**Governance and People’s Participation at the Local Level: Issues in Health Care Delivery in Nigeria**

by

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**Abstract**

*Issues of citizen’s participation in democracy continue to be a recurring decimal in governance discourse. This is more so as it is widely believed that promoting democracy and increasing people’s participation will engender development. The inference from this is that, since development is about people, when people are part of the decisions that affect their lives, then, they would be able to make meaningful contributions to issues that concern their own development. It is therefore argued that popular participation is in essence the empowerment of the people to involve themselves in creating structures and in designing policies and programmes that serves the interests of all and contribute optimally to the development process. An over-centralized political and administrative system, where decision-makers legislate and prescribe for a whole variety of situations, often without knowledge of local circumstances and conditions may not be effective or efficient. Decentralization has thus emerged as a result of global trend to local autonomy and self-determination, and as a result of a trend to reduce reliance on centralized planning and be more responsive to market forces as well as local needs.With regard to the health sector, decentralization is concerned with changing the way health systems are organized to produce effective service delivery. It has been argued that decentralization could be useful in supporting and developing health services and bring it closer to people. This paper examines the process of decentralization and how it impacts on primary health care service delivery in Nigeria.*

**Introduction**

A feature of modern state administration is the need for closer contact between the individual citizen and officialdom (Smith, 1985). In other words, it is imperative for state administration to maintain a closer interaction with the citizen. This is more so as citizens requires accountability and responsiveness on the part of those who govern them.

The importance of reducing the concentration of decision-making at the central level has been receiving increasing recognition, especially as it concerns public service delivery. World Health Organization (WHO) (1981) observed that in most developing countries, the diversity of natural conditions economic potential, social and cultural structures and even of values and beliefs, demands flexibility in the mechanisms to achieve nationally agreed goals and adaptability in the definition of the goals themselves. An over-centralized political and administrative system, where decision-makers and officials legislate and prescribe for a whole variety of situations, often without knowledge of local circumstances and conditions may not be effective or efficient. Hence citizens’ participation becomes *sui generis* for effective and efficient service delivery. With regard to the health sector, decentralization is concerned with changing the way health systems are organized to produce effective service delivery.The argument is thatdecentralization could be useful in supporting and developing health services and bringing it closer to the people.

Decentralization is intended to promote accountability and participation of local population, make health service providers accountable to the local community, and boost the responsiveness of the providers to the local demand for services. Decentralization is therefore expected to improve the efficiency, equity, and quality of health service delivery and management (Tidemand, 2010).

I examine in this paperthe process of decentralization and how it impacts on primary health care (PHC) service delivery in Nigeria. The three tier health service, and the nature of health care delivery system in Nigeria places the responsibility for primary health care delivery at the doorstep of the local government. Though not easily implemented as it seems as a result of contradictions inherent in the nature of intergovernmental arrangement itself which oftentimes constraints local government to act especially in the area of service delivery. For instances local governments in Nigeria are often confronted with the challenge of accessing resources to implement development programmes and projects at the local level. Most times, resources of local governments are diverted by the states for other purpose for which it is meant for while projects at the local government levels suffer and eventually abandoned for lack of fund for their implementation.

The point has been made severally however, that if properly designed and implemented, decentralization has significant potential for widening political representation and for targeting resources in favour of the poor (Bardhan and Mookherjee, 2006). I therefore argue that effective delivery of the health care services especially the PHC will depend largely on the extent to which people participate and feel part of the whole process. I also argue that local government must possess the authority (within the limit of the constitution) and resources for it carry out its responsibilities creditably well.

**Decentralization: Conceptual and Theoretical Discourse**

Decentralization is a multi-level concept and usually difficult to define. This has led to various conceptualisations and perspectives on the concept. Different scholars view it through a variety of diverse, often inconsistent, sometimes overtly contradictory, analytic lenses (Bankauskaite and Saltman,2007).The term decentralization is used to describe a wide variety of power transfer arrangements and accountability systems. Public administration theory conceptualizes decentralization as the transfer of authority in public planning, management and decision-making from the national to sub-national levels (Kawonga, 2005). According to Rondinelli (1981) decentralization is conceptualised as the transfer or delegation of legal and political authority to plan, make decisions and manage public functions from the central government and its agencies to field organizations of those agencies, subordinate units of government, semi-autonomous public corporations, area-wide or regional development authorities; functional authorities, autonomous local governments, or non-governmental organizations.

