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CITIZENS' PARTICIPATION AND PRIMARY HEALTHCARE POLICY IMPLEMENTATION IN OGUN STATE, NIGERIA: AN EMPIRICAL AND SYSTEMS ENQUIRY

Adeola I. Oyeyemi[1+]
Daniel E. Gberevbie[2]
Jide Ibietan[3]

[1,2,3]*Department of Political Science and International Relations Ota, Ogun State, Nigeria.*
[1]*Email: adeola.oyeyemi@covenantuniversity.edu.ng Tel: +234(810)9213080*
[2]*Email: daniel.gberevbie@covenantuniversity.edu.ng Tel: +234(802)3628562*
[3]*Email: jide.ibietan@covenantuniversity.edu.ng Tel: +234(805)0490850*

(+ Corresponding author)

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ABSTRACT

Health in its complete state of wellbeing is of utmost importance in the achievement, development and sustainability of societal goals, as envisioned in the United Nations Sustainable Development Goal (SDG) 3, and joint efforts are required for its attainment. Studies have focused on the importance of citizen participation in diverse fields, including health care, but little attention has been paid to this in developing countries' primary healthcare (PHC) systems, such as Nigeria. Thus, this paper seeks to ascertain the relationship between citizens' participation and primary healthcare policy implementation challenges in Nigeria. A cross-sectional survey research design was adopted with a multi-stage sampling technique used to select 500 Ogun State citizens. Primary data were analyzed using the Pearson Product Moment Correlation to ascertain the relationship between the variables. Findings show that there is a significant positive and strong relationship between citizens' participation and policy implementation (R-value: 0.696; p-value: 0.000), but there is no significant relationship between citizens' participation challenges and PHC policy implementation (R-value: -0.105; p-value: 0.120). The study is premised on the political system theory that explains citizens' participation with a holistic and integrated approach of involvement, empowerment and accountability in the healthcare system. The study, therefore, recommends an integrated decision-making process that is bottom-up, which would support a sustainable healthcare system with enlightened citizens' input towards the actualization of an effective PHC system.

Contribution/Originality: This study contributes to existing literature by providing a collaborative approach in PHC policy implementation, which is a radical departure from the stereotypical nuances and bifurcation of the top-down model, which characterizes parts of the policy process (formulation and implementation) in Nigeria.

1. INTRODUCTION

Ensuring the health and well-being of all citizens through policies that are well-formulated and implemented in a bid to reduce, prevent and eliminate health issues rampaging the country, is a major responsibility of governments (Bath & Wakerman, 2015; Iyanda & Akinyemi, 2017; World Health Organization, 2017). This is in line with the United Nations Sustainable Development Goal 3. Achieving sustainable development nationwide is dependent on the health of the citizens because a healthy individual is economically and socially active and consistently contributes to the nation's prosperity. Furthermore, it is critical to the achievement of universal health coverage

that ensures access, quality, affordability of health, safety and availability of medications for all. These are deficient in many countries' healthcare systems, especially developing countries such as Nigeria. In an attempt to address these challenges, the government enacts policies and regulations and propose plans and programmes directed at achieving the specified objectives of primary healthcare, as set out in the Nigerian Health Policy since 1988 (Federal Ministry of Health, 2016). Over the years in Nigeria, the principles of primary healthcare (PHC) have been grafted on the attainment of a health for all agenda. Programmes targeted at reduction in the maternal and under-five mortality ratings, and reduction or elimination of communicable and non-communicable diseases such as polio, tuberculosis and HIV/AIDS were initiated (Aregbeshola & Khan, 2018). Furthermore, under the leadership of Professor Olikoye Ransome-Kuti, former Minister of Health in Nigeria, efforts to reduce the incidence of HIV/AIDs and child mortality were observable (Aregbeshola & Khan, 2018; Scott-Emuakpor, 2010). To consolidate the small gains recorded, the focus of the nation's healthcare system shifted to grassroots for effective monitoring by the local government (Abdulraheem, Oladipo, & Amodu, 2012; Aregbeshola & Khan, 2018). During this time, primary healthcare centers were built in every local government area (LGA) with health officers responsible for coordinating the services delivered through the policy (Aregbeshola & Khan, 2018). This enabled health facilities to be built and to bring health care closer to the people for more direct contact with the healthcare system. This was to ensure that individuals' health needs in the community were addressed and at an affordable rate that is sustainable (World Health Organization, 1978, 2017). Despite this, health challenges and lack of an appropriate nationwide healthcare framework constituted major issues of concern. To overcome these shortcomings, the country aligned with different national and global agendas, such as the National Health Insurance Scheme of 1991, the Millennium Development Goals (MDGs) of 2000 and, currently, the Sustainable Development Goals of 2015.

