Journal of Agricultural Extension Innovations
Volume 8, Number 1, 2022
ISSN:7288 - 6819
Published by University Press

FACTORS MILITATING AGAINST THE UTILIZATION OF MICRO HEALTH SERVICES IN THE NIGER DELTA REGION, NIGERIA

Uruang, E. S.[1], Harry A.T[2]
[1]Department of Agricultural Technology School of Science and Technology, Elechi Amadi, Polytechnic Rumuola, Port Harcourt, R/S, Nigeria
[2]Department of Agricultural Extension and Rural Development, Rivers State University, Port Harcourt, Nigeria.

Author for Correspondence: Email:harryariamebo@yahoo.com, ariaebo.harry@ust.edu.ng

ABSTRACT

This study evaluated the Factors Militating against the Utilization of Micro Health Services in the Niger Delta Region, Nigeria. The specific objectives were to: describe the personal characteristics of the beneficiaries of the health services, ascertain the factors militating against the utilization of the health services by the beneficiaries and determine the impact of the health services on the well-being of the beneficiaries. Data for the study were collected from Imo, Akwa-Ibom and Abia States. Primary data for the study were obtained from a structured questionnaire and response recorded from the respondents during Focus Group Discussions (FGDs). The respondents were the beneficiaries of the healthcare services and personnel of the various health centres. They were selected using the multistage sampling techniques from which a total of 300 respondents were chosen. However, 270 questionnaires were returned and used for analysis. Percentages mean score; multiple regression and one way Analysis of Variance (ANOVA) and Focus Group Discussions (FGDs) were employed for data analysis. The major findings showed that majority of the respondents in their active ages comprised of more female who acquired more education than the male. On primary occupation, (39.2%, 47.1% and 57.6%) of the respondents in Imo, Akwa-Ibom and Abia States respectively were into farming and also belonged to different organizations and more to the religious organization. Based on the findings from the study, some of the conclusions drawn were; that: the study revealed a general level of dissatisfaction on the part of the respondents with the health care project. The was because they were neither contented nor happy with the impact of the health project on their well-being, Health Service personnel across the three states of Imo, Akwa-Ibom and Abia expressed dissatisfaction in their job conditions. Job dissatisfaction had effect on personnel attitude to work and further access and utilization of the health care services by the respondents. Hence, the study therefore recommended that the condition of service of the health services personnel should be adequately addressed so that their performance in the discharge of their duties will be enhanced, Governments (Federal, State and Local Government) in sitting primary health projects should always aimed at addressing the well- being of the vulnerable groups such as youth, women and the elderly and Health centre projects should be properly conceptualized, to allay the fear, misconception and lack of confidence of the people in the health care services and further improve their access to the health care services.

Keywords: Militating, Utilization, Micro, Niger, Delta and Region

INTRODUCTION

In a simple and important sense, health is wealth. If one measures welfare more broadly than income or consumption, poor health is itself a deprivation that is part of poverty. Sen (2002) characterized poverty as "capability deprivation where a person lacks the substantive freedom he or she needs to lead the kind of live he or she has reason to value." Health has always been a valued possession. Alleyne and Cohen (2002) stressed that the Millennium Poll, a huge worldwide survey

prepared for the Millennium Report of the Secretary General of the United Nations, revealed that health consistently ranked number one in the things men and women desired in life. This is the reason why healthy population is considered as an engine for economic growth.

Generally, the average population growth in the Niger Delta is 3% as against 2.8% for the rest of the country, with life expectancy of 45 years compared to Nigeria's national life expectancy rate of 57 years (Aibokhan, 2007). The lower life expectancy in Niger Delta can be attributed to poor health conditions in the region.

This poor health condition in the Niger Delta region could have been minimized if people have adequate access to good health and delivery system. Accessibility of the people in the Niger Delta region to good health care services is being hampered by the high level of poverty and high cost of available health services in the region.

With the inauguration of the civilian government in May 1999, the European Union lifted the sanctions that had blocked the European Development Fund (EDF) for Nigeria. Consequently, the European Union and Federal Government of Nigeria designed and agreed upon a "quick start" package which, among other elements includes the provision of micro projects in the Niger Delta responding to the needs and priorities of local communities. This agreement started with the initiation in November 2001 by the Federal Government of Nigeria with the support from the European Union (EU), Micro Projects Programme (MPP_3) in three Niger Delta States of Bayelsa, Delta and Rivers.

Objectives of the Study

(i) describe the personal characteristics of the beneficiaries of the health services
(ii) ascertain the factors militating against the utilization of the health services by the beneficiaries
(iii) Determine the impact of the health services on well-being of the beneficiaries
(iv) Determine the level of job satisfaction of the health services personnel in the study area?

Hypotheses of the Study

The following null hypotheses were tested:

(i) There is no significant relationship between the utilization of the health services and the well-being of the beneficiaries.
(ii) There is no significant difference in the utilization of the health services among the beneficiaries across the project states.

LITERATURE REVIEW

Theoretical Framework

Dependency Theory

Dependency theory is a theory of how developing and developed nations interact. It was first formulated in the 1950s (McGuigan, 2003). The dependency school of thought sought to explain the underdevelopment of the third world within the context of the world system. Using a Marxian-type historical approach, apostles of dependency school exposes the negative consequences of capitalism on the development of the third world countries. Scholars like Walter (1972), Claude (1981), Taylor and Francis (2009), simply argued that in the world capitalist system, development of the metropolis (centre) creates a corresponding underdevelopment in the satellite countries (periphery). Walter Rodney, for instance, bluntly charges that it was Europe that underdeveloped Africa through the unequal exchanges that occurred during the colonial encounters and continues to occur through post-colonial imperialism.

McGuigan (2003) posited that the degree of dependency increases as time goes on. The report noted that wealthy countries are able to use their wealth to further influence developing nations into adopting policies that increases the wealth of the wealthy nations, even at their own expense. At the same time, they are able to protect themselves from being turned on by the developing nations, making their system more and more secure as time passes. Capital continues to migrate from the developing nations to the developed nations, causing the developing nations to experience a lack of wealth, which forces them to take out larger loans from the developed nations, further indebting them.

Conceptual Framework

The operational definition of Primary Health Care (PHC) will be necessary to define the breadth and boundaries of the result – based logic model, and the unique distinguishing activities, outputs and expected outcomes (Watson *et al,* 2004). For this purpose, PHC is defined as products or services designed to address acute and episodic health conditions and to manage chronic health conditions. It is also where health promotion and education efforts are undertaken; patients receive first care and where those in need of more specialized services are connected with other parts of the health care system. PHC can also be described in terms of the degree to which it is responsive to the needs of patients and populations.

The framework shows some of the more explicit link between inputs, activities and outcome of the health project. Arrows on the logic model linearly links resource inputs to activities performed, services delivered and outcome achieved based on the health project goals and objectives. The model establishes a common theory about the logic links among the different dimensions and a shared set of assumptions about these dependencies. It therefore focused principally on services directed towards individuals rather than Primary Health Care (PHC) services directed towards communities. The constructs and links in the logic model can be used to evaluate and report the health project as follows:

Contextual Factors

The contextual factors that may influence the Primary Health Care system include religion, social, and the culture of the people. Others are political, economic, the physical environment and public participation. Socio-economic, cultural and political contexts could influence the availability of informal/volunteer care and the relative importance of different activities, outputs and outcomes. According to Watson *et al* (2004), political and cultural contexts may likely influence the degree to which regulations enable or thwart services to the intended beneficiaries. Physical environments influence geographic distribution and accessibility of primary health care services. Social and cultural priorities may influence the relative importance of different activities, outputs and outcomes.

PHC Inputs

Watson *et al* (2004) defined Primary Health Care (PHC) inputs as resources (human, material and financial) used to carry out activities, produce outputs and/or accomplish results. The following inputs would collectively provide structure for the provision and receipt of PHC products and services.

PHC Activities

The next link in the logic chain after inputs is activities which are the operations or work processes intended to produce specific outputs. Activities are the primary link in the chain through which outcomes are achieved. Work processes internal to the PHC sector include policy/governance, health management and clinical activities intended to produce specific products and services.

PHC Outputs

Outputs are direct products or services delivered as a result of the activities of a policy, programme or initiative. Outputs represent the interface between the health care providers and the intended beneficiaries of the health care services. PHC Providers are responsible for delivering health promotion, disease/disability prevention, and rehabilitation. Others are curative, palliative and supportive services to target groups or populations. They also deliver services that can be described as patient-focused or family centered. PHC providers also refer individual with unusual or complex needs to more specialized health care service sectors. Indeed, referrals represent the formal mechanism of interaction between primary and secondary or tertiary care. The volume of PHC outputs is influenced by contexts and determined by inputs (e.g. fiscal and human resources used), as well as governance, healthcare management and clinical – level activities and decision.