Olowu (2001:2) observes that decentralization is a relative, complex, instrumental and multidimensional process. It is relative in that it describes the distribution of state resources (responsibility, finance, personnel or discretionary authority) between various institutional actors within the state and/or society against some normative mode in space or time. It is complex in that it incorporates and is impacted upon by political, economic, institutional and cultural factors. It is a multidimensional process which defines the distribution of power and resources between state and society, the executive and other branches of the government, at micro level between central and local governments, central government and their field administration, between central/local governments, and non-governmental entities as well as at higher levels between governmental units within a federal or international system.

Decentralization whether it is local administrative or political actors, entails the creating of a realmof local autonomy defined by inclusive local processes and local authorities empowered with decisions and resources to deliver welfare services in meaningful ways to the local population Abdulwaheed and Samihah, 2012). The focus is the way power and authority are given to the local authorities to take decisions that will bring development to the local populace.

Arguments for decentralization have been based on widely differing criteria, ranging from expected improvements in allocative efficiency, welfare, and equity (Smoke 2003), to increased participation, accountability, and responsiveness on the part of local authorities (Talpur, 2000; Mills, 1994; Smith 1985).According to Robinson (2003), a leading rationale for decentralization is that it can generate financial efficiency and quality gains by devolving resources and decision-making powers to local governments for the delivery of services. In the same vein, Jimenez and Smith (2005) argue that sub national governments have access to better information about local circumstances than central authorities, and therefore can use this information to tailor services and spending patterns to citizen’s needs. In contrast, centralized government structures face significant informational and political constraints that are likely to prevent them from providing an efficient level of a local public good or service.

Decentralization often involves the need for extensive reform of intergovernmental relations. This reform process most times challenges entrenched practices, vested interests, powerful actors, the inertia of existing institutions, and a lack of will for change. From the local perspective up, decentralization is challenged by the many ways in which the central government may circumvent and undermine local authority. From the national perspective, decentralization is sometimes seen as a way to undermine the authority and efficacy of national-level government, which must make tough decisions that benefit the entire country (sometimes at the expense of local actors) (Sisk, 2001). Whatever way one perceives it, the challenges of decentralisation are always inherent and require sometimes political intervention to resolve the logjam.

Decentralization emerged as a result of global trend to local autonomy and self-determination, and as a result of a trend to reduce reliance on centralized planning of economics and be more responsive to market forces as well as local needs and characteristics (UNFPA, 2000). As observed by Akinboye and Quadri (2013), decentralization is not a new phenomenon or something foreign to the African continent, most of the African states have sought to decentralize their state structures since independence (Olowu,2000).Wamwangi and Kundishora (2003) have observed that:

(a) The purpose of decentralization should be to devolve power and responsibility to lower echelons, promote local democracy and good governance, with the ultimate objective of improving the quality of life of the people.

(b) Decentralization should be to local government structure, which are representative of, and accountable to, all sectors of the local population, including marginalized and disadvantaged groups.

(c) Decentralization should be to levels of local government structures, which enable effective community participation in local governance.

(d) Decentralization should involve the transfer to local government institutions those powers and functions necessary to enable them: i) provide services for the local population efficiently and effectively; ii) provide a conducive environment for local economic development; iii) develop and manage local resources in a sustainable member.

(e) Decentralization should include the provision of access to the resources needed to execute the above powers and functions efficiently and effectively, including financial and manpower resources.

(f) Financial resources should be available to local authorities in a manner which is reliable, adequate, predictable, transparent, accountable, sustainable and equitable.

(g) The basic components of a decentralized system of local government should be enshrined in the constitution.

