Africa's Health Burden: Assessing the Role of Community in Health Care Delivery

by

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Abstract

The enormous health challenges confronting Africa and the lack of capacity of the health systems to address those challenges stimulate a new thinking on the role of the community in improving health systems' performance in Africa. The health systems must respond effectively to these challenges if Africa as a continent must be free of all the burden of ill-health. The decline in most health indicators of some African countries were as a result of the inability of their health systems to address health problems confronting them. A failure of health service delivery in Africa is due to dysfunctional organization of the health system. The inadequacy of community involvement in community health services or the decline of the community participation in health planning and management has resulted in the poor performance of the health care system and its failure to solve the basic health problems in some countries. This paper using a case study of health care delivery in Lagos state, Nigeria examines the degree to which the people are involved in health care delivery and the implications for their health needs. The paper concludes that, since development is about people and their participation in the process that leads to such, effective participation of people especially at the community level is necessary to achieve development.

Introduction

The following conversation ensued between a group of villagers from Bengal (on tour of the Indian Assembly in Delhi) and a Deputy in the Assembly.

Deputy asks:

> *"Did you come to see your great government? Here India, the greatest democracy in the world, is ruled. Here we make the plans for your crops, we make the arrangements with foreign countries to give us aid, and we preserve the ancient traditions of political wisdom which have been known in India for longer than anywhere else in the world. This is where everything you do is governed. This is the people's assembly…"*

A little later one of the villagers asks:

- *'Please tell us what is democracy and why is India the biggest democracy?'*
- *'It is government by the people, and we have the most people who vote of any country in the world'*
- *'But you said voting was a choice.'*
- *'Yes of course'.*
- *'But we are always told by the money-lender where to put the mark on the paper. Where is the choice?'*
- *'You should not be told by anyone.'*
- *'Then how would we know where to put the mark?'*
- *'You should put it by the man you think is the best, who will do what is right for you here in the assembly.'*
- *'But why should any man in Delhi be concerned with our village? We have seen no one knows our village.'*

(Culled from Walt, (1994) Health Policy: An Introduction to PROCESS and POWER.

This narrative forms the basis of the discussion in this paper. What do I find instructive in the conversation? Take for instance; *'But why should any man in Delhi be concerned with our village? We have seen no one knows our village.'* This could be interpreted that the villagers were told that somebody represents them somewhere, takes decisions on their behalf, yet this stranger is not known in their village. (This is strange enough to warrant questioning). If this stranger never visited their village (community) how did he know their needs? Is the stranger perception of their needs the same thing as the peoples?

It is possible to come to the conclusion that the villagers do not participate in the process of taking decisions that affect their lives. Every decision is taking at the 'Assembly' in Delhi.

On this basis I posed these questions: why should the villagers be involved in the process of taking decisions that concern them? What are the benefits for people taking part in community decision-making process? Specifically about peoples' health and participation, what are likely to be the benefits of community participation?

Participation it is argued derives from an acceptance that people are at the heart of development (Damayanti, 2004). Development is about the people and they must be seen to be part of the process. I argue however that development can only be meaningful to people when it is conceived by them or they are part of the conception. Participation of beneficiaries of development programmes both at the formulation and implementation stages will enhance successful management of such programmes.

The enormous health challenges confronting Africa and the lack of capacity of the health systems to address those challenges stimulate a new thinking on the role of the community in improving health systems' performance in Africa.

Africa suffers from a burden of ill-health. Infectious diseases- Tuberculosis, HIV/AIDS and non-communicable ones - diabetes, hypertension, cancer and chronic respiratory conditions are increasing rapidly. The World Health Organization (WHO) projects that over the next ten years the continent will experience the largest increase in death rates from cardiovascular disease, cancer, respiratory disease and diabetes (de-Graft Aikins, Unwin, Agyemang et al, 2010). Non-communicable diseases and injury which can lead to disability now contributes more significantly to the burden of disease in Africa. This development is quite worrisome and the consequence is enormous pressure on countries' health systems. The health systems must respond effectively to these challenges if Africa as a continent must be free of all the burden of ill-health. The decline in most health indicators of some African countries were as a result of the inability of their health systems to address health problems confronting them.