Based on these agendas, Nigeria's success rate has been low with an overall global ranking of 187 out of 191 rated countries on the Human Development Index (United Nations Development Programme, 2018). Nigeria, being one of the largest countries in Africa with a healthcare system driven predominantly by the public sector and with support from the private sector, its overall healthcare system remains in a deplorable state (World Health Organization, 2017). Nigeria has a high number of both communicable and non-communicable diseases that result in a 66% rate of morbidity, polio, tuberculosis, a HIV/AIDS epidemic, and poverty with a life expectancy of 54 years (Federal Ministry of Health, 2016; United Nations Development Programme, 2018). Many studies have investigated these issues and suggested some reasons for these unfortunate circumstances, such as weak political will, corruption, and inadequate funding among others, and these hinder the implementation of various health policies in both urban and rural areas.

In recognition of these facts, citizens' participation, public participation and patient participation in the last 40 years have become a topic of interest (Rasak, 2013; Reeve et al., 2015; World Health Organization, 1978). For Nigeria, this can be seen in the deregulation of healthcare administration and services to the local government, creation of health facilities within a 5 km radius and the availability of Ward Health Associations as a source of communication between citizens and the local administrators (Adeyemo, 2005; Kironde & Kahirimbanyib, 2002; Tierney et al., 2014). Citizens' participation, according to Mirzaei et al. (2013), is often initiated at the local government level in the administration of successful public goods and services for the citizens' well-being. It helps communication, empowerment and mobilization in health care. Also important is citizens' involvement in policymaking from the planning stage to implementation and evaluation of policies, especially in primary healthcare, thus promoting grassroots governance (Gberevbie, Joshua, Excellence-Oluye, & Oyeyemi, 2017; Ndegwa, Mavole, & Muhingi, 2017; Williamson, 2014). Partnering with citizens' in the healthcare system and their usefulness in achieving sustainable systems and services are considered critical for inclusive healthcare implementations, democratic practices and global development agendas typified by the Sustainable Development Goals.

2. THEORETICAL FRAMEWORK AND APPLICATION OF THEORY

The theoretical framework upon which this paper is predicated is the political systems theory as postulated by Easton (1953). It explains the influence and need for diverse stakeholders' inputs, especially those that are often ignored, in the political system. It recognizes and welcomes citizens' contributions as salient political entities with power that is relevant to national and global agendas. This theory is useful in drawing attention to the citizens' involvement (as users, actors, planners and political and interest groups) in the health system and policy discourse. The interconnected cycle or system in which governance occur in countries has a role for international agencies and their agendas, institutions, interest groups and associations, public administrators and workers that can affect the day to day life of the citizens as outputs (Cinaroglu, 2018; Gore & Parker, 2019). Therefore, an open system, which allows free movement of ideas, information and resources in society impacts constituent parts effectively. Society reacts to the policy and programmes, in this case health policy and programmes and provides feedback to the system, thereby creating a cyclical process that leads to a good and balanced health status (Katz & Kahn, 1966; Olaniyi, 2005).

Achieving a sustainably developed health system requires an open, holistic, integrated and universal approach. That is, an inclusion of diverse parties, agencies and stakeholders (general public, policymakers, politicians, and national and international agencies) with the goal of universal access and health coverage (Egharevba, 2017). Primary healthcare and its elements are agents of attaining healthcare solutions envisioned by SDG 3 (health and well-being) for universal health coverage (Stewart & Ayres, 2001; World Health Organization, 2017). The explanation of the relationship between enlightened citizens and healthcare problems is comprehensible through the solutions offered by the political system in achieving an integrated process to policymaking anchored on the bottom-up approach (Cinaroglu, 2018; Gore & Parker, 2019; Stewart & Ayres, 2001).