In a nutshell, decentralization of authority and power is justified by the argument of efficiency and effectiveness, responsibility and accountability, as well as providing opportunity for people to participate in decision-making-process since power is no longer concentrated in a central/national government but distributed widely between the national and sub-national and subordinates units of governments.

**Health Policy and Decentralization of Health System in Nigeria**

Decentralization of the health system is concerned with strengthening health system performance to deliver better quality and equitable health services that will respond to the needs of the local populace. Conceptually, it involves a change in power relation between the national (or central) government level and other actors in the health system, including statutory local government entities, other sub national levels of government administration, private enterprises and non-governmental organizations.

Health policy is an important vehicle for influencing the health of individuals, families, and communities. Most health care policy initiatives are designed to address one or more of three concerns; cost, access, and quality (Smart, 1999).

With the global declaration in 1978 of PHC as the key to the attainment of Health for All and its reaffirmation by the African Health Ministers in 1985, Nigeria adopted the Three-Phase Health Development Scenario (TPHS) as a strategy for national health systems (NPHCDA, 2001).

The Three-Phase Health Scenario recommended three-tier levels for health care delivery with PHC forming the primary level and central focus. This influenced the development of Nigeria’s maiden health policy, which was developed between 1985 and 1986 and launched in 1988.

The overall goal of the policy is the attainment of enhanced standards of health by all Nigerians in order to promote a healthy and productive life (African Development Bank, 2002). A health system based on PHC was adopted as the means of achieving the goal.

The policy identified PHC as the cornerstone of the national health system and recommended four main strategies for its implementation.

1. The promotion of community participation.
2. The involvement of health-related sectors in the planning and management of the services.
3. Strengthening of functional integration at all levels of the health system, and ;
4. Strengthening of the managerial process for health development.

The policy prescribed a functionally integrated three-tier structure for the nation’s health service.

The Federal government is to be responsible for:(a) the development of national policies; (b) the strategies to promote primary health care; and (c) the provision of tertiary care.

The State Government is to be responsible for:(a) technical assistance, logistic support and supervision of the Local Government Areas.(b) secondary care in the form of General Hospitals and;(c) training institutions especially for levels below that of the doctor, including primary health care workers.

The Local Government is to be responsible for:(a) the development and maintenance of primary care; (b) the training of community-based health workers such as the village health workers and the traditional birth attendants.

Each of the 774 LGAs in the country is responsible for operating the health facilities within its area, including the provision of basic out-patient, community health, hygiene and sanitation services. The State Ministry of Health coordinates activities and provides technical support. Health service delivery in each LGA is the responsibility of the Health and Social Welfare Counselor (ADB, 2002). Within this system of health governance and in relations to provision of PHC, the local government assumes the larger responsibility.

The Local Governments, assisted by the Federal Ministry of Health, started the implementation of the policy. In order to meet the national health policy goal of health for all by the year 2000, the emphasis of the PHC programmme of work for 1986-90 was to develop health system infrastructure necessary for PHC that will ensure adequate coverage of the population with effective health services that meet the essential needs of individuals, families, and communities with their active involvement and participation at all levels.

Two levels of care were identified in the LGA: the village and the ward/district. At the village level were the health centers. The process of implementation began from the bottom, by developing village health services.

Village communities are mobilized to discuss and agree on their health problems, and the strategies and activities to tackle them.

With technical assistance from the federal, state and local governments, villages were encouraged to form village health committees. These committees selected individual and traditional birth attendants for training as village health workers to provide the integrated preventive, curative and midwifery services at the village level.

The service provided by the village health team is supervised by community health workers based in the community and the health centers. The village health committee has full authority over the village health services. Problems that cannot be solved at the village level are referred to the Health Center.

The local government provides a health center in every ward/district manned by the team of community health workers. The services provided at the health center are under the authority of the ward/district health committee consisting of the chairmen of all the village health committees in the ward. The health center is the highest level of health care facility under the jurisdiction of the local government and in the nation’s primary health care system. Problems that cannot be solved there will be referred to the secondary health care system- the General Hospital, under the jurisdiction of the state government.