The point has been made that a principal objective of a health system is to improve people's health. However, a failure of health service delivery in Africa is due to dysfunctional organization of the health system (WHR 2000). The inadequacy of community involvement in community health services or the decline of the community participation in health planning and management has resulted in the poor performance of the health care system and its failure to solve the basic health problems in some countries. How then can health system be made to perform better while incorporating the role of the community in the process. This question is germane because community participation is widely agreed to contribute to good governance, and is most advocated for providing a mechanism for potential beneficiaries of health services to be involved in the design, implementation and evaluation of activities, with the overall aim of increasing the responsiveness, sustainability and efficiency of health services or programmes (Mubyazi and Hutton, 2003).

Community Participation in Health Care: A Theoretical Discourse

Community participation has had bewildering arguments on what it actually connotes. What is usually at issue is the lack of agreement by both theoreticians and professionals on what constitutes community participation. No universally accepted definition of community participation exists in health literature and this adds to the confusion surrounding the concept (Taylor, 2004).

As a result of different interpretations, terms and processes used to understand community or citizen participation, a clear and commonly shared concept of community participation in health planning is difficult to establish (Murray, 2004). Murray however argues that the level of participant's influence or control of decision making, actions and outcomes are often key to the descriptions of community participation.

Community participation is a process that increases a community's capacity to identify and solve problems (Gryboski, et al., 2006), while Rifkin (1985) sees it as a strategy and process to help individuals develop their full potentials and capacities. It is a process of involving the community by promoting dialogue with, and empowering, countries to identify their own problems and solve them (WHO 2003). Community participation means having input into structures of decisions making and planning (Crowley, 2001). It is a strategy that provides people with the sense that they can solve their problems through careful reflection and collective action (Zakus and Lysack 1998).

In emphasizing the importance of community involvement in health care planning and implementation, Ekunwe (1996, p. 52) identifies three distinct phases in the process of achieving community participation:

> The first phase is where the expert plans and implements a programme and merely invites the community to 'rubber stamp' the project. In this case the community becomes the passive recipient of plans formulated by professionals.
>
> The second phase is one in which the professionals identify what they consider to be the health needs of the community and invite members of community to plan and implement projects aimed at meeting these needs. Community impact is only felt at the implementation stage of the process.
>
> The third phase is the one in which the community identifies a health need and approaches the professionals for technical advice and support in formulating and implementing solution(s) to the needs. Ekunwe thus argues that the identification of a health need may occur independently (felt health need) or may be the result of health education by the professional who thus help the community to convert a real health need to a felt health need.

These so called ‘phases’ in reality are different approaches which may bring out different understanding of community participation theoretically and in its application.

Chu cited in Murray (2004) allows for different types of community participation and indicates the type used should be matched to the agenda setting and type of community involved, which also influences the strategies used. For example when the agenda is to be the joint responsibility of the community, health professionals and government, the type of community participation suggested by Chu is ‘community representation’, and strategies of collaboration are required.

Conceptual Framework of Participation: Type of Community, Participation, Ownership/Agenda Setting and Health Promotion Models

Type of participation	Agenda set by	Type of community	Health Promotion Strategies
Community control	Community	Locality	Community development
Community representation	⇳	Social system	Systems change collaboration
Community involvement	External bodies and Interested Professional	Network of Initiatives	Community-based Initiatives

Adapted from Murray (2004)

Individual, groups, communities, organizations may have different perception about community participation, and this may inform its different reasons and benefits for different categories of people.

WHO (1999) for example observes that citizens and communities may make the following arguments.

> “We have a right to have a say about decisions that affect our lives.”
>
> “We know more about where we live and what we want and what is best for us than do people working for big organizations.”
>
> “We are fed up with politicians and civil servants asking us what we think and then not taking our views into account – we want to be actively involved and to have an influence.”
>
> “We all have something to contribute – and our ideas and views are as valid as anyone else’s.”

Professionals working in local authorities, health authorities and other organizations may voice a range of different arguments.

> "Community participation can help us target resources more effectively and efficiently."
>
> "Involving people in planning and delivering services allows them to become more responsive to need and therefore increases uptake."
>
> "Community participation methods can help develop skills and build competencies and capacities within communities."
>
> "Involving communities in decision-making will lead to better decisions being made, which are more appropriate and more sustainable because they are owned by the people themselves."
>
> "Community participation is a way of extending the democratic process, of opening up governance and of redressing inequality in power."
>
> "Community participation offers new opportunities for creative thinking and innovative planning and development."

The point is that the voices of communities and professionals put together provide a convincing argument for giving priority to community participation as an active two-way process that may be initiated and sustained not only by individuals and communities alone but also by local and health authorities and other local organizations (WHO, 1999).

