the way they are being regarded in the whole process.

Various policies and interventions in primary health seems to prepare the necessary measures to ensuring that women are adequately taken care of, especially as primary health have much concern for women and children. The area that concerns governments, NGOs and international donor agencies such as W.H.O. and UNPF is in the child and maternal health. For instance, statistics of June 2011 states that maternal mortality rate per 100,000 births for Nigeria in 2010 was 840. This is compared with 608.3 in 2008 and 473.4 in 1990.

The less than 5 mortality rate, per 1,000 births is 143 and the neonatal mortality as a percentage of under 5's mortality is 28. To address this alarming situation, several bodies, international and local have fashioned out strategies and policies to reduce child mortality and improve maternal death. In Nigeria, policy making in health is considered as serious business because the goal of Primary Health Care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade. According to Abdulraheem et al. (2012), the following issues tends to inundate or shroud the achievements of these policies owing largely to the following reasons namely lack of political will/attitude to public policy implementation, poor implementation design, conception and discipline, poor program leadership and management, lack of resources, corruption, sectionalism and ethnic biases, egocentrism and duality/multiplicity of public policies, cultural and religious factors, selective and non-implementation budgets and misplaced priority are the paradoxes of public policy implementation, which has continued to militate against public policy success in the country.

In all these factors, scholars, female activist and feminists are worried and are assertive that women who are predominantly the major beneficiaries of primary health care are not given adequate opportunity to contribute in what really concerns them at the level of policy making. This has however generated debates which is basically premised on the platform that governments marginalization of women in playing key and active role in politics, health, education etc has resulted in less representation in policy making especially in the areas of health is appalling.

However, what seems to be overtly conspicuous in terms of participatory gap is the fact women are often not squarely involved in the policy planning as well as implementation and general framework. A lot of arguments have ensued in the direction

that women's roles are not limited to domestic responsibilities and the fact that women play significant roles in nation building and ought to be given opportunities to contribute meaningfully in nation building processes such as policy formulation. The argument in favor of women is centred on the assumption that the prevalence of unequal power relation resulting in disproportionate distribution of rights and privileges to women has been a great issue of concern leading to different interventions by individuals and women's groups to eradicate such concepts. This is against the background that women have in no small measure advance the course of this country especially struggles to correct acts of discrimination and violence which have been in existence since the 19th century. Formation of women's movements has led to several interventions by women in social and political landscape which has further helped to improve their status at the grassroots, national and regional levels. Worthy of mention is the ideology of Feminism in Nigeria which emerged out of the demands of women to improve women's status and eliminate debilitating factors that deprive women of enjoying their full human rights. According to Adamu (2006) women in Nigeria have faced a wide spectrum of experiences in navigating through several hindrances that have confronted them. The culture of patriarchy, male chauvinism and anarchy has undermined the rights of women and the outcome of this is the exploitation and marginalization of women in the affairs of development both at the private and public spheres.

Recently, however, more women in most countries and particularly in Nigeria are beginning to get involved and participate in development intervention, but as Anifowose (1999) rightly pointed out, their participation is still at the peripheral level. Women are being manipulated in development process. A process he described as detrimental to health development in Nigeria.

This study aligns with the need to involve women in primary healthcare communication but very importantly, it looks beyond just involving women in the process of primary health communication, but active participation with diverse women groups across communities, because only by forging interactions among diverse groups with divergent views can genuine participation and development processes be forged.

2.9 Theoretical Framework

Theoretical framework is an important aspect of every research. It provides the platform from which issues in the research can be examined and even analysed. Therefore, it is imperative that researchers should adequately provide theoretical basis for their work. In corroboration of the above assertion, Daramola (2003: 29) posits that theory is a statement of prediction or a symbolic construction based on individual view point about an explanation for something. Wilbur Schramm (1963) describes theory as a "Crap detection", which enables us to seperate scientific statements from unscientific ones. Therefore a theory can be understood as a set of ideas of varying status and origin which may be used to explain or interpret some phenomena.

Kerlinger as cited in Anaeot (2008:90) defines "a theory as a set of inter related constructs, definitions and prepositions that give systematic view about "phenomena" by specifying relations among variables with the purpose of explaining and predicting such phenomena. The theory has helped the researcher in guiding, understanding, interrogating, discussing and explaining issues surronding women's participation in Kebbi State. Based on the importance of theoretical framework, the following theories have been selected to guide and underpin this work. They are:

i. The Participatory Communication Theory and

ii. The Nair-White transactional model of communication

The need for these two theories is to underscore the importance of participatory communication framework which forms the nexus of this research. In addition, the main goal of participatory communication is to empower local communities to manage their own development and in this sense, it is considered as people oriented activity and mechanism that allows an open participatory dialogue between sender and receiver as opposed to the usual unidirectional and vertical message transmission. It stressed further the need for dialogue with rural people in dissemination of a particular idea.

Participatory Communication Theory

According to Anaeto *et al* (2008) the participatory communication theory emanated from the ideologies of Paulo Freire in 1970. He explains that the participatory approach to national development arose to replace the modernisation theorists' emphasis on knowledge diffusion and technology transfer. It places its highest value not on transfer of knowledge from outside developing societies, but rather on reliance upon local knowledge and local capabilities. Rather than encourage residents of developing societies to participate in development initiatives planned by outsiders, it encourages residents to make their own plans. Based on this theory, participatory projects began in the 1970s and focused on self-determination and empowerment. Theoretical studies have endeavoured to determine what exactly compromises participation and how participation can be effectively accomplished.

Servaes (1999) posits that communities and people should be main actors of all the processes of social change rather than being passive beneficaries of decisions made in far away offices in urban areas. Secondly participatory communication is a process that "no longer attempts to create a need for people, especially for the information one is disseminating, but rather disseminates information for which there is a need".(Servaes 1999:50) Contrary to the persuasive goals of diffusion of innovation approach, true participation encourages the development of a country "within its cultural and enviromental

framework".(Servaes 1999:50) When women are given opportunity to be part of formulation and communication of primary healthcare processes in development, they will feel a seense of belonging, thereby giving their best to achieve sustainable development, but in a situation where they are made to cooperate in what has already been researched and planned on their behalf, little or no success is achieved.

Participatory communication theory is an approach capable of facilitating people's involvement in decision making about issues impacting their lives – a process capable of addressing specific needs and priorities relevant to people and at the same time assisting in their empowerment. Infact, participatory communication is "a necessary component, consistent with a democratic vision of international development, needed to increase projects sustainability and ensure genuine ownership by the so-called "beneficiaries".

Promoting the sustainable and systematic use of communication approach in development process helps to ensure people's participation at all levels, as part of an effort to involve them helps to increase greater participation. Participatory communication is a term that denotes the theory and practice of communication used to involve people in the decision making of the development process. It intends to return to the roots of its meaning which similarly to the term communicate originate from the Latin word communis, i.e common (Mody,1991). Therefore, the purpose of communication should be to make something common, or to share meanings, perceptions, world views or knowledge.

In this context, sharing implies an equitable division of what is being shared, which is why communication should almost be naturally associated with a balanced two-way-flow of information. The participatory communication theory sees people as the controlling actors or participants for development. People will have self-appreciation instead of self-depreciation; the approach sees people as nucleus of development. Development means lifting up the spirits of local community to take pride in its own culture, intellect and

environment. Development communication research embraced participation virtually as a panacea for development (Servaes 1992).

To be genuinely participatory and truly effective, communication should occur among all patries affected, ensuring all have similar opportunities to influence the outcome of the initiative. Optimally participatory communication should be part of the whole development project process, from beginning to the end. Since this approach promotes the active involvement of stakeholders in investigating options and shaping decisions regarding development objectives, participatory communication also facilitates sustainability. In this way the effects go beyond the project boundaries, spilling into a sustaining force that remains with the individual.