The state provides at least, a general hospital in every local government to serve as the apex of the local government health care system. Each local government health committee must select one of its village health committee chairmen to represent it on the management committee of the General Hospital.

Problems that cannot be solved at the level of the General Hospital will be referred to the Tertiary system under the jurisdiction of the federal government. The plan is for the federal government to provide a tertiary facility in each state to serve as the apex of the health system in the state. In order to complete the management system designed for the National Health Service that ensures its ownership by the community, a village health committee chairman is on the Board of the Teaching Hospital in the State.

This arrangement in health care delivery shows the state of decentralized health care delivery system in the country. The local government which is the lowest on the hierarchy is the first point of entry into the health system with primary health care located at that level.

**Governance and Health Care Service Delivery in Nigeria: the Real Issues**

A governance debate needs first to be based on the realization that health cannot be addressed without a real involvement of people and their organizations at all levels (Xhafa, 2007). This invariably involves effective participation of stakeholders (including community people) in health decision-making. Participation gives the people the opportunity to share in the responsibilities that determine their health outcome. The participation of the people at the community level thus becomes an imperative if the principle of popular participation at the local level is to be enhanced. Decentralized form of government can guarantee this form of participation as power of decision-making will lie on the people at the grassroots level.

The process of community oriented approach focuses on the population health needs as determined by them and not by the health officials alone. Community themselves are seen as part of the decisions that inform the nature of health care delivery. Conceived this way, health decision making commences from the bottom-up through the community people, and not to be seen as the sole responsibility of health bureaucrats.

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 come as a result of felt needs which the community people identified themselves and rely on health professionals to solve. Again, 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). When community people participate at identifying their health needs and programmes arising from this, it can be taken for granted that they would likely see to the successful implementation of such health programmes.Mansuri and Rao (2012) rightly note that the two major modalities for inducing local participation are community development and decentralization of resources and authority to local governments. Efforts of community to affect decision-making on development programmes including health and education will be meaningless not only if resources for adequatefunding for implementation are hard to come by, but also if the local government lacks the authority to coordinate activities and be able to take responsibility for success or failure of programmes and projects within its jurisdiction.

Another critical issue in health care delivery is the health care financing and the role of the community in the process.

Health care financing refers to the strategies for paying for health care expenditures and these are for services and goods whose primary aim is to promote health. It is one of the major factors that drives health care delivery generally and PHC in particular (Nigerian Health Review 2007). The sources of finance of the health sector as well as the mechanisms used to allocate those resources within the health systems directly affect poor people’s access to health services, and thus the final health outcome (Sida in Nigerian Health Review, 2007 p.73).

The revised National Health Policy of 2004 provides a comprehensive strategy of health care financing in the country. The main mechanisms of health care financing in the country are; Government Funding, Donor Funding, Health Insurance and Out of Pocket payments (OOPs) also known as user fees.

Specifically for PHC financing, the federal government provides budgetary allocation to PHC department of the Federal Ministry of Health (FMOH) and NPHCDA. Also, there are budgetary allocations to various PHC activities in the country, such as malaria control programme, immunization programme, HIV/AIDS amongst several others. Financing of day-to-day health facility functioning is largely provided by local governments (Nigerian Health Review, 2007).

Other sources of funding for PHC include, Donor Financing, the Mandatory or Social Health Insurance (SHI), Voluntary Health Insurance, Community Based Health Insurance, Drug Revolving Fund (DRF) and Out-of Pocket payments (OOP) or User fee.

Government funding takes the largest share of health care financing in the country. Where this is largely effective, health care financing and consequently health care service provisions is likely to meet the basic health demands of the people to some extent. Paradoxically government provisioning for health care services has been on the decline. The Table below shows total expenditure to health sector in the country between 1999 and 2005.