3. METHODOLOGY

The cross-sectional survey design was adopted for this research. This is because it allows the variables under investigation (citizens' participation and primary healthcare policy implementation) to be studied simultaneously without manipulation (Kumar, 2011; McNabb, 2012). The population of the study comprises three million citizens of Ogun State, Nigeria (National Population Commission, 2009; Nigeria Demographic and Health Survey, 2013) and a multi-stage sampling technique was utilized to select the respondents. The first step was to choose the local government areas (LGAs) in Ogun State to be sampled. LGAs are responsible for the implementation of primary healthcare policy. From the 20 LGAs, 12 were selected within the three senatorial districts of the state: Ogun Central, Ogun East and Ogun West. This method allows for an equal selection of citizens thereby reducing the probability of sampling error, noting the diversity in each area (rural and urban). The next step was the use of purposive sampling to select health facilities within the LGAs. The selection process also took into consideration the different types of facilities in the state (comprehensive primary health centers, primary healthcare clinics and health clinics or health posts). This selection process included the primary healthcare coordinators of the selected LGAs, which further helped to create diversity making generalization possible.

The final stage of the method was the simple random sampling technique. Simple random sampling entails the random selection of citizens at and around the health facilities who are readily available and able to complete the questionnaire. Therefore, from the selected 12 LGAs with a population of two million, the sample size of 400 was drawn from +/-5 percent precision level with 95percent confidence using (Israel, 2012), but was increased to 500 to account for improperly completed questionnaires (National Population Commission, 2009; Nigeria Demographic and Health Survey, 2013). In total, 477 questionnaires were used for analysis, amounting to 95% of the administered questionnaires. Ethical approval was sought for this paper through the guidance and approval of the Covenant University Health Research Ethics Committee. The respondents were informed of the research purpose and reassured of their anonymity and confidentiality of information.

4. PROCEDURE FOR DATA ANALYSIS

Data were analyzed with the Statistical Package for Social Sciences (SPSS) version 21.0 and the results were used to proffer recommendations. The study used a bivariate tool of analysis, the Pearson Product Moment Correlation, to test hypotheses at the 0.05 level of significance of the relationship between the independent and dependent variables.

5. RESULTS

The respondents of the study were citizens from within the local government areas with proximity to and familiarity with the healthcare posts and clinics. To determine the relationship between citizens' participation and primary healthcare policy implementation in Ogun State, a correlation statistical tool was used. Also, the different challenges that hindered full and proper citizens' participation were expressed for analysis.

The demographic characteristics presented in Table 1 show that majority of the respondents were female (268 or 56.18%), while there were 209 males, making up 43.82%. There were 173 respondents (36.27%) who fell within the age bracket of 21–30 years, 167 respondents (35.01%) were in the 31–40 year age range, 103 respondents (21.59%) were in the 41 years and above bracket and 34 respondents (7.13%) were under 20 years of age. The table also reveals that majority of the respondents were married (72.96%) with a portion of them at a higher level of education (49.69%) and 171 (35.85%) in a professional occupation. In summary, the respondents of this study are educated, professional, mature, married women.

Table 1. Demographic characteristics of respondents.

Bio-data Information			
Items		**Total**	**Percent %**
Gender	Male	209	43.82
	Female	268	56.18
	Total	**477**	**100%**
Age	Below 20 years	34	7.13
	21–30 years	173	36.27
	31–40 years	167	35.01
	41 years and above	103	21.59
	Total	**477**	**100%**
Marital Status	Single	121	25.58
	Married	348	72.96
	Other	7	1.47
	Total	**477**	**100%**
Education	No education	13	2.73
	Primary	40	8.39
	Secondary	187	39.20
	Other	237	49.69
	Total	**477**	**100%**
Occupation	Unemployed	39	8.18
	Farmer	77	16.14
	Trader	130	27.25
	Artisan	60	12.58
	Professional	171	35.85
	Total	**477**	**100%**

Source: Field Survey, 2019

Table 2 shows a coefficient of correlation result of 69.6% with a p-value of 0.000. This is less than the significance level of 0.01, which, in essence, translates to a significant relationship between citizens' participation and primary healthcare policy implementation in Ogun State in the period under study. Therefore, a positive,

strong relationship is interpreted as showing a significant relationship in Ogun State between citizens' participation and primary healthcare policy implementation. Table 3 shows the variables used in the study.

The results presented in Table 4 show the coefficient of correlation result of -8.1% with a p-value of 0.229, which is more than the significance level of 0.05. This translates to a negative weak relationship between citizens' participation challenges and primary healthcare policy implementation at grassroots in the focus period of study. Table 5 shows the variables used to test for correlation.