Participatory theory considered necessary redefinition of Development Communication. One set of definitions stated that it meant systematic utilization of communication channels and techniques to increase people's participation in development and to inform, motivate, and train rural populations mainly at the grassroots. Participatory Communication identified encouraging participation, stimulating critical thinking, and stressing process, rather than specific outcomes associated with modernization and progress as the main tasks of development communication (Altafin 1991). Participation needed to be present in all stages of development projects. Women in rural communities should be encouraged to participate in decisionmaking, formulation, communication, implementation and evaluation of health policy projects. This can give a sense of involvement in their lives and communities, and provide them with a sense of ownership and skills that they can use beyond the timetable of development projects (Kavinya Alam & Decock 1994). Community participation is a vital ingredient in successful development projects; this is due to the acknowledgement of an entire generation of "top down" projects.

The Nair-White Transactional model also gives credence to most of the features of participatory theory/paradigm. The Nair-White transactional model enumerates its tenets thus.

i) The model rests on the assumption of dialogue opening, with the source and receiver interacting continously, thinking constructively about a developmental need, and deciding on what is to be done about the situation, and acting together on it.

ii) The model incorporates concepts such as bottom-up development, grassroots involvement, participatory decision-making, power sharing, indigenous knowledge participatory message development, citizen empowerment, team building, interpersonal trust, dynamic dialectical process, interface of top-down and bottom-up information flow.

iii) The model seeks to integrate the "top-down and "bottom-up and unite them through effective communication.

iv) The model is intended for development and renewing societies of the world where there is a widening information and socio-economic gap between the rich and the poor (Nair and White,1999).

v) The entire model embodies a communication process which takes into account indigenous knowledge and self-reliance gained through increased information access and acquisition, facilitated by external experts. Inherent in the participatory approach is making people feel being, 'a part of the process'. In the transactional model, the basic elements-source, message,channel and receiver are combined with organisational and socio-cultural change interfaced by process of communication and participation.

The model conceives development as a social process implying participatory communication that facilitates horizontal exchange of information among all parties involved mostly driven by dialogue. The outstanding approach in participatory communication is dialogue, and therefore, planning of development projects that claims to be participatory can no longer be decided in urban areas, but with the relevant stakeholders in their communities. The transactional model is relevant to the study because it emphasizes on people taking initiative to participate in activities that will enhance their development. The participation of women in health policies will lead to personal development, self sustenance. The model encourages a practical approach to peoples development processes while participating in development process.

Applying this model to this study it strongly encourages small scale community actions such as taking active step in contributing to primary healthcare formulation and communication. Hence, it encourages the participation of the majority of the population, especially women, the youth, the illiterate and marginalised in the process of development (Coetzee & Graaff, 19696). Thus, the model is in line with the design, implementation and evaluation of development as a programme for continuity and sustainability.

The research strongly advocates active mainstreaming of women in primary health communication research and development by relevant development agencies. This can not only enhance the smooth and willing adoption of primary health care policies that are introduced to women but can also build their capacity to contribute effectively to research, communication and primary healthcare policy development in Nigeria.

CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction

A methodology is a strategy which a researcher follows in order to gain knowledge of study phenomena and it broadly consists of the quantitative and qualitative approaches. Omika (2003:58) observes that "since research is a process, there is the need to follow sequential steps before arriving at a solution". He adds that to achieve the desired objectives of research, there is a need to determine what is to be done and how it is to be done. The study was conducted in order to examine and evaluate women's participation in communicating Primary Health Care policy using Kebbi State as a case study. To be able to gather the necessary data, the researcher utilised the descriptive survey research, using qualitative approach. Herein, the chosen respondents were purposively selected from two local government areas of Zuru and Danko-Wasagu in Kebbi State.

The credibility of findings and conclusions extensivey depend on the quality of research design, data collection, data management, and data analysis. This chapter is dedicated to the description of the methods and procedures done in order to obtain the data, how the data was analyzed, interpreted, and how the conclusion were met.

3.1 Research Design

Nworgu (1991) describes research design as a plan or blueprint which specifies how data relating to a given problem is collected, collated and analyzed in a study.

Hence, qualitative research design is adopted for this study and the adoption of qualitative research approach for the study helped the researcher to go indepth in understanding the world-views of the research participants, as well as the degree of the impact of participatory communication processes which numericals cannot adequately capture. The adoption of qualitative approach also provided an opportunity for the

researcher and the research subjects the possibility to ask questions and clarify issues when the need arose.

3.2 Instrument for Data Collection

Some research scholars have suggested a series of research methods in a single study-that means combining two or more research instruments (triangulating). This process of multiple techniques in gathering of data can easily strengthen the objectives of the study. It is in the light of this that researcher employed the Focused group discussions, (FGDs), interviews, observation method, documentary observation and the use of library. This combination of instrumentation provided the researcher with the opportunity of getting data to do an analysis of the role of women in communication of primary healthcare policy in Kebbi State.

3.2.1 Focus Group Discussion (FGD)

Focus Group Discussion according to Wimmer and Dominic (2003) is a qualitative research strategy which is aimed at understanding people's attitudes and behaviours. They further pointed that it involves the interview of six to twelve people in a group who share certain characteristics, quality, or interest. This may be streamlined along behaviour, gender, age and language, among many others (Wimmer and Dominic, 2003). It can be used for collecting information about attitudes, behaviours, ideas and beliefs in a community/setting.

The Focus group Discussion (FGD) or group interviewing is a research strategy for understanding audiences attitudes and behaviours. The primary advantage of FGD is that it can be conducted very quickly for collecting large amount of data. It also allows the researcher some flexibility in question design and follow- up.

Ajala and Taylor (2009:11) highlight the imperative of FGDs in a study of this nature. They pointed out that FGDs are apporiate when you want to explore the depth and

nuances of opinions regarding an issue; understand the differences in perspectives and what factors influence opinions or behaviour, as Adeniji (2001) argues, that FGDs lead to uncovering of deeper meaning and truths, as the facilitator can dig deeper, thereby getting responses that can highlight and illuminate reasons for actions.

This study therefore, took the above into consideration by engaging women and men groups and other stakeholders in Zuru and Danko-Wasagu Local Government Areas in Kebbi State respectively. 10 different groups comprising of 10 members in 6 communities in Zuru and Danko-Wasagu were engaged in focus group discussions and 38 members for indepth interview, so as to have an in-depth knowledge of the communities in relation to women's participation in Primary Health Care Communication in Kebbi State.

Areas of Focus Group Discussion

The issues the research discussed include the following:

The knowledge of primary health care communication by women in Kebbi State.

i. Women's participation in primary health care policy issue in Kebbi State.
ii. The role women play in primary health care communication in Kebbi state.
iii. The extent of women's participation in conceptualisation, formulation, planning, implementation, monitoring and evaluation of primary healthcare policy.
iv. Factors hindering adequate participation of women in primary health care policy issue in Kebbi State.
v. How lack of participation affects women.
vi. How these challenges can be addressed, and how women participation can be encouraged and sustained in the areas understudy.

The Focus Group Discussion in this research was to ascertain the role of women in health policy making in Kebbi State. The study therefore took the above into consideration by engaging women and men in the selected communities. focus group discussions was done

in each of the communities of Ribah, Chonoko, Waje, Unashi, Diri-Daji and Senchi communities, because of high rate of maternal and child mortality in the communities. Each group had from 8-12 pople, and the group discussion was done in Hausa language with the help of another interpreter who translated in the local language dominant in the visited communities. As the moderator, the researcher was able to listen, observe, ask questions and also keep the group on track.

3.2.2 In-Depth Interview Method

In-depth interview can be seen as the conversation between two or more people where the interviewer (researcher) asks the interviewee questions in order to obtain information (Dennis,1999). It enables a dialogue with the specific aim of getting specific information. In view of the above, the researcher therefore, used the structured face to face interview methods which needs to follow laid down pattern of asking questions.

This method is very suitable for this research because of its nature, it is one of the reliable way of getting data for the study.

In-depth interviews were conducted with rural women and men groups who are beneficiaries of primary healthcare facilities, and also primary healthcare workers in the communities, in other to have their general views on extent of women's participation in primary health care policy formulation and communication. This process gave the researcher first hand information from women, because women are key factors in this study. The use of interview also served as an opportunity for interviewer to explore unexpected issues and it gave more detailed information on the issue under study. The interview had an interpreter and all sessions were recorded with the agreement of participants.