There is also the recognition that community participation has many potential benefits, both direct and indirect. Mubyazi and Hutton (2003) thus argue that if it works well community participation can:

- Increase the resources available for health
- Sensitize communities to health problems and possible solutions
- Increase the uptake and effectiveness of interventions
- Improve specific quality elements of health care (e.g. drug availability)
- Increase the quality of management, through introducing accountability and performance measurement
- Improve governance and the responsiveness of services to the population. It is argued that lack of community participation in the supervision and control of financial administration hinders the sustainability of any community-oriented financing scheme

- Direct resources towards vulnerable groups
- Increase the feeling of solidarity in a community
- Increase self-reliance and local skill base

The point has been made somewhere else that community's effort at determining their health needs has implications for community participation in health care delivery (Quadri, 2011). One of the reputed benefits of community participation is the belief that resources will be more often directed to the so-called 'felt needs' of those in the community, and that health activities will be carried out more appropriately when the community is given greater control than when decision about community health matter is externally directed (Zakus and Lysack 1998).

Taking from either the angle of the community or the professionals, what is not in contention is that community has a role to play in health care delivery and study across the globe has demonstrated the importance of community in this project. Some of these studies explore the broader concept of community participation in health services development: Bjaras, Haglund and Rifkin (1991) investigated community intervention programme in Sollentuna municipality in Sweden.

Mahmood, Moss and Karmaliani (2003) discovered that organized interests at the community level determine the fate of any health system in Karachi in Pakistan. Eyre and Gauld (2003) carried out an investigation of a trust model in a small community of Lawrence in New Zealand. Jacobs and Price (2003) investigated most appropriate actors and strategy for initiating community participation in externally funded health projects in two communities- Maung Russay and Kirivong operational health districts in Cambodia. Ngum, Medi, Fang, Ekema and Linonge (2003) conducted a fact-finding survey on Knowledge, Attitudes and Practices (KAP) with respect to community participation in Tiko Health District in Cameroon. Chilaka (2005) carried out a multidimensional assessment of community participation in Roll Back Malaria (RBM) initiative in five countries namely; Burkina Faso, Ghana, Nigeria, Tanzania and Uganda. Gryboski, Yinger, Dios, Worley and Fikree, (2006) examined a range of approaches that community-level health programs have taken to implement participatory methods, and the evidence of such outcomes as impact and sustainability in India, Nepal, Peru and Senegal.

In all of these studies, the importance of community involvement in health care services was recognized and the benefits derived from their participation. The failure to recognize that decisions about community health need to incorporate the community population so as to give effect to implementation of health care delivery strategy at the community level often times have led to failure in heath programmes.

The How and Why of Community Participation: A Case Study

A qualitative study conducted (using focus group discussion (FGD) and key informant interview (KII) as instruments of data collection) by this author in four communities; Akoka, Ijeshatedo (two urban communities) Ilado, and Igbogbo/Baiyeku (two rural communities) in Lagos State, Nigeria in 2008 shows the significance of community participation in health care decision-making The study was able to draw a breadth of community participation process in health care decision-making in the four communities (Quadri, 2011).

Methodology of Research

The study used the Pentagram Framework of Rifkin, Muller and Bichmann (1988) to make an assessment of the process of community participation in the communities. Rifkin et al (1988) identified five indicators of participation; Needs Assessment, Leadership, Organization, Resource Mobilization and Management. These indicators take as their starting point that health improves through community participation and that broad participation builds on a wide range of activities and involvement of different community groups (Rifkin et al. (1988). Following analysis of more than 100 case studies, Rifkin et al. (1988) designed methodology outlining the above indicators for participation in health care programmes. These indicators were incorporated into an analytical framework known as the pentagram model. For each of the indicators, a continuum with wide participation (community people plan, implement and evaluate the programme using professionals as resources) is developed at one end. At the other end, is the narrow participation (professionals take all decisions, there is no participation). The continuum is then divided into a series of points and a mark is placed at the point which most closely described participation in the health program being assessed. When a mark has been placed on the continuum, these marks are then connected in a spoke configuration that brings them together at the base where participation is the narrowest. By placing the appropriate mark on each continuum and connecting the marks, the degree of breadth of participation to describe a baseline which provides for a comparative assessment at a later time or by other assessors can be shown. These indicators could be used for measuring participation and to compare differences in participation (1) at a different time in the same program, (2) by different assessor of the same program and (3) by different participants in the same program (Rifkin, Muller and Bichmann, 1988, P. 934).