**Table 1 Distribution of Total Expenditure to Health Sector (N millions) from 1999 – 2005**

|  |  |
| --- | --- |
|  **Year**  |  **Description** |
|  |  **Allocation**  | **% Budgetary Allocation** |
| 1999 | 16,180.00 |  1.7 |
| 2000 | 18,181.80 |  2.6 |
| 2001 | 44,383.50 |  4.4 |
| 2002 | 59,778.20 |  5.9 |
| 2003 | 47,934.70 |  3.9 |
| 2004 | 54,927.40 |  3.9 |
| 2005 | 77,473.60 |  4.3 |

Source: CBN Statistical Bulletin 2007 adapted from Nigeria’s Social Indicators for Policy and Legislative Guide 1999 – 2007.

**Figure 1 Distribution of Total Expenditure to Health Sector (N millions) from 1999 – 2005**

The Federal Government’s commitment to health care varied considerably as indicated by the above data. The table shows that the highest budget allocation to the health sector was in 2002, which was 5.9% after which there was a decline in the two successive years; 2003 and 2004 with a percentage of 3.9 each.

The year 2005 however witnessed increase in the budget allocation from the two preceding years. What is instructive here is that government’s commitment and budgetary allocation vary considerably. It is conditioned by the total resources available to the government to base its appropriation. Within this context health sector has to compete with other sectors in the system and its appreciation depends on the value the government places on health care development. Community health care financing invariably becomes part of the process.

Community financing for health is a mechanism whereby households in a community (the population in a village, district or other geographical area, or a social-economic or ethnic population group) finance or co-finance the current and/or capital costs associated with a given set of health services, thereby also having some involvement in the management of the community financing scheme and organization of health (Ojo, 2006, p. 215-216). However, direct payment / user fees also known as Out-of-pocket payments (OOPs) is very common in developing countries although there has been calls for its removal in response to evidence of its regressive impact and its role in enhancing social exclusion particularly in primary care level (Nigerian Health Review, 2007).

The Bamako Initiative (BI) of 1988 introduced a strategy of health care financing where community operates the ‘Drug Revolving Fund’. The main purposes of the initiative are to secure community funding of recurrent costs, enhance essential drug supply system and strengthen community participation and control (Oliveira-Cruz, Hanson and Mills, 2003). A study I conducted in four communities in Lagos state reveals that,most efforts of the communities at resources mobilization for health care are carried out by the community organizations in the communities. One of the interviewees at the communities avers:

Committee members raise money among themselves to buy drugs although we follow orders from the nurses as to what type of drugs to buy, this we sell and the profit saved for other future use, but you see we are finding it difficult now to even raise money to buy the drugs because of the economic situation which is affecting most of us or how do you ask someone that cannot feed himself and the family to come and contribute money for drugs? (FGD, Ilado, 2008).

Evidence from this qualitative study shows that community members are not positively disposed to making financial commitments towards health care development. Furthermore, ‘Drug Revolving Funds’ are either not in existence anymore or not been run effectively in some of the communities studied and this affects availability of drugs in most health facilities. This resonates with the reports of the survey carried out by NPHCDA in 2001 which states that there has not been an improvement. The NPHCDA health facility survey of 202 LGAs measured the availability of essential drugs list and drug revolving fund system. The reports indicate that drug supply is inadequate in public sector PHC facilities (Nigerian Health Review, 2007). We can argue that the exclusion of communities from core decision-making also affects their participation in health care financing in the communities.

As observed earlier in this paper, within the three tier structure, the local government is responsible for the provision of PHC services, the state government takes the responsibility of secondary health care, while the federal government handles the tertiary health care. The delegation of PHC to local governments was intended to bring decision-making and services closer to where people lived and worked, thereby permitting the delivery of health care to be adapted and fine-tuned to local needs (Nigerian Health Review 2007). PHC is the first level of contact of the people with the nation’s health care system, and it is at the grassroots level that this contact is made. By extension, the people at this level are to take responsibility for their health by taking part in the planning and management of the health system.

Within the system of health care administration and health care financing, local government is constrained in its function as the provider of basic PHC services in the country.