3.2.3 The Observation Method

Observation is a process by which researchers establishes a link between reality and people's assumption. (Marias 1990) It is an in-depth approach which gives understanding of values, motives and practices of those being observed (Chilisa 2005).

The observatory aspect of this research covered the role and extent of women's participation in Zuru and Danko-Wasagu Local Government Areas of Kebbi State, which accounts for high maternal and child mortality in the state. Women as well as views of men and some key primary health workers were observed. It was observed that women were not actively involved in primary health care research processes through responses by women. The women discussants were reluctant to identify with primary healthcare policies available, because most of the discussants affirmed that it is an outsider idea brought for them to consume.

3.2.4 Documents

Documents constituted another source of information which was utilised to enable the researcher discover information about specific situation and confirm or question other information collected. Existing documents and reports were valuable source of data for analysing organisations and the policy process because they constitute a record of "development and implementation of decisions and activities that are central to organisational functions". (Hakim,2000:46). Documents and reports were accessed from Centre of Excellence Library, A.B.U, Zaria. to obtain data on the extent of women's participation in primary healthcare policy communication.

3.2.5 Use of Library and Internet Sources

A communication research of this nature may be very difficult to achieve without using library and internet sources.The library proves to be very significant in the realisation of the study objectives.This was greatly employed to enrich the review of related literature,

and vital aspects of the research. The net is a tremendous resource, but must be used carefully and critically.

3.3 Guide for Analysis

Data collected from discussants were analysed, using descriptive technique analysis. Descriptive analysis is the collection of various data reports and describing them in an understandable form.The facts and ideas gotten were discussed thematically with other prevailing issues in the study.

CHAPTER FOUR1
DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter will bring into limelight the presentation of the findings and analysis derived from the data collected. A total of 138 discussants were engaged in Focus Group Discussions and indepth interviews from different groups in the communities. Initially 180 discussants were targeted but only 138 participated because of cases of absenteeism.

Participation in health and development communication programmes can strengthen the voice of ordinary citizens and ensure their involvement in decisions that affect them, their families and their communities. Those directly affected by issues in any health intervention have wisdom, abilities, and experiences which the intervention should build on and not displace.

It has been noticed by participatory research scholars that when people participate actively in matters that affect them, there is the possibility of having sustainable solution to the problem. To achieve this praxis, it is necessary to trust in the participants/ stakeholders' ability to reason (Freire 1971:66)

This chapter focuses on the issues, problems and prospects of women's participation in formulating and communication of primary healthcare policy in Zuru and Danko-Wasagu Local Government Areas of Kebbi State because of high rate of maternal and child mortality in the 2 Local Government Areas. Some very critical issues that this study sought to examined is the extent of women participation in selected local government areas of Kebbi State, and suggest ways through which women greater participation in health communication can be achieved and sustained. Therefore the objectives of the study are highlighted below.

1) To identify and examine the extent to which women actively participate in communicating primary health care policies within the Local Government Areas under study.
2) To evaluate factors that hinder women's active inputs and committment in formulating and communication of primary healthcare policies within the 2 Local Government areas understudy.
3) To critically examine how primary health care policies are communicated to women within the study area.
4) To suggest ways through which women's greater participation in health communication can be achieved and sustained.

4.1 Brief History of Kebbi State

Kebbi State is a state in North-western Nigeria. Its capital is Birnin Kebbi. The state was formed from part of Sokoto State in 1991. The state is bordered by the new Sokoto State, Niger State, and Benin, and has a total land area of 36,800 km. Kebbi State is divided into 21 local government areas, four emirate councils (Gwandu, Argungu, Yauri and Zuru), and 35 districts.

Kebbi State shares boundaries with Sokoto State on the North-Eastern axis, Zamfara State on the Eastern part, Niger state on the Southern part and Republic of Niger on the Western part.

Kebbi State came into being on August 27, 1991. It was created out of the old Sokoto State. The capital is Birnin-Kebbi. Its major towns include Birnin-Kebbi, Argungu and Yelwa with a population of 2,062,226.

The state has 21 Local Government Area: Birnin Kebbi, Yauri, Sakaba, Wasagu, Danko, Zuru, Koko-Besse, Bagudo, Dandi, Suru, Maiyama, Jega, Bunza, Arewa, Gwandu, Argungu, Aliero, Augie, Fakai, Shanga and Kalgo. Kebbi State is Mainly populated by Dakarkari, Fakawa, Dukkawa, Hausawa, and Fulani. Hausa is the commercial language among the people in the main town but those in the villages communicate mostly in their local language.

Kebbi state is a cultural society like every other state in Nigeria where culture is revered and held in high esteem. People from basically all the local government areas have their distinct cultural activities which they hold in high esteem. These cultural activities are still celebrated till date not just for entertainment but because they are part of the people's cultural make up. The activities include the famous Argungu fishing festival celebrated with pomp and pageantry, the Uhola festival, the Yadato and Dibiti festival. The people of Kebbi state are primarily farmers producing food and cash crops.

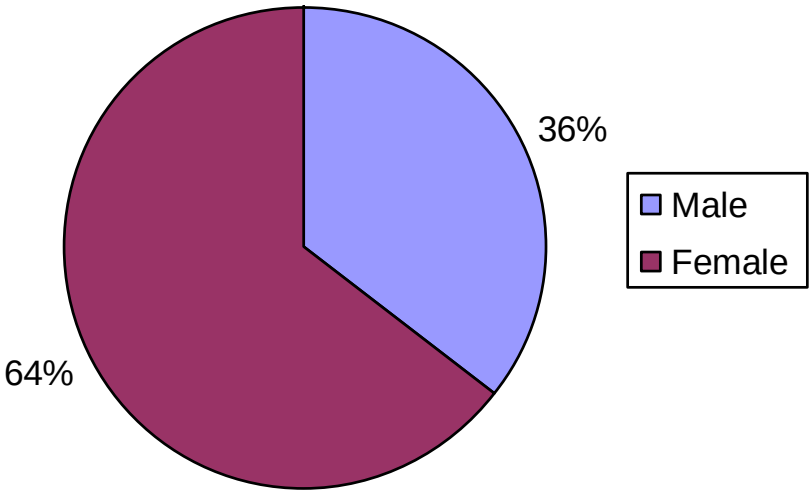
4.1 Characteristics of Focus Group Discussants

The table below gives characteristics of discussants groups of women and men groups from all the six communities of (Ribah, Chonoko, Waje, Unashi, Dirin Daji and Senchi) through whom data was collected for the study. The table gives information about discussants sex, educational and religious background.

Table1: Sex of Discussants

Sex	Ribah Community	Chonoko Community	Waje Community	Unashi Community	Dirin Daji community	Senchi community	Total
Male	9	6	5	8	9	12	49
Female	19	12	7	16	15	20	89
Total	28	18	12	24	24	32	138

Source: Field Study, 2014



From the information on Table 1 in terms of sex, the table clearly shows that female discussants were more than half of the population. The reason for this was deliberate because the issues raised in the study directly affect the women and their opinions were more crucial to this study. The researcher observed during discussions that some of the male discussants were reluctant to give full cooperation because they considered the issues raised in the study not related or less important to the men folk.

From the information on Table 1, the expected sample size of one hundred and eighty (180) respondents for the Focus Group Discussions (FGD) was not achieved. This was due to cases of absenteeism by some of the discussants earlier chosen to take part in discussion. However, 138 discussants participated which stands for over 70% of the initial target sample size and thus large enough for analysis and interpretation of the data collected.

Table 2: Educational Background of Discussants

Educational Qualification	Ribah Community		Chonoko Community		Waje Community		Unashi Community		Dirin Daji Community		Senchi Community		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
Never Attended Primary School	2	5	1	2	1	1	1	3	1	3	1	3	24
Primary	2	4	1	2	1	2	2	5	2	4	3	6	34
Secondary	3	7	3	6	2	3	3	6	4	6	5	8	56
NCE/Diploma	1	2	1	2	1	1	1	2	1	2	2	3	19
B.Sc	1	1	-	-	-	-	1	-	1	-	1	-	5
Postgraduate	-	-	-	-	-	-	-	-	-	-	-	-	-
SUB-TOTAL	9	19	6	12	5	7	8	16	9	15	12	20	
GRAND TOTAL	**28**		**18**		**12**		**24**		**24**		**32**		**138**

Source: Field Study, 2014

F = Female
M = Male

Table 2 shows that most of the discussants have gone above primary education, thus able to give useful information.