This qualitative method allowed us to assess and describe community participation process in the communities. Focus Group Discussion (FGD) and Key Informant Interview (KII) were used as instruments of data collection.

Focus Group Discussion (FGD) and Key Informant Interview (KII)

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

FGD sessions were held in Ilado, Akoka, Ijeshatedo and Igbogbo-Baiyeku communities. Members of Community Development Committee, Health Coalition and Community Health Promoters in these communities were purposively selected for interviews. The selection was based on their rich experience in working with the health facilities in their communities. Each group consisted of between 8-12 participants (with at least 2 females) who had lived in the community for at least 10 years. The FGD sessions were conducted with the aid of a discussion guide, responses were audio-taped, transcribed and analyzed.

Key Informant Interview

Key Informant interviews were conducted with health officials working in selected PHC centre. Questions asked centred on the services provided at the health facility, adequacy of facility in meeting community health problems, community health financing and the involvement of community people and their representatives in health care development in the community.

Analysis of Findings

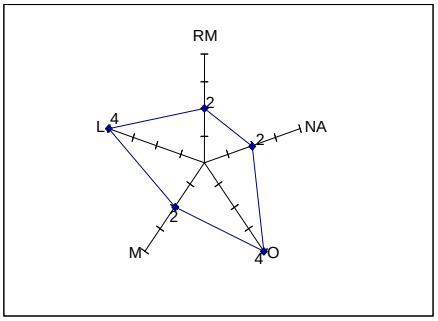
A major key finding of the study shows that an important element for success in health care delivery is ensuring that community organizations are well connected to diverse people in their local communities and participation of local communities could enhance healthcare service delivery.

The study was able to draw a breadth of community participation process in health care decision-making in the four communities; Akoka, Ijeshatedo, Ilado and Igbogbo/Baiyeku.

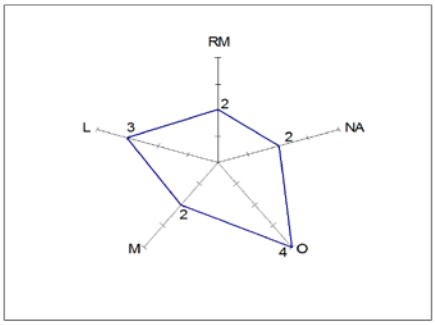
	Akoka	Igbogbo-Baiyeku	Ijeshatedo	Ilado
Needs Assessment (NA)	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by the health professionals.	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by the health professionals.	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by health professionals.	2= (restricted, small community participation) although community organizations are involved in identifying the health needs of the community, but services provided are largely determined by health professionals.
Resource Mobilization (RM)	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.	2= (restricted, small community participation) Community people make little financial contributions towards health projects in the community.
Organization (O)	4= (open, good community participation) community	4= (open, good community participation) community	4= (open, good community participation) community	4= (open, good community participation) community

	organizations evolve from within the community.	organizations evolve from within the community.	organizations evolve from within the community.	organizations evolve from within the community.
Management (M)	3= (mean, fair community participation) community organizations discuss health issues with health officials but do not take part in health care planning and management.	2= (restricted, small community participation) community organizations do not participate in health care planning and management.	2= (restricted, small community participation) community organizations do not participate in health care planning and management.	2= (restricted, small community participation) community organizations do not participate in health care planning and management.
Leadership (L)	4= (open, good community participation) community organizations active and representative of community. Enjoy support from the community.	4= (open, good community participation) community organizations active and representative of community. Enjoy support from the community.	3= (mean, fair community participation) community organizations are recognized by health professionals but do not enjoy much support from the community.	3= (mean, fair community participation) community organizations are recognized by the health professional but do not enjoy much support from the community.

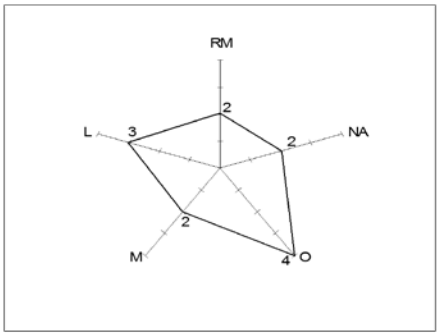
Table 1: Rankings for the four Communities.