PHC Outcomes

Watson *et al* (2004) noted that an important aspect of the result – based logic model is the differentiation between areas of control and areas of influence, as well as the concepts of efficiency and effectiveness. Inputs, activities and outputs are areas in which a programme, organization, or sector have some degree of control, while outcomes are areas of influence. Watson *et al* describes efficiency as the extent to which organization, policy, programme or initiative is producing its planned outputs in relation to expenditure on resources. And this is a function of inputs and activities. Inputs and activities occur prior to and in preparation for outputs. Outputs represent the interface between PHC products and services. Information about inputs, activities and outputs is needed to measure and monitor the efficiency of the PHC system.

Furthermore, Watson *et al* (2004) considered effectiveness as the extent to which an organization, policy, programmes or initiative is meeting its planned results and a function of outputs and outcomes. Effectiveness can be measured at a system level and at a service level. The effectiveness of the PHC system is a function of all product and service outputs. By comparison, the effectiveness of a single product or service delivered by a provider is a function of that output and the outcome attained by the individual who received it.

Theoretical Review

Furthermore, since programmes and projects are mostly developed in close collaboration with the stakeholders, there is therefore the need for the framework to rely extensively on a collaborative process (Chen and Rossi, 2004). This process according to Chen and Rossi leads to the incorporation of the participatory evaluation approach into the theory – based approach to make it the theory-based, participatory evaluation model.

The philosophy of the health project suggests that services are collaborative characterized by the service providers, intended beneficiaries, health services personnel and other stakeholders working in partnership to address the project goals. The use of theory – based, participatory evaluation model provides a useful framework for translating these principles into methods (Green et al, 2006). For example, the use of participatory methods facilitates collaboration among the stakeholders. The theory-based, participatory model, Green et al noted, provides a way to capture the comprehensive nature of the project within an organizing framework, and facilitates flexibility by outlining the likely developmental sequence of project changes.

In addition to these benefits, Weiss (2005) noted that the theory-based, participatory evaluation model further the understanding of the project functioning at a broader level. These kinds of evaluations foster the exchange of ideas, information, and assumptions among researchers, service providers and project beneficiaries, which can lead to a richer and more complex understanding of how and why these projects work. Further, by definition, theory based evaluation focus directly on

understanding the mechanism underlying programme functioning and can thus address complex conceptual questions about the nature and effectiveness of interventions.
Finally, Weiss suggests that, because theory-based participatory evaluation model focus on explanation of project effect (rather than just documentation), an increased use of this theory may lead to an improved ability to integrate evaluation results into a larger body of theoretical and project knowledge. Thus, using a theory-based, participatory approach has both immediate benefits to the project, as well as enhancing usefulness of evaluation results on a broader level.

METHODOLOGY

Study Area

Niger Delta region is situated in the Southern part of Nigeria and bordered to the South by the Atlantic Ocean and to the East by Cameroon. It occupies about 12 percent of Nigeria's total surface area (FGN, 2006). The current population of the Niger Delta is 31 million, constituting almost 24 percent of Nigeria's total population of which 75 percent live in rural areas and constituting of over forty different ethnic groups, speaking 250 different languages (World Bank 2007a). The States with the largest populations are Rivers, Delta, Akwa Ibom and Imo (FRN, 2007). There are indications of a predominance of males in the population of the Niger Delta: 54:56 according to the Niger Delta Development Commission (NDDC) Master Plan (NDDC, 2005); and 52:48 according to the provisional 2006 census figures (UNDP, 2006). This trend may be due to the influx of migrant males from other parts of Nigeria. The population is youthful: 62 percent are below 30 years of age, while 36 percent are between 30 and 69, and just 2 percent aged 70 and above. The age structure of the population has important implications for development planning making social investment a crucial need (UNDP, 2006).
The predominant occupation of the people are farming and fishing (NDDC, 2004). The Niger Delta region has the world's third largest mangrove forest with the most extensive fresh water swamp forest and tropical rain forest (Alamieyesigha, 2004). It consist of three major wetlands types: the upper fresh water flood plains, the lower tidal flood plains, and an outer chain of barrier islands (Obot, 2006). The upper fresh water floodplains may be further subdivided into the Ase River floodplains, the Niger Delta floodplains and the Forcados/Escravos/Benin River estuaries based on floral affinities. Other workers (e.g. Powell, 1995) recognized other subtypes based on hydrological variations. Within these wetlands, district vegetation types (the mangroves, freshwater swamp forests, and low and rain forests with grassy marshland).

Population of the Study

The population of the study included the beneficiaries of the European Union (MPP6) Micro Health Project in the six Niger Delta States. The states are Ondo, Edo and Imo. Others are Abia, Akwa-Ibom and Cross River.

Sampling Procedure

A total of 446 micro health projects were executed in different communities in the six project states (Bawa, 2008). A multi-stage sampling procedure was used in selecting the sample for the study. The six project states were divided into 3 (three) zones during project execution stage. They were:

- Zone 1- Abia and Imo States,
- Zone 2 – Akwa - Ibom and Cross River States, and
- Zone 3 - Edo and Ondo States.

Three states (Imo, Abia and Akwa-Ibom) were sampled for the study. Ten villages hosting the project from each of the three states were selected and eight households in each of the villages

were randomly selected for the study. Again, sixty health service personnel were randomly selected from the three representative states for the study. These gave a total sample size of 300. However, 270 questionnaires were returned and used for analysis.

Method of Data Collection
The study was carried out using both primary and secondary data. The secondary data was sourced from published and unpublished project reports and documents that were obtained at the project coordinating office. The primary data were obtained using both qualitative and quantitative interviews.

Analysis of Data
Data collected were analyzed using both descriptive and inferential statistics. Objectives one, two, three, four, five, six and seven were analyzed descriptively using frequency, percentage and mean. The Ordinary Least Square (OLS) multiple regression was used to analyze hypotheses one, two and three. Hypothesis four was analyzed using the Analysis of Variance (ANOVA).

Measurement of Variables
The dependent variable of the study includes the well-being of the beneficiaries of the health service. Similarly, the independent variables were the personal characteristics of the beneficiaries of the project, adequacy of physical infrastructural facilities, and performance of the health service. Others were accessibility of the beneficiaries to the health services, factors affecting the utilization of the health services by the beneficiaries and the job satisfaction of the health service personnel.

Dependent Variable
Well-being – According to White (2008), the dominant approach to the subjective in well-being research has been quantitative, with the generation of numerical profiles reflecting people's self-assessed quality of life. 'Global happiness' scores are now a common feature in economic household surveys. The degree of individual satisfaction of respondents with the health services was obtained using the Yes or No option.

Independent Variables:
Personal Characteristics of the beneficiaries:
The personal characteristics of the respondent were assessed using the variables below:

- Age - age (years)
- Sex - (1 = female, 0 = male)
- Educational attainment – (number of years spent in school)
- Marital status – (1 = Married, 2 = Single)
- Occupation – (1= Farming, 2 = Fishing, 3= Salaried work, 4= others)
- Membership of social groups – [(e.g. cooperative societies, village improvement unions, etc), (1 = member, 0 = non - member)]
- Household size (number of people in the household)

Performance of health services:
Dimension of health care are those definable, preferably, measureable attributes of the services that are related to its functioning to maintain, restore, or improve health (Mirianda et al (2010). The report noted that the Importance – Performance Analysis (IPA) technique can be used to analyze the performance of health services provision. This was done by using the Yes or No option to elicit response from respondents on the performance of the health services considering attributes such

as the cost of drugs, quality and availability of drugs. Others are the way children are being treated, attitude of health service personnel such as doctors, pharmacist's nurses, etc.

Factors affecting the utilization of the health services by the intended beneficiaries
The factors affecting the utilization of health services by the beneficiaries was determined using multiple questions with either the Yes or No option or other options such as None, Sometime or Frequently as may be applicable.

RESULTS AND DISCUSSION
The results of this research are discussed under the following sub-headings:
Socio-economic characteristics of the beneficiaries of health service
Socio-economic characteristics of the respondents to a large extent influence their utilization of health services. Socio-economic variables considered in this study were gender, age of respondents, marital status, educational attainment, primary occupation and membership of organization.
Gender of the respondents
Table 1 below shows that in Imo State, 30(49.2%) of respondents were male as against 31(50.8%) females. While in Akwa Ibom State, the male and female respondents surveyed were 37(36.3%) and 65(63.7%) respectively. Similarly in Abia State, 26(38.8%) of respondents were males, while 41(61.2%) were female. The results of this analysis show a higher response of the female than the male across the states of Imo, Akwa-Ibom and Abia.
The findings confirm the earlier studies on gender difference in the utilization of health care services by Rohlfs *et al* (2009) that women are homemaker whose activities include taking their babies to the health centre for immunization. This was exactly the situation in the rural communities where the health centres were located.
Age of Respondents
In Imo state, the age range were 18-38 years (49.2%), 39-58 years (29.5%) and 59-70 years (21.3%). For Akwa-Ibom state, the ranges were 18-38 years (43.1%), 39-58 years (32.4%) and 59-70 years (24.5%). Similarly, in Abia state, the age ranges were 18-39 years (62.7%), 39-58 years (23.9%) and 59-70 years (13.4%). The overall picture of the age distribution was an indication that majorities (48.3%), of the respondents were within their active and reproductive ages (18 – 38) years.
The findings corroborates the study of Rasak (2013**)** on patrons' perception of quality of healthcare services in Primary Health care centres (PHCs) in Oyo State that majority of Primary Health Care centres attendance are females who are active and in their child bearing ages.