Using Evans (1996) as a guide, the correlation of coefficients for Tables 2 and 4 were interpreted as follows: 0.00-0.19 "very weak"; 0.20-0.39 "weak"; 0.40-0.59 "moderate"; 0.60-0.79 "strong"; 0.80-1.0 "very strong".

Table 2. Correlation results between citizens' participation and primary healthcare policy implementation.

Respondents		Citizens' Participation	Primary Healthcare Policy Implementation
Citizens' Participation	Pearson Correlation	1	0.696**
	Sig. (2-tailed)		0.000
	N	477	477
PHC Policy Implementation	Pearson Correlation	0.696**	1
	Sig. (2-tailed)	0	
	N	477	477

Table 3. Variables measured under citizens' participation.

S/N	Items
1	I am aware of healthcare programmes around me
2	The healthcare services I use came from my ideas and points
3	The ward/community representative is available to listen to my healthcare concerns
4	The ward/community representative utilizes different tools, such as Facebook or WhatsApp, to get my views on healthcare
5	There is a place to go to share my healthcare concerns when the community has a pressing healthcare development issue

Table 4. Correlation between citizens' participation challenges to primary healthcare policy implementation at the grassroots of Ogun State, Nigeria.

Respondents		Challenges of Citizens' Participation	Primary Healthcare Policy Implementation
Challenges of Citizens' Participation	Pearson Correlation	1	-0.081
	Sig. (2-tailed)		0.229
	N	222	222
Primary Healthcare Policy Implementation	Pearson Correlation	-0.081	1
	Sig. (2-tailed)	0.229	
	N	222	477

Table 5. Citizens' participation challenges to primary healthcare policy implementation.

S/N	Items
1	Illiteracy
2	Access to social amenities
3	Financial responsibility
4	Insufficient manpower for engagement
5	Time factor for involvement
6	Lack of government engagement
7	Poor overall leadership

6. DISCUSSION

To achieve the sustainability of health for overall well-being of the populace in a country, the tools of implementation must be ascertained. In this case, citizens' participation is considered to be a strategic tool for

attaining healthcare; however, in Nigeria, the relationship has not been well researched to show its significance. This is because the evidence of relationship ought to show the relational requirement to achieve the goal. The level of relationship will dictate influence and impact, which is needed to ensure citizens' participation. The findings from this study indicate that there is a strong, positive relationship between citizens' participation and primary healthcare policy implementation. This is in line with other studies, such as those by Kironde and Kahirimbanyib (2002); Tierney et al. (2014); Bath and Wakerman (2015); Reeve et al. (2015); Iyanda and Akinyemi (2017); World Health Organization (2017), in places like South Africa where the management of tuberculosis patients yielded positive outcomes with citizens' engagement and in Australia where the Aborigines combatted pre-term births and maternal mortality. There has also been a reduction in gender-based violence against women by their male partners in Papua New Guinea and the Solomon Islands (Bath & Wakerman, 2015; Kironde & Kahirimbanyib, 2002), which can be attributed to participation. This adds to existing literature that supports and encourages citizens' participation in the healthcare system.

Regarding the challenges affecting citizens' participation in the implementation of primary healthcare policy, the findings revealed that there was a negative, weak statistical relationship between the variables. This implies that no challenge mentioned notably hinders citizens' participation in policy implementation. However, it was observed that there are common challenges, which include manpower, finance and infrastructural deficits. This validates the study by Ibietan and Ikeanyibe (2017) on observable challenges at grassroots in Nigeria. Many citizens are comfortable availing of state and federal hospitals instead of the poorly equipped and managed primary healthcare facilities. Only a quarter of the nation's health facilities have more than 25% of the minimum equipment package (Oyekale, 2017; Uzockuwu, 2017). A large proportion of these facilities are in a poor state, mostly as a result of inadequate funding at primary and secondary levels due to pervasive corruption. This reduces the PHC facilities to mere centers of immunization (Abdulhamid & Chima, 2016).

In Nigeria, the number of PHC facilities providing immunization services ranges from 5% in the North East to 90% in the South West; this is in line with the respondents' affirmations. Most centers are poorly managed by few health professionals in these communities. It is observable that many diseases, such as malaria, the common cold and other common conditions that affect citizens, occur frequently and require medical attention that could be directed elsewhere with the limited number of health professionals; 63% of medical cases are incorrectly diagnosed as a result of this, and only 38% of births occurring within health facilities are assisted by specialized health attendants (Aigbiremolen, Alenoghena, Eboreime, & Abejegah, 2014; Oyekale, 2017).