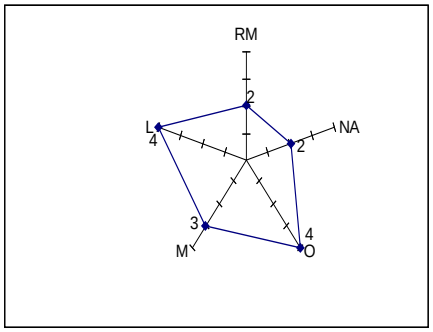
Diag. 1 Igbogbo/Baiyeku Community



Diag. 2 Ijeshatedo Community



Diag. 3 Ilado Community



Diag. 4 Akoka Community

Figure 1: The Pentagram showing levels of Participation in Igbogbo/Baiyeku, Ijeshatedo, Ilado and Akoka Communities.

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

Discussion

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

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

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

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

When the health needs are identified by the communities, they are perceived as 'real health needs'. But as the study revealed, health needs of the communities are largely determined by the government. For example, in all the health facilities surveyed in Igbogbo/Baiyeku, Ijeshatedo, Ilado and Akoka, services provided include; Ante-natal Clinic, Child Welfare, Family Planning, Maternal Health Delivery, Health Education, General Outpatient and Outreach Services. These are health services whose guidelines and structures are predetermined by the government, though community organizations most times are called upon to participate in the implementation process. The implication of this is that the impact of participation is only felt at the implementation stage of the process (in terms of health care planning and implementation) of community participation. The inability of the community to participate in this aspect of the process of health care delivery has resulted in the unmet needs of those communities. Pre-determined health services without input from the communities might deviate from the actual health needs of the communities.

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

The opinion of one of the interviewees suggests this much:

> We participate in mobilizing community people, we go out for out-reach programme with health officers here in this community, we help to pass information about health to people and we report back, for example, when there is health epidemic, we normally report to them but they don't take all our advice, so we can say that we don't really take part in the management of the community health system (FGD, Ilado, 2008)

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

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

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

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

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

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

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

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

The reality of community participation thus reflects the decline of community people in health care decision-making especially at the local level where the contribution of community people can be made feasible.

Conclusion

This paper has been able to bring into fore the degree to which the people are involved in health care delivery and the implications for their health needs. The goals of encouraging community participation is said to include providing more acceptable services that respond to expressed local needs, and increasing the availability of services through expanding the service delivery system (Askew and Khan, 1990). Since development is about people and their participation in the process that leads to such, effective participation of people especially at the community level becomes necessary to achieve development. Evidences have shown that there is a positive relationship between peoples' participation in health care delivery and the effectiveness of the health system in addressing community health problems. Community participation is recognized globally as an important aspect of achieving a healthy future (Murray, 2004). Therefore, a renewed call for the role of community in health care delivery cannot be over emphasized.

Governance debate in health needs to recognise that health cannot be addressed without a real involvement of people and their organizations at all levels. This will involve effective participation of those stakeholders in health decision-making. Participation gives the people the opportunity to share in the responsibilities that determine their health outcome(s). Community participation requires an arrangement which gives community members or organizations in which they participate, a more active role in health promotion. There is therefore the need for policy-makers in developing countries, especially Africa to reinvigorate the strategy of health care delivery which recognizes the role of community and ensure that they are made to perform such roles. Policy initiatives should direct attention and efforts at further integrating community participation into health care delivery.

References

Africa Health Strategy: 2007-2015. (2007) "Strengthening of Health System and Development in Africa". Third Session of the African Union Conference of Ministers of Health. Johannesburg, South Africa, April, 9-13.

Askew, I and Khan, A. R (1990) Community Participation in National Family Planning Programs: Some Organizational Issues. *Studies in Family Planning, 21 (3): 127-142.*

Bambra, C., Fox, D. and Scott-Samuel, A. (2005) Towards a Politics of Health. *Health Promotion International. Vol. 20 No 2.*

Chilaka, M.A. (2005) "Ascribing Quantitative Value to Community Participation: A Case Study of the Roll Back Malaria (RBM) in Five African Countries". *Public Health. 119, 987-994*

Crowley, P. (2005) *Community Participation and Primary Care: Learning from the Building Healthy Communities Programme.* Dublin: Combat Poverty Agency.