Financing of day-to-day health facility functioning for example is largely provided by local government. The federal and state governments are expected to provide logistical and financial assistance to the LGAs, primarily for programmes of national importance such as the National Programme of Immunization, or controlling the spread of HIV/AIDS (Nigerian Health Review, 2007).

Local governments get 20% of statutory allocation from the federation account. They are expected to internally generate revenue to meet their assigned responsibilities. In these areas, local governments are confronted with daunting challenges that invariably constrained them in performing. The 20% statutory allocation to local governments is channeled through the state governments. It is no gainsaying that the experience of local governments in this respect has been tales of woes as state governments oftentimes divert local governments’ allocation for other purposes.

Furthermore, the nature of inter - governmental arrangement which specify areas of operations amongst the three tiers of government is dysfunctional. Opinions have been expressed concerning the nature of the relationship between the three tiers of government as it relates to their roles and responsibilities in health care delivery. According to the Appraisal Report of African Development Bank (2002),

The organizational structure of the Nigerian health care system suffers from lack of specificity and ambiguities in the definition of roles and responsibilities of the three tiers of the system, the Federal, State and Local Government levels. Even when roles are clearly assigned there are instances where some tiers of Government take on responsibilities that are clearly not within their mandate (ADB, 2002, p. 18).

It is clear that lack of effective coordination of various institutions responsible for the provision of health care services is one of the factors responsible for the crisis of health care delivery in the country. Nwakoby (1999) is of the view that the institutional and functional divisions of the three tiers of government are not mutually exclusive, they are to complement each other with a view to realizing the objectives of the National Health Policy.

The poor definition of roles and responsibilities of actors in the health sector has contributed to the confusion and haphazard implementation of PHC policy in the country. Furthermore, the local government which is assigned the responsibility of PHC has been described as the ‘weakest and poorest’ tier of government. Unfortunately, the community peoples are entwined in this state of confusion. It therefore becomes difficult for them to take part effectively in the process of health care delivery at the local level.

The whole argument of people participating in the decision-making at the local government revolves around the notion of ‘responsible governance’ where rulers are made accountable and responsible to the ruled. Issues of transparency, accountability, justice amongst other are perceived to be inclusive of the process of governance when people participate especially in the decision that affect their lives. As regards decision-making on health care delivery, community people are stakeholders and actors in the process.Health constitutes a strong platform for democratic participation and people’s empowerment.Developments in the health sector in the country shows the decline of the community participation in PHC planning and management. The consequence is the poor performance of the health care system and its failure to solve the basic health problems in the country.

**Conclusion**

Decentralization has emerged as a result of global trend to local autonomy and self-determination, and as a result of a trend to reduce reliance on centralized planning of economics and be more responsive to market forces as well as local needs and characteristics.

Oneof the reasons advanced fordecentralization is that it can generate financial efficiency and quality gains by devolving resources and decision-making powers to local governments for the delivery of services. The general argument for decentralizing health care however is the potential for improved service quality and coverage. Reforms in the health sector in most developing countries have promoted decentralization as a means of achieving objectives such as improved efficiency, better responsiveness to local conditions and local accountability to community priorities especially in the provision of health care services. However, not all the potential benefits of health care decentralization have been realized. Among these problems is the lack of clear delineation of tasks and management structures between and within different levels of the health system. This has often been neglected at the design stage of decentralization. The division of authority for budgetary management is also important but in many countries, although recurrent budgets have been devolved to districts, development budget remain with the Ministry of Health. Thus budgetary decentralization remains limited. This may likely constrain the ability of districts to improve the efficiency and effectiveness of service provision through improved resource allocation as decentralization without delegation of appropriate financial and administrative powers does not work. It can be argued that decentralization creates more challenges for health provision. Since the argument is that decentralization in most countries has been poorly designed and implemented, there is the need for involvement of all stake holders in the service of health provision in the process of decentralization design and implementation. Decentralization policy should also include effective coordinating mechanisms to enhancing efficient service delivery.

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