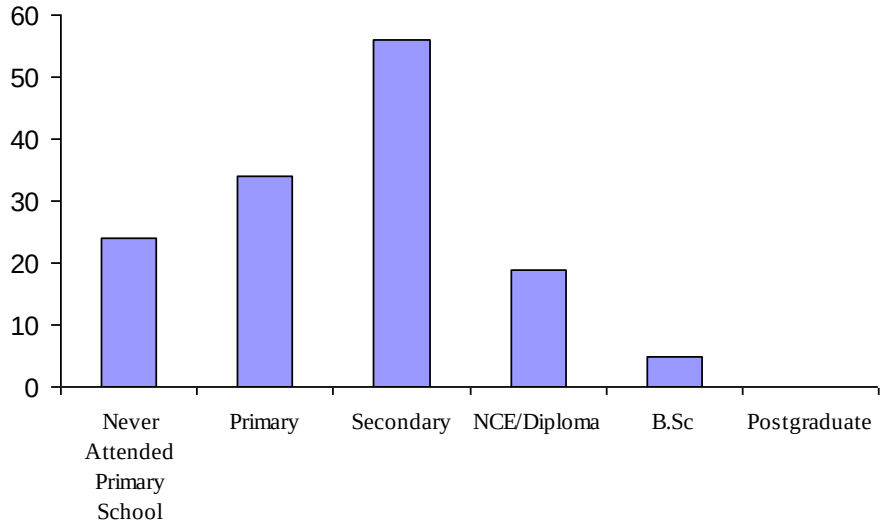
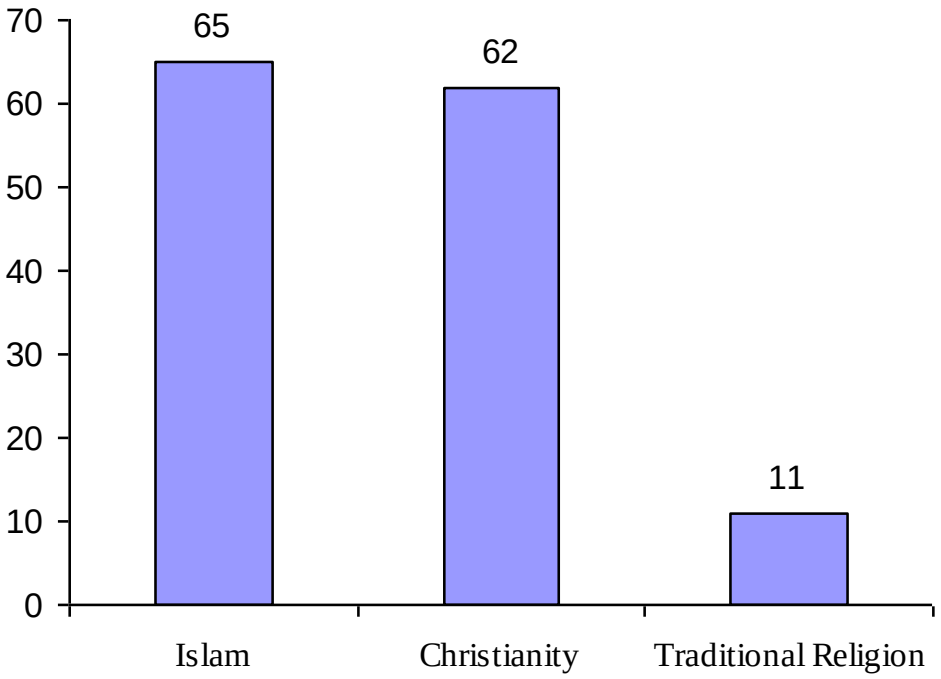


Table 3: Religious Background of Discussants

Religion	Ribah Community		Chonoko Community		Waje Community		Unashi Community		Dirin Daji Community		Senchi Community		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
Islam	5	8	4	6	3	5	5	7	4	7	6	8	67
Christianity	4	9	2	5	2	2	3	8	5	6	6	9	62
Traditional Religion	0	2	0	1	0	0	0	1	0	2	0	3	9s
SUB-TOTAL	9	19	6	12	5	7	8	16	9	15	12	20	**138**
GRAND TOTAL	**28**		**18**		**12**		**24**		**24**		**32**		

Source: Field Study, 2014



Religion is a very important socio-cultural factor in Nigerian society. It serves as motivation for what people believe and practice and so can be an effective determinant of society's response to how people perceive development. Religion influences cultural and social beliefs of people in every known society. Table 3 shows that 67 discussants represent the Islamic faith, 62 discussants represent the christain faith, while 9 discussants represent

traditional faith respectively. Thus, there was a balanced perception on how religion and traditions affect women's active participation in development process.

4.2 Data Presentation, Analysis and Interpretation

Data collected were analyzed and presented thematically according to the research checklist provided below.

Women's Participation in primary health care policy formulation and communication in Zuru and Danko-Wasagu L.G.A.S of Kebbi State.

This theme is aimed at achieving the objective of identifying whether women participate at all in health communication. In a focus Group Discussion with women in Danko-Wasagu Local Government in Dirin Daji Community, 60% of the discussants agreed that women should participate in primary health care policy formulation, to them the number of women workers in primary healthcare centres is in their own understanding participation. For them, since most health workers are women, they have a feeling that those women are the ones making health policies for them.

In contrast, 20% women among the group in Dirin Daji community, during the Focus group discussion, argued that having more women in healthcare centres as health workers does not mean participtiion. The 20% women disagreed that women participate in policy formulation regarding primary healthcare policy such as maternal and child health policy, reproductive health policies in the state. They 20% revealed that, there is minimal women participation, because most health interventions come from people "above**"** **(**development experts**)** who carry out their desktop research and do most of the thinking for women who are considered mostly as ignorant and unfit to take part in health policy process.

Also 20% of men in focus group discussion in the same Dirin Daji community rated women participation in health policy making very low, they maintained that a handful of

women just help in carrying out policies that have been formulated by others in far away offices in urban areas.

Although communities like (Senchi, Ribah, Dirin Daji and Unashi) where Focus Group Discussions took place, earlier agreed that women participate, they took another position, when the researcher probed further about their active participation in health policy making, in the context of formulation, communication, implementation, and evaluation. 70% of the women and men shared the same view that women are not fully involved in the initial stages/process of policy making. It emerged that women were not actively involved in health policy formulation and communication. It also sprang up that women were mostly involved at the evaluation stage. 80% the women concurred that they only got to know about a policy at the concluding phase of the intervention, mostly at the evaluation phase. Here, it has clearly been revealed that it is not a question of participation, but rather the extent/level of women participation as seen from the various responses. The health development experts defined both problems and solutions and mostly tried to modify the solution to women responses. This participatory process do not allow any share in decision making. One of the women discussant during an individual interview in Ribah community captures the issue in this light.

> … Nobody has ever come to ask us of our input; what and what we want to be included in the draft document of any health policy in the State. We only get to hear about any health care policy after it has been concluded. The development health workers believe we rural women cannot contribute any meaningful thing. At best we are made to use what has been prepared and documented from urban areas. People who do not understand our plights are made to think and act on our behalf. All these things we are using as health policy are somebody's ideas not ours
> **(**Interview with Mallama Sabatu Dauda a health care attendant in Ribah community.**)**

These findings imply that the extent of women participation in formulation and communication is shallow and limited. It also indicates that the woman is treated as a recepient of already made primary healthcare policies, rather than a partaker in the decision making process. When women are involved in all the processes of healthcare policy making, there are no assumptions as to what their needs are; their needs are put into perspective in whatever health policy that will eventually be formulated. 65% of women asserted that women did not comply with the primary healthcare policy because they were not part of the process that gave birth to the idea.