Damanyati, M. (2004) Sustaining Participation in Local Governance, 40th ISoCaRP Congress

De-Graft Aikins, A. Unwin, N., Agyemang, C. et al., (2010) "Commentary" Tackling Africa's Chronic Disease Burden: from the Local to the Global. *Globalization and Health, 6:5.*

Ekunwe, E. O. A (1996) *Nigerian Primary Health Care Delivery System: The Challenge of Implementation.* Lagos: Blaze Publications.

Eyre, R. and Gauld, R. (2003*)* "Community Participation in a Rural Community Health Trust: the Case of Lawrence, New Zealand". *Health Promotion International, 18, (3), 189-197.*

Gillam, S. (2008) "Is the Declaration of Alma-Ata still relevant to Primary Health Care?" *BMJ: 336; 536-538.*

Gryboski, K, Yinger, N.V., Dios, R.H., Worley, H. and Fikree, F.F. (2006) "Working with the Community for Improved Health", *Health Bulletin 3.* (Washington, DC: Population Reference Bureau).

Jacobs, B and Price, N. (2003) "Community Participation in Externally Funded Health Projects: Lessons from Cambodia". *Health Policy and Planning: 18 (4): 399-410.*

Lewis, M. 2006) Governance and Corruption in Public Health Systems. Working Paper, Norbert Center for Global Development.

Madriz, E. (2003) Focus Groups in Feminist Research in Denzin, N. K. and Lincoln, Y. S. (eds) *Collecting and Interpreting Qualitative Materials*. London. SAGE Publications. Pp 363-368

Mahmood, M.A, Moss, J. and Karmaliani, R. (2003) "Community Context of Health System Development: Implications for Health Sector Reform in Pakistan". *Eastern Mediterranean Health Journal, 9(3).*

Mubyazi, G.M. and Hutton, G. (2003) Understanding Mechanisms for Integrating Community Priorities in Health Planning Resources Allocation and Service Delivery. Results of a Literature Review. Report Commissioned by Southern African Regional Network on Equity in Health. (EQUINET). EQUINET Discussion Paper B. IDRC. Canada.

Murray, Z. (2004) Community Participation in Public Health Planning. Proceedings of the 8th World Congress on Environmental Health. Durban, South Africa.

Ngum, J.W., Medi, C. Fang, E., Ekema and Linonge (2003) Community Participation in the Tiko Health District, Cameroon. Action Research e-Reports,019,availableon-line at www.fhs.usyd.edu.au/arow/arer/019.htm. Accessed on 08/06/07.

Olmen, J., Marchal, B. et al., (2012) Health Systems Framework in their Political Context: Framing Divergent Agendas. *BMC Public Health 12: 774.*

Quadri, M.O. (2011) Community Participation and Politics of Primary Health Care Delivery in Lagos State. (Unpublished Thesis).

Rifkin, S. B (1985) Health Planning and Community Participation: Case Studies in South Asia. England. Croom Helm.

Rifkin, S.B., Muller, F. and Bichmann, M. (1988) "Primary Health Care: On Measuring Participation". *Social Science and Medicine, 26, 931-940*

Sepehri, A. and Pettigrew, J. (1996) "Primary Health Care, Community Participation and Community-Financing: Experiences of Two Middle Hill Villages in Nepal". *Health Policy and Planning: 11(1):93-100.*

Walt, G. (1994) *Health Policy: An Introduction to Process and Power*. London. Zed Books Ltd.

World Health Organization (1981) - National Decision-Making for Primary Health Care. A Study by the UNICEF/WHO. Joint Committee on Health Policy. Geneva).

World Health Organization (1999) Community Participation in Local Health and Sustainable Development: A Working Document on Approaches and Techniques, European Sustainable Development and Health Series: 4, WHO Regional Office for Europe, Copenhagen, Denmark

World Health Organization (2000) – (The World Health Report) "Health Systems: Improving Performance". Geneva.

World Health Organization (2008) – (The World Health Report) "Primary Health Care- Now More Than Ever". Geneva. Xhafa, E. (2007) Global Health in the Intensive Care Unit: The Strategic Role of Trade Unions in achieving "Health for All" International Labour Office –Geneval. ILO.

Xhafa, E. (2007) Global Health in the Intensive Care Unit: The Strategic Role of Trade Unions in achieving "Health for All" International Labour Office –Geneval. ILO.

Zakus, J.D. and Lysack, C.L. (1998) Revisiting Community Participation. *Health Policy and Planning 13: (1): 1-12.*