Marital Status of the Respondents
In Imo State, 54.1% were married; Akwa-Ibom had 52.9% married, while it was 50.8% in Abia State respectively. It was 22.9%, 19.6% and 26.9% single women for Imo, Akwa-Ibom and Abia States respectively. For the divorced, it was 6.6% for Imo State, 3.9% for Akwa-Ibom State and 5.9% for Abia State. Respondents who separated from their marriages were 4.9% for Imo State, 6.9% for Akwa-Ibom and 8.9% for Abia State, while widowed were 11.5% for Imo State, 16.7% for Akwa-Ibom State and 7.5% for Abia State. The findings revealed that majority (52.6%) of the respondents in the study area were married.

Educational Attainment of Respondents
The results shows that the level of respondents without formal education were low (16.4%, 15.7%, 20.8%) in Imo, Akwa-Ibom and Abia states respective. For those who were in school for about six years, the result were 19.7%, 29.4% and 28.4% for Imo, Akwa-Ibom and Abia States respectively,

while the result for those who spent between seven to twelve years in school showed 37.7%, 47.1% and 43.3% for Imo, Akwa-Ibom and Abia states respectively. It was found that a higher proportion of the respondents (41.7%) had between 7–12years education indicating secondary education. This result corroborates the findings of Oluwatayo (2006), Awotunde *et al.,* (2007) and Nnodim (2011). In their separate studies of educational attainment of rural women in Nigeria, it was discovered that majority of them benefited from formal education.

Primary Occupation of Respondents

Regarding primary occupation majority (39.4%, 47.1% and 58.2%) of the respondents in Imo, Akwa-Ibom and Abia states respectively were into farming. For fishing, the result showed 13.1% of the respondents in Imo State, 15.7% in Akwa-Ibom State and 7.5% in Abia State. The result confirmed Ijere 1984 cited by Ogueri (2006**),** that a typical Nigerian rural setting is agrarian where farming and fishing are major occupations and also corroborated the findings of Beth (2004) and Akpabio (2005) that agriculture is the mainstay of rural economy especially in the sub-Saharan Africa. In all, about 46.3% of the respondents in the study area were farmers.

Aside from farming activities, analysis showed that salaried work (26,55%, 26.2% and 25.4%) were the next dominant occupation of respondents in Imo, Akwa-Ibom and Abia states respectively while the result for other occupations showed 21.3% for Imo State, 12.7% for Abia State and 8.9% for Abia State.

Membership of Organization

Majority (88.6%) of the respondents from the three states agreed were members of different organizations. Table 1 below showed that 91.8%, 8.2% and 100% of the respondents from Imo, Akwa-Ibom and Abia states respectively belonged to different social organizations. The importance of being a member of social organization is for self development and the development of the rural communities. This result agreed with the assertion of Nayamuddin and Manraguliani (2006) that rural organizations are very important in rural development.

Type of Organization

Social, political, cultural, religious and professional were the different organizations that the respondents belonged to. Result of analysis showed that majority (36.1%, 42.1% and 32.8%) of the respondents in Imo, Akwa-Ibom and Abia states respectively belonged to religious organizations. This could be because most Nigerians believe that religion still remains an important agent for sustainable development especially in rural communities. It agreed with the findings of other social researchers such as Ajadi et al (2010) and Eshiet (2007). In their separate studies, Ajadi *et al* assessed the impact of women's organizations on sustainable rural environment and livelihood in Nigeria and found that women worldwide have contributed greatly to sustainable development including primary health care. Similarly, Eshiet (2007) in his study of the socio-economic potentials of rural women and the contribution of women associations found that membership of organizations encourage the articulation of women's interest in the community and play a key role in the socio-economic development of their various communities. These assertions underscore the fact women constituted majority of the respondents in this study.

Table 1: Distribution of respondent based on their socio-economic characteristics

Variable	Imo State (N=61)	Akwa Ibom State (N=102)	Abia State (N= 67)

	Frequency	%	Frequency	%	Frequency	%
Gender						
Male	30	49.2	37	36.3	26	38.8
Female	31	50.8	65	63.7	41	61.2
Age Range						
18-38 years	30	49.2	44	43.1	42	62.7
39-58	18	29.5	33	32.4	16	23.9
59-70	13	21.3	25	24.5	9	13.4
Marital Status						
Married	33	54.1	54	52.9	34	50.8
Single	14	22.9	20	19.6	18	26.9
Divorced	4	6.6	4	3.9	4	5.9
Separated	3	4.9	7	6.9	6	8.9
Widowed	7	11.5	17	16.7	5	7.5
Educational Attainment (Year)						
No Formal Education	10	16.4	16	15.7	14	20.8
1-6	12	19.7	30	29.4	19	28.4
7-12	23	37.7	48	47.1	29	43.3
13-18	16	26.2	8	7.8	5	7.5
Primary Occupation						
Farming	24	39.4	48	47.1	39	58.2
Fishing	8	13.1	16	15.7	5	7.5
Salaried Work	16	26.2	25	24.5	17	25.4
Others	13	21.3	13	12.7	6	8.9
Membership of Organization						
Yes	56	91.8	90	88.2	67	100
No	5	8.2	12	11.8	0	0
Type of Organization						
Social	17	27.9	13	12.8	13	19.4
Political	6	9.8	8	7.8	10	14.9
Cultural	12	19.7	31	30.4	15	22.4
Religious	22	36.1	43	42.1	22	32.8
Professional	4	7.8	7	6.9	7	10.5
Religion						
Christianity	49	80.3	85	83.3	50	83.6
Islam	2	3.3	1	1.0	0	0
Traditional	10	16.4	16	15.7	11	16.4

Factors militating against the utilization of health services by the beneficiaries

The results in Table 2 below indicated that the variables such as culture, religion and conflict did not show high level of response across the three states. For culture (Imo = 1.50; Akwa-Ibom = 1.51; Abia = 1.32); religion (Imo = 1.59; Akwa-Ibom = 1.54; Abia = 1.35); conflict (Imo = 1.40; Akwa-Ibom = 1.22; Abia = 1.20). Others are too much population to the health centre (Imo = 1.38; Akwa-Ibom = 1.2; Abia = 1.23), house too far from the health centre, (Imo State = 1.49; Akwa-Ibom = 1.40; Abia = 1.46); bad access road, (1.14, 1.07 and 1.09) for Imo, Akwa-Ibom and Abia States respectively; inadequate patient beds 1.15 (Imo State), 0.30 (Akwa-Ibom state) and 0.31 (Abia State).

Variables such as lack of money to attend the health centre, inadequate staff at the health centre and inability of the doctors, pharmacists, nurses, etc to attend to the people promptly elicited high

responses across the states. Lack of money to attend the health centre, (Imo = 2.08; Akwa-Ibom = 2.02; Abia = 2.05); inadequate staff at the health centre (2.01, 2.10 and 2.11) for (Imo, Akwa-Ibom and Abia States) respectively. Inability of doctors, pharmacists, nurses, etc to attend to patients promptly 2.02 (Imo State), 2.05 (Akwa-Ibom State), and 2.07 (Abia State), while the result for inadequate electricity supply, at the health centre was 2.10 (Imo State), 2.05 (Akwa-Ibom State) and 2.03 (Abia State). In the same vein, the other variables that elicited high response from the respondents were lack of safe source of water supply at the health centres (Imo = 2.07; Akwa – Ibom = 2.08; Abia = 2.13), inadequate drugs (Imo =2.11; Akwa-Ibom = 2.04; Abia = 2.01), and high cost of available drugs at the health centre, 2.06 (Imo State), 2.04 (Akwa-Ibom State), and 1.11 (Abia State).

This situation as noted by Adesiji et al (2012) must have discouraged the respondents from accessing primary health care facilities and probably increase the patronage of the traditional healers. The result also corroborates the earlier studies of Sule et al (2008) and Thaddeus (2011). Sule et al (2008) in their studies on the utilization of primary health care facilities: lessons from a rural community in South West, Nigeria reported that some of the reasons for the underuse of the services provided by the primary health care centres include inadequate physical infrastructural facilities, attitude of health care providers, cost of care, personnel inadequacy, etc. Thaddeus (2011) also shared the view that attitude of health care officials is very significant in accessing the adequate utilization of health care facilities.