The extent of women's participation in conceptualization, formulation, communication, planning, implementation, monitoring and evaluation of primary health care policy

The study sought to know the extent at which women actively participate in health policy making issue. 70% of the discussants in (Ribah, Senchi, Dirin Daji, and Unsahi communities) where the Focus Group Discussion took place agreed that women have been marginalised when it comes to the above mentioned chain/processes of health policy issues. 50% discussants (men and women) agreed that the level of women participation in policy making issue is very shallow and passive. When probed further, responses of some female discussants 55% revealed the level of women participation in policy making in Kebbi is at its lowest ebb (inadequate). Therefore, there is a limit to women participation in these communities and in the state at large because of high level of marginalization of women in health policy issues. One of the women in Senchi community has her submission on women participation like this

> .....Nobody wants to come up and engage women,but they are always calling for women participation, is it not when they come to us that we will participate? or do people participate in things they do not see?
> (Interview with women leader Hajiya Hussey Nasiru in Senchi community).

The responses from the discussants have futher revealed that there is passive participation of women in primary health policy formulation and communication in Kebbi state. At best women were made to use what has already been documented as healthcare policy. Thus women participation in development issue is always celebrated on paper, but her right to participate in matters that directly affect her is being denied her. The woman as an end user of primary healthcare policies is intelligent enough and knowledgeable about her health and environment to know what works for her, and what will not. Therefore, it is not about result of adopting a process especially as regards health and well-being of an individual, but also about processes leading to the end.

The discussants clearly stated during Focus Group Discussions and Indepth interview that much is still expected from the government in Kebbi state through its programmes and policies to enhance women's greater participation in their various local government areas and communities. The skeletal nature of women participation in healthcare discourse and health policy formulation and communication is very alarming due to cultural and religious hinderances. (Culture of Purdah.)

As Sanddrook and Halfani (1993:80) have noted that empowering women to participate in development implies that women will be accorded accessible opportunities to develop their individual talents and also contribute more meaningfully to societial development.

Factors hindering adequate women's participation in primary health policy formulation and communication in Kebbi State.

In focus group discussion in Senchi and Ribah communities, one strong factor the discussants emphasised to be a hinderance to women's active participation is the strong hold of religious and cultural issues which are inherent in the state. Women are believed not to be seen or heard, so there is no need to consult them. Religion and harmful

traditional practices have been used as manipulative tool to further keep women from corridors of participation in health policy issue. They explained that religion and culture has placed women as second class citizens that should not be heard or seen in public places, thereby making them hidden and inaccessible. These, according to discussants were enough reasons to limit women participation. Therefore, in many societies especially in northern Nigeria, women are limited by such age long practices, even till date. A male discussant in Ribah community expressed his views this way.

> Our culture is really taking women backwards....but we have little or nothing to do about it because we came and met it this way, and it will be very difficult to change what has been on ground.
> **(**Interview with Mallam Yakubu Rambo in Ribah community)

Another male discussant in Ribah community share his views on women participation in this direction.

> Our culture of has reduced women to mere spectators in issues that concern their general wellbeing, and this has taken them to the back seat. Our culture is really drawing women backwards.
> (Interview with Alhaji Musa Danbena in Chonoko community).

Similarily in a group discussion session, in Chonoko and Waje community, discussants also pointed low literacy level among women as another huge challenge encountered by women in the communities and most communities in the state at large. Most women are not literate. Lack of education of primary health issues keeps women from making meaningful contribution to health policy intervention targeted at them. The low level of formal education can affect effectively the realisation of active participation of women, because education remains the bedrock of any meaningful development.

80% of the discussants in Chonoko and Waje have same views on the issue, they acknowledged the fact that education gives women an edge over those who do not have. About 70% of the discussant mantained that only through education and conscientization

that women could have a louder voice in development and health policy formulation at the rural level, and also assist women to discover and develop new ideas, orientations and initiatives.

In view of the foregoing responses, 80% of the discussants in (Senchi, Ribah, Chonoko and Waje) also have the view that education of women should be given serious attention. One of the participants from the Focus Group Discussion (FGDs), a staff of General hospital Ribah asserted that the more a woman gets educated, the better chances she stands to contribute meaningfully in issues that concern her health and wellbeing. This agrees with Emecheta in Bamidele (2000:75) :

> In order to strengthen and enhance women participation efforts, African women need education, which will help them read and understand the world as well as control their own world. African women need education that will enable them form strong groups that will make them gain more control over their lives and break their traditional silence and make them visible.

The main issue here is that the state government must find a way to ensure that women's education does not just stop at primary and secondary levels. Another important challenge raised by discussants in Dirin Daji and Waje community is the issue of the concentration of health policy making in urban towns and allowing health development experts to decide on health policies that are not favourable to women. This is done through assumption by health policy formulators about women's health needs. This is done through formulation of policies that are not peculiar to the needs of rural women. When interviewed about factors hindering adequate women's participation formulation and implementation in Kebbi, a woman leader in Chonoko has this as her submission.

> … There are still high cases of maternal and child mortality in the state, they still abound in very high numbers because the women are in a better position to give first-hand information on how to curb these menace, but they are not consulted.
>
> *(*Interview with Hajiya Zegro Musa Rikoto in Chonoko community.)

Communication of Primary HealthCare Policies to women in Kebbi State

The study also found out the communication methods or means in the local government areas, through which primary health care policy formulation and communication are carried out, and to assess their effectiveness and accessibility to women. For most of the discussants, in Unashi, Senchi, Ribah and Dirin Daji**,** they have never been mobilised or called upon for any primary healthcare policy making. At best they only hear or see jingles and adverts on mass media (Mostly television and radio) which also the content of those messages are alien and mostly not able to comprehend the messages, and which accounts for shortfall in the participation of women, and these mediums have been queried by most development communication scholars as inadequate for achieving sustainable development. 75% of the women affirm that the jingles and advert means little or nothing to them, since they hardly comprehend the message content.

Rogers and Shoemaker (1971) criticize the trend of communication practice that concludes that communication means mass media. They insist that difussion of technology and ideas in the rural areas should be via interpersonal communication. They also argue that, print and other form of mass media alone have not be found to be effective for influencing rural society. To be effective, it must be utilised in connection with other media like folk media which involves listening and participation, and should be presented in simple, clear and concise language, that rural women can understand. Media programmes must not be universal but people centered particurarly in content and context. Hence, communication scholars called for a blend between mass media and other indigenous media of communication, which the people are familiar with like folk media and other interpersonal channel that will give the desired results in achieving sustainable development.

Folk media embraces the cultural, social, philosopphical, historical, moral, religious, developmental, ethical and aesthetical values of the society. They are quite indispensable to the wellbeing and continual survival of local communities in Africa.

As a matter of fact, folk media according to Jegede (2010), if properly packaged and deployed can be effective in delivering a pool of data stimulating interactive discussion among stakeholders and in the process strengthening the communication process of Primary Health Care Policy. For example local choreography, drance drama, folk-drama and storytelling properly conceptualised and effectively performed could modify the attitudes and entrenched practices of the local communities. These cultural tools are vital in developmental process because they are capable of stirring communal enthusiasm, and they also consitute traditional ways of life of the people capable of being used to effectively portray socio-political, cultural, economic, religious realities and health challenges especially in rural communities.

Developmental intervention for indigenous communities that do not carve a niche for traditional folk media and cultural practices of the people have limited chance of achieving huge success.

In fact, MacDonald and David in Uzo (2003:10) substantiate this position:

> Traditional channels are communication methods and have been used for centuries. In rural areas, such as songs, play, stories etc. They are often neglected, though in Many societies they may be the most powerful ways of communication. We have become too dependent on, and influenced by so-called "Modern Method". Our development agents and organisations must go back and examine traditional communication methods of the country/ communities in which they work in order to avoid unecessary failure in developmental programs.

Essentially, folk media in the context of indigenous development may be more effective in project planning because they are culturally and democratically configured. One thing is critical about these traditional folk media; they involve the key stakeholders

within communities; they contain engage or release a whole world of information and cosmology, aesthetics, myths, legends, social organisation, customs, values and cherished traditions. Therefore, celebrating and enacting them within Primary Health Communication and development planning process is way of preserving them, perpetuating as well as transmitting them to bring lasting and sustainable development especially to the rural people.