The poor qualities of services in the PHC facilities that are supposed to provide 24-hour service in the communities are due to lack of basic infrastructure. In some instances, services and care that are meant to be free are now priced, which accounts for the financial issues mentioned as challenges. The poor quality of services at PHC facilities and the limited periods of operation force patients to use secondary and tertiary facilities with high-priced services at locations distant from the grassroots (Ogbuabor & Onwujekwe, 2018; Oyekale, 2017; Uzockuwu, 2017).

Furthermore, primary healthcare centers in Nigeria's rural environments are seriously disadvantaged compared to their counterparts in the urban centers. This dismal state of affairs is attributable to factors such as lack of political commitment, inadequate funding or misappropriation of funds, weak inter-sectoral collaboration and inter-agency rivalries for power and control (Abdulraheem et al., 2012; World Health Organization, 1991). These exacerbate the low levels of community participation in healthcare policy implementation.

7. CONCLUSION AND RECOMMENDATIONS

This study concludes that a great deal of work is required to achieve the goal of citizens' participation in primary healthcare policy implementation in Ogun State, Nigeria. It is obvious that there is a relationship between the two variables and the relevance of political systems theory to this research cannot be overemphasized. The study underscores the need to build a more inclusive and integrated policy process that emphasizes citizens'

participation through the bottom-up approach to healthcare operations. The highlighted challenges revealed a negative and weak relationship to policy implementation that must be addressed. Extant literature underscored channels of engagement and their positive outcomes, which can robustly impact citizens' participation in primary healthcare policy in the focus of study. There is a compelling need to retrain community health workers, who in turn educate citizens, in order to enhance health services at a grassroots level. It is also beneficial to create partnerships locally, nationally and globally to reach the improvement target set out in Sustainable Development Goal 3.

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REFERENCES

Abdulhamid, O. S., & Chima, P. (2016). Local government administration in Nigeria: The search for relevance. *Commonwealth Journal of Local Governance*, *18*(1), 181-195.

Abdulraheem, I. S., Oladipo, A. R., & Amodu, M. (2012). Primary healthcare 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.

Adeyemo, D. O. (2005). Local government and healthcare delivery in Nigeria: A case study. *Journal of Human Ecology*, *18*(2), 149-160.

Aigbiremolen, A. O., Alenoghena, I., Eboreime, E., & Abejegah, C. (2014). Primary health care in Nigeria: From conceptualisation to implementation. *Journal of Medical and Applied Bioscience*, *6*(2), 35-43.

Aregbeshola, B. S., & Khan, S. M. (2018). Primary health care in Nigeria: 24 Years after Olikoye Ransome-Kuti's leadership. *Frontiers in Public Health*, *5*(48), 1-2.

Bath, J., & Wakerman, J. (2015). Impact of community participation in primary health care: What is the evidence? *Australian Journal of Primary Health*, *21*(1), 2-8.Available at: https://doi.org/10.1071/py12164.

Cinaroglu, S. (2018). Politics and health outcomes: A path analytic approach. *The International Journal of Health Planning and Management*, *34*(4), 824-843.

Easton, D. (1953). *The political system*. New York: Knopf.

Egharevba, M. (2017). Demographic dynamics, governance and the attainment of democratic development: The case of Nigeria. *Etude de la Population Africaine*, *31*(2), 3769-3786.

Evans, J. D. (1996). *Straightforward statistics for the behavioral sciences*. Pacific Grove, Calif: Brooks/Cole Publishing.

Federal Ministry of Health. (2016). *National Health Policy 2016: Promoting the health of Nigerians to accelerate socio-economic development*. Abuja, Nigeria: Federal Ministry of Health.

Gberevbie, D., Joshua, S., Excellence-Oluye, N., & Oyeyemi, A. (2017). Accountability for sustainable development and the challenges of leadership in Nigeria, 1999-2015. *Sage Open*, *7*(4), 2158244017742951.

Gore, R., & Parker, R. (2019). Analysing power and politics in health policies and systems. *An International Journal for Research, Policy and Practice*, *14*(4), 481-488.

Ibietan, J., & Ikeanyibe, O. (2017). Decentralisation and local government autonomy: Implications for grassroots development in Nigeria's fourth republic. *Administrative Culture*, *18*(1), 5-25.

Israel, G. (2012). *Determing sample size. Institute of food and agricultural sciences*. Gainesville, Florida: University of Florida.