Table 2: Respondents rating of the factors militating against the utilization of health services

ITEMS	IMO (N=61)		AKWA-IBOM (N=102)		ABIA (N=67)	
	M	REM	M	REM	M	SD
Some cultural factors in your community	1.50	Low	1.51	Low	1.32	Low
Your religions consideration	1.59	Low	1. 54	Low	1.35	Low
Lack of money to attend the health centre	2.08	Low	2.02	Low	2.05	Low
Communal conflict in your community	1.40	Low	1.22	Low	1.20	Low
Other insecurity in your community	1.50	Low	1.27	Low	1.24	Low
Too much population to the health centre in your community	1.38	Low	1.27	Low	1.23	Low
Inadequate staff at the health centre	2.01	High	2.10	High	2.11	High
Inability of doctors pharmacists, nurses, etc to attend to you promptly	2.06	High	2.05	High	2.07	High
Inadequate electricity supply at the health centre	2.10	High	2.05	High	2.03	High
Lack of safe source of water supply at the health centre	2.07	High	2.08	High	2.13	High
Bad access road to the health centre	1.14	Low	1.07	Low	1.09	Low
Inadequate drugs at the health centre	1.02	Low	1.09	Low	1.08	Low
High cost of drugs at the health centre	2.11	High	2.04	High	2.01	High
Inadequate patient beds at the health centre	1.15	Low	1.10	Low	1.11	Low
Lack of Knowledge of the existence of the health centre in your community	1.63	Low	1.58	Low	1.60	Low

Midpoint = 2
Mean score < 2.00 suggest low
Mean score ≥ 2.0 suggest high

The Impact of the health service on the well-being of the beneficiaries

Results from table 3 showed that the health services had made little or no impact on the well-being of beneficiaries. Respondents in the study area noted that their health is not well taken care of (Imo = 1.97; Akwa – Ibom = 1.74; Abia = 1.79). They also noted that the health of their family members was not well taken care of (Imo = 1.96; Akwa - Ibom = 1.74; Abia = 1.89). The results further indicated a general level of dissatisfaction of the respondents on the impact of the health service project on their well-being. This assertion is in line with the different studies of Andrews and Withey (2008), Diener et al (2008), and Schaffer (2010). Andrew and Withey (2008) in the study on the Social indicators of well-being agreed that at, minimum, well-being includes the presence of positive emotions and mood such as contentment and happiness. The result of the analysis showed that the respondents were neither contented nor happy with the health service in their communities. It also corroborates the views of Deiner et al (2008) that well-being can be described as judging life positively and feeling good and that of Schaffer (2010**)** that well-being may be more significant than it at first appears especially its simple association of the target group with positive concept.

Table 3: Respondents rating of the impact of the health services on their well-being

ITEMS	IMO (N=61)		AKWA-IBOM (N=102)		ABIA (N=67)	
	M	REM	M	REM	M	REM

Your health is well taken care off	1.97 Low	1.74 Low	1.79 Low
The health of your family members is well taken care off	1.96 Low	1.74 Low	1.89, Low
You are healthier now than before	2.11 Low	1.75, Low	2.11, Low
You are happy within yourself	1.86 Low	1.63, Low	1.89 Low
You are happy with your health status now	2.26 Low	1.78 Low	2.70 Low
You are spending less money on your health care now	1.97 Low	1.80 Low	1.94 Low
You are spending less money on the health care of your household members	1.95 Low	1.80 Low	1.92 Low
You are able to save move money now	1.95 Low	1.78 Low	1.99 Low
You are able to attend to your other needs now	1.99 Low	1.78 Low	2.00 Low
You are able to attend to the other needs of your household members now	1.96 Low	1.80 Low	1.92 Low

Midpoint = 2.00
Any mean score < 2.00 suggest low
Any mean score ≥2.00 suggest high

Job Satisfaction

Job satisfaction is one of the most frequently studied work attitudes and assessment of organization's performance. The result from table 4.9 showed that personnel of the health services did not have job satisfaction. Respondents noted that their salaries were not promptly paid (Imo = 1.85; Akwa-Ibom = 1.89; Abia = 1.91). In the same vein, there was no regular promotion of staff (Imo = 1.91; Akwa – Ibom = 1.83; Abia = 1.96). Results also indicated inadequate supply of electricity and safe source of water supply to the health centre (Imo = 1.78; Akwa-Ibom = 1.71; Abia = 1.78) and Imo = 1.78; Akwa – Ibom = 1.78; Abia = 1.89) respectively. Furthermore, there inadequate supply of drugs in the health centres (Imo = 1.96; Akwa – Ibom; Abia = 1.94), while the response from clients was reported to be low (Imo = 1.49; Akwa – Ibom = 1.81; Abia = 1.72). The work load of the health service personnel was reported to be high (Imo = 2.01; Akwa – Ibom = 2.14; Abia = 2.03). This could be due to shortage of personnel in the health centres. However, results also show more availability of health centre buildings (Imo = 2.55; Akwa – Ibom = 2.30; Abia = 2.71) and adequate provision of pesticide treated nets (Imo = 2.47; Akwa – Ibom = 2.21; Abia = 2.42). The fact that the personnel of the health services did not have job satisfaction could negatively affect their output and later the overall performance of health services.

This finding agreed with the earlier study of Aksu and Aktas (2005) that job dissatisfaction has negative impacts on the organizational structure and work flows of establishments such as greater non-conforming to procedures and policies, employee absence and turnover and decline in productivity. It was because of this that Donik (2009) noted that job satisfaction plays a prominent role in the lives of workers and the general positive performance of an organization.

Table 4: Respondents determination of the level of their job satisfaction

ITEMS	IMO (61)		AKWA-IBOM (102)		ABIA (67)	
	M	REM.	M	REM	M	REM
Your total emolument	1.94	Low	2.13	High	2.26	High
Prompt payment of salary	1.85	Low	1.89	Low	1.91	Low
Provision of capacity building	1.89	Low	1.92	Low	2.08	High
Regular promotion to next salary grade	1.91	Low	1.83	Low	1.96	Low
The health center building	2.55	High	2.30	High	2.71	High
Your work load at the health centre	2.01	High	2.14	High	2.03	High
Provision of electricity to the health centre	1.78	Low	1.71	Low	1.74	Low
Provision of safe source water to the health centre	1.78	Low	1.78	Low	1.89	Low
Provision of drugs to the health centre	1.96	Low	1.80	Low	1.94	Low
Provision of pesticide treated nets	2.47	High	2.21	High	2.42	High
Provision of hospital beds	1.98	Low	1.78	Low	1.88	Low
The response from your clients	1.49	Low	1.81	Low	1.72	Low
The provision of consulting room	1.92	Low	1.89	Low	2.03	High

Midpoint = 2
Mean score < 2.00 suggest low
Mean score ≥ 2.0 suggest high

HYPOTHESES OF THE STUDY

Test of Hypotheses One

There is no significant relationship between the utilization of the health service and the well-being of the beneficiaries

The lead equation in this analysis is the exponential log. The coefficient of determination of utilization of health care services with well-being of respondents correlated positively (t = 3.881) and was significant at 0.05 probability level. It implies that the evidence of well-being of the respondents will be shown with their positive emotions, contentment and happiness with their level of utilization of health care services. The result of regression analysis confirms to the earlier study of Andrew and Withey (2008) that the social indicators of well-being agreed that at minimum; well-being includes the presence of positive emotions and mood such as contentment and happiness'. Findings further shows that if health care services are effectively utilized by the respondents, they will be happy and contented and it will positively impact on their well-being. Significant relationship however existed between the utilization of health care services and well-being of the beneficiaries. This can be further supported by the responses of the participants during the Focus Groups Discussions (FGD) held at Ikot Nfon, in Efinan Local Government Area of Akwa-Ibom State. Some of the participants said that:

Life in our community has not significantly changed since their presence here. The facilities are lacking in the health centre, even the cleaning of the premises is done single handedly by the only midwife working here. Most of us patronize the traditional birth attendants because we do not have confidence in the health centre. Religion, Culture or Polities are not barriers against people to visit the health centre. Please, help us to inform the government to fund the health centre. No drugs, no electricity, poor access road, no visiting doctor, no ambulance. In fact, the health centre is practically not working.