Way through which women's greater participation can be achieved and sustained

The study found the way how these challenges can be overcome, and how effective and greater women's participation can be enhanced in the state. For some of the discussants in, Chonoko and Dirin Daji communities, most critical decisions regarding women participation in health policy issues should be done in a forum like this (Focus group discussions, interview and indepth interview with rural women groups, and proper consultation with women groups) whereby women together with men gather to dialogue about health policy and health communication issues. The top-down system of communication, with little input from women should be discarded, because women contribute better under participatory atmosphere, as observed by the researcher during Focus group discussions and indepth interviews. Health communication should create an atmosphere of dialogue, where there is free flow of information, with the aim of negotiation rather than just prescribing for women. This was captured in Senchi community by Mallama Assibi in an indepth interview, where she remarked that

> Health policy making in Kebbi should take the form of community dialogue just like what we are doing now, where everybody is given an opportunity to contribute. Customs and traditional beliefs, where women are believed not to be heard or seen must be abolished, the community must be thoroughly educated on the importance of women participation and what that potends for national development.
> *(Indepth* interview with Mallama Assibi Dawa in Senchi community.)

Futhermore from the study it has shown that women in the communities have low literacy level, and poor educational background. This calls for massive education of women, and simplicity in development messages, so that women will be carried along no matter their level of education.

Due to the level at which most communities in Kebbi state adhere to their beliefs and traditions, participation of women in health policy making should move from the top down approach to dialogue, persuasion, negotiation and debate. This kind of approach to intervention would ensure acceptance and lead to easy decision taking on issues at stake, thereby, allowing "the community to become agents of their own change". (UNICEF, 2003:30). Therefore, awareness and conscientization through a redefined communication practice, such that aimed at negotiation rather than prescription, are forwarded as antidote for biases against low women participation in primary healthcare formulation and implementation.

Discussions and Critique of Findings

Based on the general findings of this study, it was discovered and obvious that there is low participation/role of women in formulation and implementation of health communication policy in Danko-Wasagu and Zuru local government areas of Kebbi State. This is reflected in the high number of discussants who gave their individual views during the focus group discussions and indepth interview. Thus, it could be stated that this discovery is a development problem. The implication, therefore, is that when participation is low, it brings about lack of ownership of the development project, lack of sustainability, lack of intergration of one's self into the project and understanding of health issues will not be very deep. Low participation is as good as no participation at all.

In an age like this, when the clamour for people's active participation is on an increase daily, we should not be talking about low participation we should be talking about

complete participation in everything that pertains health, right from formulation, communication and implementation of health policy, implementation and evaluation of health programmes. From the findings in Danko-Wasagu and Zuru local government areas, women's participation is very low, which is very bad. In Primary HealthCare Policy formulation, which is the genesis of life, policy issue is a very critical issue. It is an issue that is supposed to involve all stakeholders, so when participation in health policy formulation is low, the result you get from primary health care will not be encouraging. It is not just enough to engage women at the evaluation/concluding part of the policy making. Engagement and dialogue with all stakeholders must be part and parcel of the whole primary health care policy making process from conception to dissemination. The participation of women especially rural women is necessary to achieving effective primary healthcare policy and health communication agenda. The emphasis on women's participation by development communication though very important shows that not enough is being done by development policy makers to stimulate women increased participation in health policy formulation and implementation.

It is the submission of this study that it is very necessary for appropriate communication strategies, genuine to be intensified to create understanding to involve women, as well as increase women participation and achieve sustainable development among rural women. There is the need therefore for communication strategies such as women association groups,women peer groups, religious channels and folkloric/indigenous media, which is more acceptable and understandable by rural women and populace to be enshrined in health policy formulation, since majority of the respondents emphasized of highly elitist medium of communication being used, which is alien and unsuitable for them.

Women Peer Groups These groups will serve as discussion platforms which are capable of enlightening and re-awekening women on some injurious practices that tends to

limit women in health policy formulation and implementation. The platforms should ensure that regular meetings are summoned to address the need for greater participation of women. These women peer groups would serve as a reference point for critical purpose like.

1) The group will be responsible for educating, concentizing and mobilizing women folk in the areas of communication and participation as regards health policy issues.
2) Serves as a pointer or reference point to development experts, policy makers, government and non-governmental organisations in case of reliable information about women participation in a locality is needed for subsequent policy formulation and implementation mobilization.

Religious Channels Religious channels such as churches and mosques should be used to inculcate positive teachings that encourage participation in health issues. Objective, healthy and positive teachings, free from sexist biases can go a long way in encouraging women greater participation in health policy formulation. Also religious channels should be used to propagate the teaching on the **"**new religion**"** that detests inequality and promotes equality between sexes in areas of human endavours.

Folkloric/Indigenous media The research also found out that medium of communication used in communicating health issues is elitist in nature. This medium or channels of communication does not encourage indepth participation.

The study equally discovered that harmful cultural and religious practices militate against women participation. In our society, religion and culture play a critical role that is why the issues on health are more important to be allowed to be inhibited by cultural and religious factors. Culture needs to be addressed in other to allow women participation in primary health communication. Hence appropriate communication strategies and conscientization through education on the need for equal roles between men and women participation in development intervention may help in increasing women participation.

Thus, it is important to note that health issue is a very critical issues which needs to intergrate all stakeholders.

A major challenge of health development workers in Nigeria remains their inability to effectively engage rural populace who remain very critical in the success of any development intervention. The near refursal to adopt the bottom up approach in health communicating makes effective participation especially for women a challenge. This refusal is most times within the confines of the researcher who feels women and rural populace are illiterates and have little or no value in development process.

As mentioned earlier, for Kebbi State and Nigerian health sector to increase and succeed in improving on the extent of women's role/participation in primary healthcare policy formulation and implementation. This study strongly advocates for indepth involvement of women in all development processes, through consultation with women where individual and collective capacities for action, research, and problem solving techiniques are strengthened

CHAPTER FIVE

SUMMARY, FINDINGS AND CONCLUSION

5.0 Introduction

This chapter provides the summary of the research and generates conclusion and recommendations based on the analysis of the study on Women's role/participation in communicating primary healthcare policies in selected local government areas of Kebbi state.

The primary respondents of the study were composed of 138 mostly women and a few men groups located in Danko-Wasagu and Zuru local government areas, two local government areas adopted for this research work. The qualitative method of research was applied by the researcher. The research also drafted questions for focus group discussions and interview with women group to further increase understanding about subject matter. For effective analysis and interpretation of data, the researcher used the descriptive analysis method.

5.1 Summary

The study was embarked to assess women's participation in communicating primary health care policy in Zuru and Danko-Wasagu Local Government Areas of Kebbi State. To carry out this study effectively, there was a background information leading to the proper understanding of this study, the statement of the research problem was stated, the aim and objectives were provided.

Related literature on communication, primary healthcare communication and women's participation were reviewed. Two related theoretical frame works that underpinned the study were applied. The main instrument for gathering the data of this study is focus group disussion, interview method and observation method. The data gathered is presented in descriptive format in chapter four.

5.2 Key Findings

The key findings of this study include the following:

1. The study has been able to establish that participation of women especially in the area of health policy implementation and formulation in Zuru and Danko-Wasagu Local Government Areas of Kebbi state is low, because of high conservative adherence to customs and traditional beliefs. The effect cannot be over emphasised and the way it limit women from active participation cannot be measured.
2. The study also discovered a disconnect in communication between women and health policy makers,as most women in the communities are not literate hence not able to make meaning from what is been passed across, because the indigenous medium which they understand and are familiar with is not being used.
3. Futhermore, the study revealed high rate of illiteracy among women in the study areas, thereby invariably limiting their intellectual participation in health development formulation and implementation, and development at large.
4. Yet another finding of the study is religious teaching on women participation. The teachings of religion (Islam) do not favour women's visibility. This is the position of most discussants and respondents that took part in the study. Men and women discussant were of the strong view that, religion (Islam) advocated the system of patriarchy in various communities and since patriarchy puts the woman at the mercy of the men, it is almost impossible for active participation. (Weber 1964) blamed relative backwardness of the third world on traditional values and religious institutions. Weber blamed dominant religious like Islam and Christianity for teaching values and beliefs that are incompatible with modern science technology and ideology of progress and development. Hence the need to employ the right communication methods to communicate right religious beliefs and effectively

change societal perceptions about potentials of women participation in development.