Iyanda, O. F., & Akinyemi, O. O. (2017). Our chairman is very efficient: community participation in the delivery of primary health care in Ibadan, Southwest, Nigeria. *Pan African Medical Journal*, *27*(258), 1-14.

Katz, D., & Kahn, R. L. (1966). *The social psychology of organisations*. New York: John Wiley and Sons.

Kironde, S., & Kahirimbanyib, M. (2002). Community participation in primary health care (PHC) programmes: lessons from tuberculosis treatment delivery in South Africa. *African Health Sciences*, *2*(1), 16-23.

Kumar, R. (2011). *Research methodology: A step by step guide for beginners* (3rd ed.). London: Sage Publications Ltd.

McNabb, D. E. (2012). *Research methods in public administration and nonprofit management: Quantitative and qualitative approaches* (3rd ed.). New Delhi, India: PHI Learning.

Mirzaei, M., Aspin, C., Essue, B., Jeon, Y. H., Dugdale, P., Usherwood, T., & Leed, S. (2013). A patient-centred approach to health service delivery: Improving health outcomes for people with chronic illness. *BioMed Central Health Services Research*, *13*(251), 1-11.

National Population Commission. (2009). *2006 population and housing census.* Abuja, Nigeria: Population by States, LGAs and Senatorial Districts.

Ndegwa, M. N., Mavole, J. N., & Muhingi, W. N. (2017). Influence of public participation on successful implementation of public health projects in Nyeri South Sub-County, Nyeri County, Kenya. *International Journal of Social and Development Concern*, *1*(7/12), 77-90.

Nigeria Demographic and Health Survey. (2013). *National population commission.* Abuja, Nigeria.

Ogbuabor, D. C., & Onwujekwe, O. E. (2018). The community is just a small circle: Citizen participation in the free maternal and child healthcare programme of Enugu State, Nigeria. *Global Health Action*, *11*(1), 1-13.Available at: 10.1080/16549716.2017.1421002.

Olaniyi, J. O. (2005). *Introduction to contemporary political analysis.* Lagos, NG: Fapsony.

Oyekale, A. S. (2017). Assessment of primary health care facilities' service readiness in Nigeria. *BioMed Central Health Services Research*, *17*(172), 1-10.

Rasak, O. B. (2013). Patrons' perception of quality of healthcare services in primary health care Centres (PHCs) in Oyo State, Nigeria. *Developing Country Studies*, *3*(1), 75-83.

Reeve, C., Humphreys, J., Wakerman, J., Carroll, V., Carter, M., O' Brien, T., . . . Smith, B. (2015). Community participation in health service reform: The development of an innovative remote aboriginal primary health-care service. *Australia Journal of Primary Health*, *21*(4), 409-416.

Scott-Emuakpor, A. (2010). The evolution of healthcare systems in Nigeria: Which way forward in the Twenty-First Century. *Nigerian Medical Journal*, *51*(2), 53-65.

Stewart, J., & Ayres, R. (2001). Systems theory and policy practice: An exploration. *Policy Sciences*, *34*(1), 79-94.

Tierney, E., McEvoy, R., O'Reilley de Brun, M., de Brun, T., Okonkwo, E., Rooney, M., . . . MacFarlane, A. (2014). A critical analysis of the implementation of service user involvement in primary care research and health service development using normalization process theory. *Health Expectations*, *19*(3), 501-515.

United Nations Development Programme. (2018). *Human development indices and indicators: 2018 Statistical Update: Nigeria.* New York: UNDP.

Uzockuwu, B. (2017). *Primary health care systems (PRIMASYS): Case study for Nigeria.* Geneva: World Health Organization.

Williamson, L. (2014). Patient and citizen participation in health: The need for improved ethical support. *The American Journal of Bioethics*, *14*(6), 4-16.

World Health Organization. (1978). *Primary health care: A report of the international conference on primary health care, Alma-Ata, USSR, 6-12 September 1978.* Paper presented at the Geneva, Switzerland: World Health Organization and the United Nations Children's Fund.

World Health Organization. (1991). *Health promotion in developing countries.* Paper presented at the Briefing book to Sundsvall Conference on Supportive Environments. Geneva, Switzerland: World Health Organization.

World Health Organization. (2017). *World health statistics 2017: Monitoring health for the SDGs, sustainable development goals.* Geneva, Switzerland: World Health Organization.