We, the majority of us have not registered with the health centre. Why should we register when there are no drugs and doctors do not come. Infact, some of us like going to Chemists to take care of our health challenges. We do not go to check our blood pressure, after all, after checking where are the drugs? MPP6 only came to renovate our existing health centre building in 2003. Apart from

re-roofing, we have not seen any other development; you can see that this is an abandoned health centre. We are not happy that we cannot get the required service from the health centre. Women have just started to attend antenatal clinic and immunization because one nurse was posted to the health centre. The presence of this health centre has not changed our life style. We are saying this because, how can the health centre without essential facilities change somebody's life (FGD, 2013).
The F- ratio, 15.09 which was significant at 0.05 level probability level and multiple R of 0.667 also confirmed the significant relationship between the utilization of health care service and well-being of the beneficiaries. From the analyses, the null hypothesis which states that there is no significant relationship between the utilization of the health services and the well-being of the beneficiaries was rejected.

Table 5: Multiple regression analysis of utilization of health services and the well-being of beneficiaries

Variables	Exponential +	Double Log	Semi Log	Linear Log
Constant	0.122	-0.058	0.841	1.418
	(5.103)	(-0.849)	(3.664)	(17.479)
Well-being	0.005	0.219	0.702	0.016
	(3.881)*	(3.969)*	(3.768)*	(3.701)*
R^2	0.677	0.602	0.387	0.305
F- ratio	15.059	15.757	14.199	13.696
N	230	230	230	230

Figures on the first row are Regression coefficients
t - ratios are in parentheses
*t - ratios significant at 0.05 level

Test of Hypothesis Two
There is no significant difference in the utilization of the health services among the beneficiaries across the project states.
Table 6 shows that F- cal of 17.16 is greater than the F – tab of 3.00. Table 4.12 also shows that there is a significant difference in utilization between Imo (M = 1.696) and Abia (M = 1.955). Also, significant difference was found between Akwa Ibom (M = 1.539) and Abia (M = 1.955). In order to determine where actually the differences in utilization of health services lies, the Post Hoc test was done using the Scheffe model. The results suggest that the null hypothesis which states that there is no significant difference in the utilization of the health services among the beneficiaries across the project states is rejected.

Table 6: Analysis of variance of utilization of health service among beneficiaries across the project states

Source	Sum of squares (SS)	Degree of Freedom (DF)	Mean Square (MS)	F – cal	F - tab
Between groups	6.915	2	3.457	17.16	3.00
Within groups	53.785	267	0.201		
Total	60.700	269			

CONCLUSION
The following conclusions were drawn from the study:

1. The study revealed a general level of dissatisfaction on the part of the respondents with the health care project. This was because they were neither contented nor happy with the impact of the health project on their well-being.

2. Health Service personnel across the three states of Imo, Akwa-Ibom and Abia expressed dissatisfaction in their job conditions. Job dissatisfaction had effect on personnel attitude to work and further access and utilization of the health care services by the respondents.
3. Utilization of health care services was not affected by culture, religion and communal conflict but, was rather affected by population bad access road and inadequate patient beds. Also, the study showed that lack of money, inadequate physical facilities, service personnel and attitude of health personnel and high cost of drugs affected the utilization of health care service.

RECOMMENDATIONS

Based on the conclusions of this study, the following recommendations were made.

1. The condition of service of the health services personnel should be adequately addressed so that their performance in the discharge of their duties will be enhanced.
2. Governments (Federal, State and Local Government) in sitting primary health projects should always aimed at addressing the well- being of the vulnerable groups such as youth, women and the elderly.
3. Health centre projects should be properly conceptualized, to allay the fear, misconception and lack of confidence of the people in the health care services and further improve their access to the health care services.
4. It is further recommended that health centres should be sited closer to the people to encourage easy access and effective utilization.

REFERENCES

Ajadi, K. O., Adebisi, J., A. & Alabi, F. M. (2010). Assessment of the impact of Women Organisations on Sustainable Rural Environment and Livelihood in Nigeria. *Ethopian Journal of Environmental Studies and Management. Vol. 3, No.2*

Aksu, A. A. & Aktas, A. (2005). Job satisfaction of managers of tourism. Cases in the Antalya region of Turkey. *Managerial auditing journal*. 20(5): 479-88

Alamieyesigha, D. S. P. (2004) The Niger Delta and Youth Restiveness: The way forward*.* *Environment watch*, Retrieved November, 15, 2021.

Alleyne, G. A. O. & Cohen, D. (2002). Health, economic growth and poverty reduction. *The report of working group of the commission on macro-economic and health.* World Health Organization. Genera

Andrews, F. M. & Withery, S. B. (2008). Social indicators of wellbeing. Newb York: Plenum Press; pp 63 - 106

Awotunde, J. M., Adamu, C. O., Adubi, K. O. & Osunwole, B. D. (2007). Socio-economic factors associated with small-scale processing of locust bean seed (*Parkia biglobosa*) among rural women in Akinyele Local Government Area, Oyo State*. Nigerian Journal of Rural Sociology 7(1&2), 70-75.*

Bawa, M. (2008). European Union Micro Projects Programme in Six Niger Delta States (MPP6). *A Compendium.* ABG Multimedia Services 161 pp.

Akpabio, I. (2005). *Rural and Agricultural Sociology, In: Agricultural and Rural Sociology.* Nwachukwu, Ike and Onuekusi, G (eds), Snap Press Ltd, Enugu, Nigeria.

Chen, H. & P. Rossi (2004). Evaluating with sense: The theory – driven approach. *Evaluation Review* 7(3), pp283 – 302

Claude A. (1981). *A Political Economy of Africa*. London. Longman Publications.

Eshiet, I. (2007): The role of Rural Women Associations in harnessing the socio-economic potentials of rural women for effective development. Available at www.statcan.calenglish/research/22-621-MIE/11-62/ME2004025.htm.28/11/2007

FGD, (2013). *Niger Delta regional master Plan.* Federal Government of Nigeria, Abuja.

FRN (2007). *Federal Republic of Nigeria official Gazette.* Federal Republic of Nigeria. 94(24). 15 May

Green, B., Mulvey. L., Fisher, H. & Woratschek, F. (2006). Integrating Programmes and Evaluation values: A family support approach to programme evaluation, *Evaluation Practice*, 17(3), pp 261-272

McGuigan, B. (2003). What is development theory? *Development ebook library.* Washington DC World Bank.

NDDC (2005). Niger Delta Regional Development Master Plan: Our Challenge – Their Future. *Draft*. January Niger Delta Development Commission, Port Harcourt, Nigeria

Nnodim, A. U. (2011). Impact of Widowhood on the livelihood activities and well-being of Rural Women in Rivers State, Nigeria. *Unpublished Ph.D thesis,* Department of Rural Sociology & Extension, Michael Okpara University of Agriculture, Umudike, Nigeria.

Obot (2006). Biophysical Characteristics. In *A. U.Ezealor and O. A. Akinsola (eds). The Renewable Naturak Resources of the Niger Delta. Options for Sustainable Developmen*t. The Nigerian Conservation Foundation, Lekki, Lagos

Ogueri, E. I. (2006). Evaluation of Rural Development Programmes of Multinational Oil Corporations in Niger Delta; a case of Bayelsa and Rivers State ofg Nigeria. *Unpublished Ph.D thesis,* Department of Rural Sociology & Extension, Michael Okpara University of Agriculture, Umudike, Nigeria.

Oluwatayo, I. B. (2006). Correlates of water demand among farming households in Ekiti State, Nigeria. *Nigerian Journal of Rural Sociology, 6(1&2) 75-82*

Powell I. (1995). *Wildlife Study Report for Shell Petroleum Development Company (SPDC) of Nigeria.*

Rasak, O. B. (2013). Patrons Perception of quality of Health Care Services in Primary Health Care Centres (PHCs) in Oyo State, Nigeria. *Developing Countries Study, Vol. 3, No.1.*

Schaffer, B. (2010). Policy makers have their needs too: Irish itinerants and the culture of poverty. *In Geof Wood (ed), Labelling in Development Policy.* London. Sage, pp 33-66

Sen, A. K. (2002). *Development as Freedom.* New York. Oxford University Press.
- (2005): *The Standard of Living.* Cambridge. Cambridge University Press.

Sule, S. S., Ijadunda, K. T., Onayade, A. A., Fatusi, A. O. & Soetam, R. O. (2008). Utilization of Primary health Care facilities: lessons from rural community in Southwest Nigeria. *Niger J. Med.,* 17(1): 98-106

Taylor S. & B. Francis (2009): Dependency Theory. *The Routledge Dictionary of Politics.* Third Edition.

Thaddeus, D. M. (2011). Social Science and Medicine. *This paper, published in Social Science and Medcine,* reviews the prevention of maternal mortality programme, a collaboration between Colunmbia University's centre for population and family health and multidisciplinary teams of reaesrchers from Ghana, Nigeria and Sierra Leone.

UNDP, (2006). Global Partnership for Development. *Annual Report.* United Nations Development Programme.

Walter R. (1972). *How Europe Underdevelopment Africa*. London: Bogle-L Overture Publication.