5. Another key finding of this study is that the processes of formulation, implementation, monitoring and evaluation of health policy have not been participatory in the areas under study, as most women in the community during discussion attest to the fact that they were not deeply involved in the decision making of health policy. This sharply contrasts with the idea of participatory communication that is aimed at getting the communities, including women to contribute to problem discussion and analysis, but must be involved as active partners in all decision making processes.

The study reveals the near absence of indigenous/fockloric medium of communication to pass across health communication messages. Although traditional means of communication outlets such as drama, poetry and story telling which takes into account the cultural practices of the people remains a viable and potent tool, these have not been adequately utilised by health communication workers.

In conclusion, this study has revealed that there is low women's role/participation in health policy formulation and implementation, with clear responses from discussants that women are not adequately consulted in formulation and implementation process of primary health care policies. Participation of women in all processes right from conception to evaluation leave much to be desired. This has accounted for low participation of women in primary health care formulation and implementation in Kebbi State.

5.3 Suggestions

Women's active participation and good commnication strategies are very democratic principles for enhancing participation in health development and instilling the spirit of sustainability among women.

It is now commonly accepted that participation approaches and partnership in health development are essential for improving the lives of the people, but these people should be active participants not just information resource. Grassroot stakeholders for example should evaluate while outsider facilitate.

Considering the issues, problems and challenges inhibiting the realisation of women's active in health policy participation health care in Kebbi State, there is need to map out ways through which they can be addressed so that meaningful health policy can have a lasting effect on the lives of women in Kebbi State.

In view of the fore going findings of this research work, the following suggestions are given

1 The use of effective and participatory communication approach/methods which is capable of giving ample opportunities to lend their voices in formulation and implementation of health policies in Kebbi State should be encouraged. These methods are capable of re-awekening and conscientizing women to the realities of some injurious practices that continue to discourage and limit women participation in development, because participatory approaches have high degree of participation in their processes.

2 There should be use of effective, functional, holistic and sustainable communication approach, that can serve as a catalyst of self confidence of grassroot women.

3 Any programme meant for communication and participation of women needs to be participative, informative and consultative.

4 Education which remains the bedrock, foundation and panacea to any given society must be given serious prority. Women in Kebbi State must be given thorough education in health communication and other related matters as most of the women expressed ignorance in health related issues during the course of discussion.

5 Development health workers should engage women directly in every process of policy formulation and implementation, and carry them along to the last stage, as this will give women a sense of belonging and ownership of any health intervention in the state.

6 The research work strongly advocates the inclusion by health communication experts and policy formulators, cultural forms of communication/strategies (indigenous channels) for health development work. These strategies should be used to cater for situations and response from the audience.

7 All relevant stakeholders especially women should be mainstreamed in health communication formulation and implementation in Kebbi State. This will not only ehance active participation by women, but will also build their capacity to contribute meanifully and effectively in primary health care policy formulation and implementation, which will translate to sustainable development in health care sector.

The study also strongly aligns with Bella Mody (1991) suggestion which strongly emphasize that people or rather critical stakeholders in development intervention should be involved right from the conception stage to the evaluation stage, because it serve as a veritable mechanism for achieving sustainable development.

5.4. Conclusion

Women around the globe often face numerous and daunting challenges, which include cultural, religious, social and economic. Efforts needs to be intensified by international, national, governmental and non-governmental organisations to eliminate barriers that militate against women's active participation .Women needs to be encouraged towards their active participation. This can be acheived when active participation of women in all the processes of development and effective communication strategies are employed. This will in turn leads to sustainable development in health policy communication in Nigeria and the world at large.

REFERENCES

Abdulraheem I., Olapipo A. R., Amodu M. O., (2012). Primary Health Care Services in Nigeria: Critical Issues and Strategies for Enhancing the Use by the Rural Communities. *Journal of Public Health and Epidemiology*. 4(1): 5-13.

Adamu F.A. (2006). *Women's Struggle and the Politics of Difference in Nigeria*. Retrieved from http://web.fuberlin.de/gpo/pdf/tagungen/fatima_l_adamu.pdf

Akinfeleye, R. A and Okoye, I. E. (2003). *Issues in Nigerian Media History Lagos*, Malt House Press Ltd.

Anyaegbuna M. C *(*1998). *Participatory Rural Communication Approach: Starting with the People*, FAO/SADC, Harare Zimbabwe.

Ascroft J. And Masilel. A. S. (1994). Participatory Decision-Making in the Third World Development; In S.A White, K. S Nair and J. Ascroft (Eds), *Participatory Communication: Working for Social Change and Development*. New Delhi Sage.

Balit, S. (2004). *Communication for Isolated and Marginalized Groups; Blending the Old and New*, retieved from http://www.Salit@mclink.it

Baylis, A. and Smith, (2001). *The Globalization of World Politics*, (2nd Ed): Oxford University Press, New York.

Bailey, D. (1992). Using Participatory Research in Community Consortia Development and Evaluation: Lessons from Beginning of a story. *American Sociologist*, 23 (4), 71-82.

Bamidele C. O. (2004). Women Empowerment vis-a- vis African Womanhood: A Critique of Buchi Emecheta's Second Class Citizen International *Journal of Social and Policy Issues 2(1)*

Bello, R. Ajayi, S. (2002). *Research Methods and Statistical Analyses*, Ilorin: Haytee Press and Publishing Company.

Bennett, P. and Murphy, S. (1997). *Psychology and Health Promotion*. Buckingham: Open University Press.

Berg, B. L. (2001*). Qualitative Research Methods for the Social Sciences*. Boston.

Bessette, G (2004*). Involving the Community*: *A Guide to Participatory Development Communication*. Penang, Malaysia: Southbound Books.

Burkey, S. (1993). *People First; Aguide to Self Reliant, Participatory Rural Development*, New York, Red Books ltd.

Bruni, A. (2004). Entreprenuer Mentality, Gender and the Study of Women Entreprenuers, *Journal of Orgnizational Change and Management*, 17(3), pp. 256-258.

CIA World Factbook (2004). Nigeria Primary Health Care Policies. Retrieved from http://www.photius.com/countries/nigeria/society/nigeriasociety primary healthcare.

Chambers, R. (1997). *Whose Reality Counts? : Putting the Last First*. Intermediate Technology Publications,

Cohen; J. M. and Uphoff, N. T. (1997). *Rural Development Participation:concepts and Measures for Project Design, Implementation and Evaluation*". Monograph series No. 2 Rural Development Commitee, Cornell University, New York.

Coldevin, G. (2003*). Participatory Communication: A Key to Rural Learning Systems*. Rome, Italy: Food and Agriculture Organisation of the United Nation.

Custers, P. (1987). *Women in the Tebhaga Uprising: Rural Poor Women and Revolutionary Leadership*. Calcutta: Naya Prokash. Pp.47

Crewe; E. And Harrision, E. (1998). *Whose Development? An Ethnography of AID*; London, Zed Books.

Daiz Bordenave, J.E.(1977). Communication and Rural Development. Paris: Unesco.

Davis, H. and Fallowfield, L. (1994). *Counselling and Communication in Healthcare*. Chichester: John Wiley.

Desai, V. (2009), *Community Participation in Development*. In: Desai, V, and R. Potter (Eds).

Berry, D. (2007). *Health Communication. Theory and Practice:* England: Maidenhead Berkshire. Open University Press.

Di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A. and Kleijnen, J. (2001). Influence of Context Effects on Health Outcomes: a Systematic Review, *Lancet*, 357, 757–62.

Dulmen, A.M. and Bensing, J.M. (2001). *The Effect of Context in Healthcare: A Programming Study*. The Hague: RGO.

Ezeigbo; A. T. (1996). *Gender Issues in Nigeria: A Feminine Perspective*. Lagos, Nigeria: Vista.

Feverstein, M. T. (1994*). Partners in Evaluation. Evaluating Development and community programs with participants*. Lagos. The Macmillan Press Ltd.