Weiss, C. (2005). Nothing as practicable as good theory: Exploring, theory – based evaluation for comprehensive community based initiatives for children and families. In Cornell, J.C., A.C. Kubisch, L. B. Schorr and C. H. Weiss (eds), New approaches to evaluating community initiatives, concepts, methods, and contexts. Washington, D.C. The Aspen Institute.

World Bank (2007). *Nigeria Data Profil*e. World Indicators Database. World Bank, Washington, DC

Adedoyin, S.F. (2004): Plentiful Agricultural Resources but Limited Adragogical Transmission: *33rd Inaugural Lecture*, Olabisi Onabanjo University, Ago-Iwoye pp. 26-35

Abdulraheem, I.S. and A. R. Olapipo and M.O. Amodu (2012): Primary Health Care Services in Nigeria: Critical issues and strategies for enhancing the use the use by the rural communities; *Journal of Public Health and Epdemiology,. 4(1), 5-13*

Ademiluyi, A. I., and S. O. Aluko-Arowolo (2009): Infrasructural distribution of healthcare services in Nigeria: An overview. *Journal of Geography and Regional Planning* Vol. 2(5), 104-11o, May

Adeniyi, J.O.; J. Ejembi; C.L. Igbinosun; P. Mohammed (2001): Report of the National Health Care Needs Assessment Survey. National Primary Health Care Development Agency, Abuja

Adesiji, G.B,; S.O. Dada and S.E. KOMOLAFE (2012): Problems faced by Rural People in Accessing Health Care facilities in Akure North and Akure South Local Government Areas of Ondo State, Nigeria.

Adeyemo, R. (2002): Self-help Promotion for Sustainable Smallholder Agriculture: Blueprint versus Greenhouse. *An inaugural lecture delivered at Obafemi Awolowo University, Ile-Ife*, OAU Press Ltd

Adeyemo, D.O. (2005): Local Government and Health Care Delivery in Nigeria: A Case Study*, J. Hum. Ecol* 18(2): 149-160

Adigun, D. (2003): Some Features of Communication in Transition. *African Journal of Contemporary Issues*: Department of General Studies, LAUTECH Ogbomoso

Agbamu, J.U. (2006): *Essentials of Agricultural Communication in Nigeria*. Asaba, Malthouse Press

Akesode, F. A. (2009): Factors affecting the use of Primary Health Care clinics for children. *Journal of Epidemiology and Community* Health 36, 310-314

Akpomuvie, O.B. (2010): Self Help for Rural Development in Nigeria: A Bottom-up Approach. *Journal of Alternative Perspectives in the Social Sciences* Vol 2, No. 1

Akinbode, I.A. (2008): Participation in Self-help Projects among Rural Inhabitants: A Comparison. *The Quarterly Journal of Administration 2(4).* Obafemi Awolowo University Press, Ile-Ife

Akinsorotan, A.O. and M.G. Olujide (2006): Community Development Associations, Contributions in Self-help Projects in Lagos of Nigeria. *Journal of Central European Agriculture* 17, No. 4.

Alabi, R.A. and D.I. Oviasogie (2005): A Preliminary Assessment of effect of Oil Exploration on Fish Farming in Niger Delta. A Case study of Delta State, Nigeria. *Journal of Agriculture and Environmental Research Studies* vol. 1(1): 29-36

Alabi, R.A.; D.I. Osasogie and A. A. Alabi (2008): Estimating the Cost of Health in Urban and Rural Areas of Edo State, Nigeria

Aigbokhan, B. (2007): *Reconstruction of Economic Governance in the Niger Delta Region in Nigeria:* The case of the Niger Delta Commission. In K. Wohlmuth and T. Urban (eds). Reconstructing Economic Governance After Conflict in Resource-rich African Countries. LIT Verlag, Berlin, Germany, pp 193-198

Amoran, O. E., F. O. Omokhodion, M. D. Dairo and A. O. Adebayo (2005): Job satisfaction among primary health workers in three selected local government areas in Southwest Nigeria. *Niger J. Med* 14(2): 195-9

Anikpo M. (1996): Hegemonic Legacies: Issues in the sociology of Nigeria's underdevelopment. *University of Port Harcourt, Inaugural Lecture Series, No. 16.* Port Harcourt. University of Port Harcourt Publishers.

Arifen, S. E.; J. Bryce, E. Gouws, A. H. Baqui, R. E. Black and D. M. Hoque (2005). Quality of care for underfives in first-level health facilities in one district of Bandgladesh. *Bull World Health Organ*

Appadurai, A. (2004): The Capacity to aspire culture and the terms of recognition. Pp 59-84 *in V. Rao and M.Walton (ed). Culture and Public Action. Stanford;* Stanford University Press.

Asiabaka, C. C. (2002), *Agricultural Extension: A Handbook for Development Practioner.* Molysfem United Services, Omoku, Rivers State.

Audu, W. (2009): *Commercialization of Public Health Service Delivery in Nigeria.* GDN Research Project. Nigeria Institute of Social and Economic Research Ibadan, Nigeria.

Babalola, E.T. and A.C. Babalola (2004): The place of functional communication in self-help development projects among adults in Osun State, Nigeria (1985 – 1999). *Nordic Journal of African Studies* 13(3): 319-342

Babier, E.B. (2007): *Economics, Natural Resources, Scarcity and Development.* Conventional and Alternative views. Lond, East Asian Publications Ltd.

Bedi, T. (2005): *Beyond Numbers – understanding the Institution for Monitoring Poverty Reduction Strategies*, Washington, D.C. *World Bank.*

Bhuvan B. and A.C. Williams (2006): Participatory Development and the World Bank: Potential Direction for Change. *World Bank Discussion Paper 183,* World Bank. Washington DC.

Bloom D. and D. Canning (2004): The Health and Wealth of nations. *Science 287(18)*

Boonstra, E.; M. Lindaek and E. Ngome (2005), Adherence to management guidelines in acute respiratory infections and diarrhea in children under 5 years old in primary health care in Botswana. *Int. J. for Quality Health Care.* Jun 1; 17(3): 221-7

Bourdieu, P. (2005): *Outline of a theory of Practice*. Cambridge, Cambridge University Press.

Brook, R. H, E. A. McGlynn and P. G. Shekelle (2007), 'Defining and measuring quality of care: a perspective from US researchers.*" International Journal for Quality in Health Care* 12(14): 281-95

Brunetto, Y. and R. Farr-Wharton(2002): Using social identitybtheory to explain job satisfaction of public sector employees. *International journal of public sector management*. 15(7): 535-51

Bruni, L., and P. L. Porta (2007): Introduction. *In Luigino, B., and P.L. Porta eds. Handbook on the Economics of Happiness.* Cheltenhan, U.k. Edward Elgar.

Caldwell, J.C. (2008): Health Transition: The cultural, social and behavioural determinants of health in the third world: *Social Science and Medicine* 36: 125 – 135

Catacutan, A. R. (2006), The health service coverage of quality-certified primary health care units in Metro-Manila, the Philipines. *Health Policy Plan.* Jan 1: 21 (1) 65-74

Camfield, L., K. Choudhury and J.Devine (2008): Wellbeing, Happiness and Why Relationships matter. *Journal of Happiness Studies*. Online

Chijioke N. (2002): Sustainable Development and Imperatives. *Earth Watch.* No. 3 January/March.

Chiu, R. and A. M. Francesco (2003): Dispositional traits and turnover intention. *International journal of manpower*. 24(3): 284-98

Christopher, J. C (2010): Situating Psychological wellbeing. Exploring the Cultural Root of its Theory and Research. *Journal of Counseling and Development.* 77(2), 141-152

Cleland J.G. and J.K. Van Ginnekan (2007): Material Education and Child Survival in Developing countries. The search for pathways of influence. Social Science and Medicine 27(2). 1357 – 68

Comaroff, J. (2003), *Revelation and Revolution: Christianity, Colonialism and Consciousness in South Africa, Chicago and London*: University of Chicago

Conteras R. (2009): *How the concept of development got started*. The University of Iowa Centre for International Finance and Development.

Cornwall, A. (2005): Beneficiary, Consumer, Citizen Perspective on Participation for Poverty Reduction, *Cida Studies.*

Cummis, R.A. (2006): The Domains of Life Satisfaction: An attempt to order chaos. *Social Indicators research* (38), 303-328

Dadoo, S. (2003) Unmasking America's New Interest in Africa. *The Beacon*, August 15-21.

Dalal-Clayton, B. (2007): Sustainable Development. *Microsoft Encarta Encyclopedia*

Dalal-Clayton, B. (2008): *What is Sustainable Development?* International Institute for Environment and Development, London.

Dasgupta, P.S. and K.G. Maler (2010): Poverty Institutions and the Environmental Resource Base. *Environmental Paper* No. 9, Washington DC, World Bank.

Deji, O.F. (2005) Understanding women association in Nigeria: The case of Osun State. *The Journal of Agricultural Education and Extension.* Wageingen, 11 Nos 1-4.

Donabedian, A. (1988), The quality of care. How can it be assessed? *Journal of the American Medical Association* 260; 1743-1748

Donaldson, M.S. and K. Nolan (2007): 'Measuring the quality of health care: State of the art'.*Joint Commission Journal on Quality Improvement.* 12(14): 281-95

Donuk, B. (2009): The Comparison of the job satisfactions of the sports managers who work in private and public sectors. Selcuk Universitesi Sosyal Bilimler Enstitusu. *Dergisi* 21: 179-185

Diener, E., E. Suh, and S. Oishi (2008): Recent findings on Subjective wellbeing. *Indian Journal of Clinical Psychology* 24: 25-41

Easterline, R. (2004): The Economics of Happiness. *Daedalus* 133(2), 26-33

Eboh, E. C (1995): Sustainable Development: Theory and Implications for rural Nigeria. *In Eboh, E. C, C. U. Okoye and D. Ayichi (eds). Rural Development in Nigeria, Concepts, Processes and Prospects*. Enugu, Auto-Century Publishing Company

Efemini, A.O. (2002): Ake and African Development. *Selected Issues.* Port Harcourt. Paragraphs.

Etteng, I.A. (1998): The Nigerian State, Oil Exploration and Community Interest. *Human Rights Defender*. October-December.

Ehrlich, P. (2007): *How to survive. A Plan to Save Spaceship* Earth. Ballutine Books. London.

Ehiri, J. E., A. E. Oyo-Ita., E. C. Ayanwu, M. M. Meremikwu and M.B. Ikpeme (2005): Quality of child health services in primary health care facilities in South-east Nigeria. *Child Care Health Dev*. Mar; 31(2): 181-91

Ekong, E.E. (2010): *An Introduction to Rural Sociology,* Uyo. Dave Educational Publishers.3rd Edition.

Enemugwem, J.H. and R.H. Sara (2007): Niger Delta Women in the Atlantic Trade and Precolonial Politics to 1885. The Obolo (Andoni) Example. *Seminar Paper.* Department of History and Diplomatic Studies, Faculty of Humanities, University of Port Harcourt, Nigeria.

ERA (2005): *Gas Flaring in Nigeria: A Human Right Environmental and Economic Monstrosity.* Environmental Rights Action/Friends of the Earth, Nigeria.

Erinosho, O. A. (2006): *Health Sociology for Universities, Colleges and Health related institutions,* Bulwark Consult, Abuja

Ezeja, E. B, C. C. Azodo, A.o. Ehiezele, O. Ehidiator and H.O. Oboro (2010): Assessment of job satisfaction and working conditions of Nigerian oral health workers. *International journal of Biomedical and Health Sciences*, vol. 6. No. 3, September

FAO (2007) Guidelines on communication for Rural Development: *a brief for development planners and project formulators.* Food and Agriculture Organization, Rome. Italy.

Fernando, H. C. (2007): The Consumption of Dependency Theory. *Latin American Research Review* Vol. X11, number 3

FGN (2006): *Niger Delta regional master Plan.* Federal Government of Nigeria, Abuja.

FMOH (1988): *The National Health Policy and Strategy to Achieve Health for all Nigerians.* Federal Ministry of Health, Lagos, Nigeria, October.

- (2004): *Health Sector Reform Programme (HSRP*): Strategic Thrust and Plan of Action, 2004 – 2007. Federal Ministry of Health, Abuja, Nigeria.
- (2007): *Integrated Maternal, Newborn and Child Health Strategy*. Federal Ministry of Health, Abuja, Nigeria.

FRN (2007): *Federal Republic of Nigeria official Gazette.* Federal Republic of Nigeria. 94(24). 15 May

Frey, B., and A. Stutzer (2002): *Happiness and Economics: How the Economy and Institutions affect Human Wellbeing*. Princeton, N. J Princeton University Press.

Gagnier, D. (2010): What is Sustainable Development? Environment, Economic and Social Wellbeing for Today and Tomorrow. International Institute for Sustainable Development, London.

Gavrov, S. (2004): *Modernization of the Empire*. Social and Cultural aspects of modernization processes in Russia

Gwatkins, D. R., S. Rutstein, K. Johnson, E. A. Wagstaff (2003): *Initial country level information about socio-economic differences in health, nutrition, and population.* Washington, DC. The World Bank.

Gray, B (2004): 'The complexity of perfection. *New Zealand Family Physician,* Vol. 31, No. 3, June

Green B. L and C. McAllister (2002): Theory – Based, Participatory Evaluation a powerful tool for evaluating Family Support Programmes. *In: The Bulletin of the National Centre for Zero to Three,* April 24.University of Pittburgh

Harris, J.M. (2010): Basic Principles of Sustainable Development. Global Development and Environment Institute. *Working paper.* Tufts University 04.

Hawi, H.O. (2005): A Search for an Alternative Afro-centric Development Theory. *A Paper Presented in CODESRIA's 11th General Assembly, Maputo, Mozambique*, 6-10 December.

Hu, J. and H. Liu (2004): Job satisfaction among nurses in China. *Home Health Care Management and Practice*. 17(1): 9-13

ICDDR, B (2005): Centre for Health and Population Research, Bangladesh. Available at: htp//www.eldis.org/go/topics/research-quide/health & id=333288type=Document. Retrived on January 17, 2011.

ISS (2005): Focus on Participation. *Development Issues.* Institute of Social Studies, vol. 7, No. 2, October.

- (2006b): Fueling the Niger Delta Crisis. International Crisis Group. *Africa Report*. No. 118, September.

IFAD (2009): *Community-driven Development Decision tools for Rural Development Programmes.* International Fund for Agriculture Development, Rome.

Isenberg, D.H., C. Loomis, K. Humphreys and K.I. Maton (2004): Self-help Research: Issues of Power Sharing in L.A. Jason, C.B. Keys and M.I. Davis (eds). *Participatory Community Researc.* American Psychological Association, Washington DC.

Imoh, G.O. (2007): Development Communication, Social Mobilization and Agricultural Development in Africa. *In Ikechukwu E.N. (ed*). *The Nigerian Journal of Communications,* vol. 5, No. 1.

Irikana, G.J. (2006) Mangrove Utilization and Poverty Alleviation in the Niger Delta: A Case Study of Andoni Women. *Unpublished Ph.D. Thesis*, Department of Sociology, University of Port Harcourt. Port Harcourt, Nigeria.

Jennings, R. (2008) Participatory Development as New Paradigm. The Transition of Development Professionalism. *Paper Prepared for the Community Based Reintegration and Rehabilitation in Post Conflict Settings Conference,* Washington DC, October.

Kerse, N (2004): 'Shades of grey: Complexity in health care of older people; *New Zealand Family Physician*, Vol.31, No. 3, June

Koustelios, A. (2001): Personal characteristics and job satisfaction of Greek teachers. *International journal of educational management*, 15(17): 354-8

Juma, C. and L. Yee-Cheong (2005): Innovation: Applying Knowledge in Development. UN Millennium Project Task Force on Science, Technology, and Innovation, London, Earth Scan.

Layard, P. R. G. (2007): Happiness and Public Policy: A challenge to the profession. *In Bruno, S. F and A. Stutzer, eds. Economics and Psychology: A Promising New Cross-Disciplinary Field*. Cambridge, Mass: MIT Press

Lele, S.M. (2009): Sustainable Development a critical view. *World Developments 19(6)*.

Lewis, M, .G. Eskeland and X. Traa-Valevezo (2005): Primary Health Care in Practice. Is it effective? Centre for Global Development. *Working Paper*. No. 55. World Bank. Washington D.C. 41pp.

Luzzi, L., A.J. Spencer, K. Jones and D. Teusner (2005): Job satisfaction of registered dental practitioners. *Aust. Dent. J.* 50(3): 179-85

Mandarins, G.N. (2003): *Modernization Theory in Cold War, America.* John Hopkins University Press.

Marafa, B. K. (2007): Primary Health Care (PHC). Student Publication Alliance International University. *American journal of public health*, v. 95, no. 5, p757, May

Mayoux, L. (2004): *Beyond Naivety: Women, Gender Inequality and Participatory Development.* Institute of Social Studies.

McDonald, J; J. Cumming, M. Harris, D. G. Powell and P. Burns (2006): *Systematic review of 'comprehensive primary health care models', Sidney and Canberra:* University of New South Wales and Australia National University.

McGillivary, M. and M. Clarke (2006): Human Wellbeing: Concepts and Measures. *In M. McGillivray and M. Clarke, eds. Understanding Human Wellbeing. Basingstoke:* Palgrave MacMillan

McGregor, A. (2004): Researching wellbeing. Communicating between the Needs of Policy Maker and the Needs of People. *Global Social Policy* 4(3)

Mclntyre P. (2009): Communication Case Studies for water supply and sanitation sector. *Core Group on Information, education and communication.* United Nations Development Programme.