Fishbein, M and Cappella, J. N. (2006). The Role of Theory in Developing Effective Health Communications, *Journal of Communication, International Communication Association.*

Florin, P., & Wandersman, A. (1990). An Introduction to Citizen Participation, Voluntary Organizations, and Community Development: Insights for Empowerment through Research. *American Journal of Community Psychology,* 18(1), 41-54.

Forbes, G. (1998). *Women in Modern India. The New Cambridge History of India*, IV (2) Cambridge, UK; Cambridge University Press.

Freire, P. (1978). *Pedagogy of the Oppressed*. New York, Continuum.

French, J. F. and Adams, L. A. (2002). From Analysis to Synthesis: Theories of Health Education. In: D.F. Marks (ed.), *The Health Psychology Reader*. London: Sage.

Greenfield, S., Kaplan, S. and Ware, J.E. (1985). Expanding Patient Involvement In Care: Effects on Patient Outcomes, *Annals of Internal Medicine*, 102, 520–8.

Grenier L. (1998). *Working with Indigenous Knowledge: A Guide for Researchers*, IDRC: Canada.

Hamelink, C. (1995). *World Communication; Disempowerment & Self Empowerment*. London: Zed Books

Hargie, O. and Dickson, D. (2004). *Skilled Interpersonal Communication: Research, Theory and Practice*. Hove: Brunner Routledge.

Hisrich, R. D. & Ozturk, S. A. (1999). Women Entreprenuers in a Developing Economy, *Journal of Management Development,* 18 (2) pp. 114-122.

Huesca, R., Brenda, D (1997) The Participatory Communication for Development Narrative: An Examination of Meta-theoretic Assumption and their impacts in Jacobson, T and Servaes (eds). *(1999). Theoretical Approaches to Participatory Communication. USA. Hampton Press Inc.*

Igube, R. B. (2003). Overview of Women's Involvement in Development and Governance. *Journal of Development and Society* 1(4).

Jackson, L. D, and Duffy, B. K, (1998). *Health Communication Research (eds),* Westport, CT: Greenwood Jersey: Hampton Press Cresskill.

Lanihun: A. (2003). Communication for Development purposes: A Gender Perspective. In E. Soola (ed) *Communication for Development Purposes*; Ibadan: Kraft Books Limited.

MacDonald, E. (2004). *Difficult Conversations in Medicine*. Oxford: Oxford University Press.

Melkote, S. (2003).Theories of Development Communication. In: B. Mody (Ed.), *International and Development Communication: A 21st- century Perspective.*Thousand Oaks, CA: Sage Publications.

Melkote, S., & Steeves H. (2001). *Communication for Development in the Third World*: *Theory and Practice for Development.* New Delhi, Sage Publications.

Moddy, B. (1991). *Designing Messages for Development Communication*. New Delhi: Sage Publication.

Mody, B. (2002). *Designing Messages for Development Communication: An Audience Participation-Base Approach.* India: Sage Publications.

Nain, Z. (2002). From Pedagogy to Praxis: Freire, Media Education, and Participatory Communication. In: M. Richards, P. N. Thomas (eds), *Communication and Development:* The Freirean Connection. Hampton Pres Inc.

Nair, K. S. and White, S. A. (1987).Participations is the Key to Development Communication, *Media, Development 34* (3): 36-40

Nair, K. S. and White, S.A. (1994) Participatory Message Development: A Conceptual Framework. In: S. A., White, K. S., Nair and Ascroft J. (eds), *Participatory Communication: Working for Change and Development*. New Delhi: Sage.

Niara, S. (2009). Women in Indigenous African Societies. In: *an e-Journal of Cultural studies,* 7(2).

Nzomo; M. (1997). *Women in Politics and Public Decision Making.* In: Kiamba's Women and Leadership Positions: *Social and Cultural Barriers to Success.* Paper Presented to the Centre of Excellence on Development Communication, Ahmadu Bello University , Zaria.

Ong, L.M., De Haes, J. C., Hoos, A. M. and Lammes, F. B. (1995). Doctor–Patient Communication: a Review of the Literature, *Social Science and Medicine,* 40, 903–18.

Pettigrew, L.S. and Logan, R. (1987). The Health Care Context. In: C.R. Berger and S.H. Chaffee (eds), *Handbook of Communication Science*. Newbury Park, CA: Sage.

Rogers, E. M. (1993). Perspectives on Development Communication. In: S. A., White, K. S., Nair and Ascoft, J. (eds), *Participatory Communication: Working for a Change and Development.* New Delhi: Sage.

Rogers; E. M. (1976). C*ommunication and Development: the Passing of the Dominant Paradigm*. In: Everret M. Rogers' *Communication and Development: A Critical Perspective.* Beverly Hills: Sage Publications.

Schofield, T. (2004). Introduction. In: E. MacDonald (ed.), *Difficult Conversations in Medicine*. Oxford: Oxford University Press.

Segrin, C. and Flora, J. (2000). Poor Social Skills are a Vulnerability Factor in the Development of Psychological Problems, *Human Communication Research*, 26(2), 489–514.

Servaes, J. (2001). Introduction: Participatory Communication (Research) For Social Change: Old and New Challenges. *Journal of International Communication*, 7(2).

Shingi, P. M. and Mody B. (1976). The Communication Effect Gap. In: Everret M. Rogers' *Communication and Development: A Critical Perspective.* Beverly Hills: Sage publications. The Companion to Development studies (2nd ed) London: Hodder Education.

Sumi, K. (2007). *Women Livelihood Rights: Recasting Citizenship for Developmet*. Los Angelos: Sage Publications.

.

U.N.O. (1992). *Women: Challenge to 2000 A.D.*

White, S. A. (ed), (1999). *The Art of Facilitating Participation: Releasing the Power of Grassroots Communication.* London: Sage Publications.

Williamo, R. (1976). *A Vocabulary of Culture and Society.* New York: Oxford University Press.

Wimmer, R. D., & Dominic, J. A, (2003). Mass Media Research: An Introduction. Boston: Wadsworth.

World Bank (1994). *The World Bank and Participation*.Washington D.C: World Bank OPD.

Worsley, P. (1984). *The Concept of Culture*. Australia: Blackwell Publications.

Yahaya, M. K. (2008). *Development Communication: Lessons from Change and Social Engineering Projects*. Lagos: Krafts books limited

APPENDIX

LIST OF KEY INTERVIEWEES

1. Research interview with Hajiya Zegro, Women Leader of Ribah Community in Kebbi State. (5th March, 2014)
2. Research Interview with Mallama Assibi, Primary Health Care Officer, Unashi. (5th March, 2014).
3. Research Interview with Mallama Sabatu Dauda, Healthcare attendnat in Chonoko. (7th March, 2014).
4. Indepth Interview with Women group at Martha Bamayi General Hospital, Senchi (7th March, 2014).
5. Focus Group discussion with women groups in Primary Healthcare Centres in Communities of Ribah, Chonoko, Waje Unashi Dirin Daji and Senchi. (8th March, 2014)

6 Indepth interview with Mallam Musa Danbena,Chonoko community. (8th March, 2014)

INTERVIEW QUESTIONS/FOCUS GROUP DISCUSSIONS

I am Julinana Mairiga, a Postgraduate Student of Development Communication, Ahmadu Bello University, Zaria. Undergoing a research thesis on the topic "***The Role of Women in the Communication of Primary Health Policy in Selected Local Government Areas of Kebbi State.***

Information of Respondents

i. Sex _____

ii. Educational Background of Discussants/Respondnets _____

iii. Religious background of discussants_____

iv. Community of the respondents/discussants_____

CHECKLIST

1. Do women participate in the formulation and communication of primary healthcare policy at all?
2. To what extent do women participate, and what role do they play in formulation and communication of primary health care policy in Kebbi?
3. Are there factors/challenges that hinder effective women's participation in formulation and communication of primary healthcare policies?
4. To what extent does the present primary healthcare policy represent the real aspiration of women?
5. What are the channels used in communication of primary Healthcare policy to women?
6. How can effective women's participation in formulation and communication of primary Healthcare be encouraged and sustained?