Mohan G. (2008): *'Participatory Development' The comparison to development studies.* Hodder Education.

Miranda, F. J., A. Chamorro, L. R. Murillo and J. Vega (2010): An Importance – Performance Analysis of Primary Health Care Servies: Managers vs Patients Perceptions. *J. Services & Management*, 3, 227-235, June

Myint, H. and A. O.Krueger (2009): Economic Development. *Encyclopaedia Britannica*

Naanen, B.B.B. (1994): Theories of Development: How Relevant to Africa. *Pan African Social Science Review,* vol. 1, No. 1, October.

Naccarella, L; D. Southern, J. Furler, A. Scott, L.Prosser and D. Young (2006): *Narrative review of innovative models for comprehensive primary health care delivery',* Melbourne and Australian National University.

National Planning Commission (2007): *Nigeria 2006 Millennium Development Goals (MDGs) Report:* February, Abuja, Nigeria.

Najamuddin, D and M. S. Manrajguliani (2006): Role of rural organizations in Rural Development. *ITPI Journal, 3:4, 49-34*

NDHDR (2006): *Niger Delta Human Development Report*. United Nation's Development Programme, UN House Garki, Abuja, Nigeria

NESREA (2008): *The Establishment of the National Environmental Standards and Regulations Enforcement Agency,* Abuja, Nigeria.

NSSD (2004): Sustainable Development: Concepts and Approaches. National Strategies for Sustainable Development (NSSD). *www.nssd.net updated 4* March.

Nwachukwu, I. (2003): *Agricultural Communication, Principles and Practice*, Umuahia, Lambhouse Publishers.

Nwosu, I.E. (2005): Rural Mobilization for Development in Nigeria. *In Ike Nwachukwu and G. Onuekusi (eds) Agricultural Extension and Rural Sociology*. Enugu, Snap Press Ltd.

Ofili, A. N., M. C. Aszu, E.C. Isah, O. Ogbeide (2004): Job satisfaction and phychological health of doctors at the University of Benin Teaching Hospital. *Occupational Medicine* 54:400-403

Ogiawara, S. and H. Araki (2006): Job satisfaction among physiotherapists in Ishikawa Prefecture, Japan. *Journal of Physical Therapy Science* 18(2): 127-132

Okerenta, S. (2005): Evaluation of the performance of Microfinance Programmes in Niger Delta region, Nigeria. *Unpublished Ph.D. Thesis, Department of Agricultural Economics, Federal University of Technology, Owerri, Nigeria.*

Okunade, E. O. (2005): Impact of Extension Agents Communication's Skill on the Adoption of Improved Farm Technology in Ife/Ijesa Agricultural Zone of Osun State. *Proceedings, of the Tenth Annual National Conference of the Agricultural Extension Society of Nigeria (AESON) 14th – 17th, June*

Oladosu, I.O. (2003): *Review of Basic Concepts in Communication for Introducing Change Programme.i Ogbomoso. New Age Publications 26pp.*

Oladosu, I.O. and W.A. Sanusi (2004*)*: Communication Effectiveness between Cocoa Research Farmers in Ibadan, Oyo*.* J*ournal of Rural Research and Information.*

Omoleke, I. I (2005): Analysis of Spatial Distribution of Health Care facilities in Owan Eat and Owan West Local Government Areas of Edo State, Nigeria. *Ph.D Thesis (Unpublished*), Ekpoma: Ambrose Ali University

Osuoka, A.I. (2007): Oil and Gas revenue and development challenges for the Niger Delta and Nigeria. *Paper presented at the expert group meeting on the use of no-renewable resources revenues for sustainable local development.* Organized by the UN Department of Economic and Social Affairs, UN Headquarters, New York, 21 September

Ojeifo, M. (2005): Analysis of spatial distribution of health care facilities in Owan East and Owan West Local Government Areas of Edo State, Nigeria *Ph.D Thesis (Unpublished),* Ekpoma: Ambrose Ali University

Peck, E. (2004): Organizational development in health care: approaches, innovations and achievements*. Radcliffe Publishing*, Abingdom.

Plsek, P (2003): Complexity and the adoption of innovation in health care. *Paper presented to the conference: accelerating quality improvement in health care strategies to speed the diffusion of evidence-based innovations*. Washington DC, 27-29, Jan. 2003

PRB (2010): *World Population Data Sheet*. Population Reference Bureau Washington, DC

Ponnarasi, T. and K.S. Devi (2008): An Enquiry into the Socio-Economic Status of Rainfed Communities. Logit Model Approach. *Indian Journal of Agri. Econ* vol. 63, No. 3, July-Sept, pp477-486.

Riddell, E. (2006): Health Unlimited. Available & id=33325 & type= Document, Retieved on January 14 2011

Roa, P.K. (2008): Sustainable Development Economies and Policy. *Centre for Development Research Princeton.* N.J. Blackwell Publishers.

Robinson, J.A.; R. Torvik and T. Verdier (2006): Political Foundation of the Resource Curse: *Journal of Development Economics*, 79, 447-468

Sahlins, M. (2009): *Culture and Practical Reason*. Chicago/London. University of Chicago Press

Schopper, D. (2002): Quality of care in resource-constrained settings. Swiss centre for International Health. Swiss Agency for Development and Cooperation (SDC). *Document No. t751-14 SKM (REM*), May.

Schuh, G.E. (2008): Some thoughts on Economic Development, Sustainability and the Environment*. In David J.J. and I.A. Schiner (eds*), *Sustainability Issues in Agricultural Development*, Washington DC. The World Bank.

Schwartzman (n.d): The Statistical Measurement of Poverty. *Retrieved*, November 2010 from http://unstats.un.org/unsd/statcom/docia/rio.pdf

Sibthorpe, B. (2004): A proposed conceptual framework for performance assessment in primary health care: a tool for policy and practice: Canberre; Australian National University. *Australian Primary Health Care Research Institute*

Siddiqur, O. (2008): Participatory Governance. *An Overview of Issues and Evidence in United Nations Department of Economic and Social Affairs (UNDESA).* Participatory Governance and the Millennium Development Goals (MDGs), United Nations.

Soyibo, A. (2004): National Health Accounts of Nigeria, 1998-2002. *Draft report presented to the World Health Organization,* Geneva.

Solow, R.M. (2007): *An almost practical step towards sustainability in assigning economic values to natural resources*. Washington DC National Academy Press.

Summer, A. (2006): Economic wellbeing and non-economic wellbeing. *In M. McGillivary and M. Clarke,eds. Understanding Human Wellbeing.* Basingstoke, U.k. Palgrave MacMillan

South Commission (1993): The Challenge to the South: *The Report of the South Commission*. Enugu, Fourth Dimension Publishers.

Surdiman, B. (2008): Participatory Development and Good Governance. *Pikiran Rakyat* Newspaper.

Tariq, B. (2007): Sustainable Development and Climate Change Policy Matters. *No 4, Newsletter of IUCN Commission of Environmental, Economic and Social Policy (CEESP),* CEEP Secretariat.

Than, R; J. Humphreys, L.Kinsman, P. Buykx, A. Asaid, K. Tuoney and K. Riley (2010): Evaluating the impact of Sustainable Comprehensive primary health care on rural health. *Australian Journal of Rural Health*, 18; 166-172

Tuan, T; V. T. Dung, I. Neu and M.J. Dibley (2005): Comprehensive quality of private and public health services in rural Vietnam. *Health Policy Plan*. Sep; 20(5) 319-27

UNDP (2003): *Human Development Report*. *The millennium Development Goals (MDGs): A compact among nations to end poverty*. United Nations Development Programme. New York. Oxford University Press.

- (2006):

UNPF (2010): *State of World Population*. United Nation's Population Fund.

Uphoff, N. (2009): Fitting projects for people: *In Cernea, M.N. (ed).Putting People First. Sociological Variables in Rural Development*. Oxford University Press, Oxford, UK.

Van Eijk, A. M.; H. M. Bles; F. Odhiambo; J. G. Ayisi; I. E. Blokland; D.H. Rosen; K.Adzu, L.Slutsker; K. A. Lindblade, (2006): Use of antenatal services and delivery care among women in rural Kenya: a community based survey. *Reproductive Health*. 3:2

Van Hoorn, A. (2007): A short Introduction to Subjective Wellbeing, its Measurement, Correlates and Policy Uses. *Background paper prepared rof OECD Conference on measuring progress of societies*. Istanbul, June, 27-30

White, S.A. (2005): The Concept of Participation; Transforming Rhetoric to Reality. *In White, S.A. et al (eds) Participatory Communication:* Working for change and development. New Delhi, India, Sage publications.

White, S.C. and M. A Ellison (2007): Wellbeing, Livelihoods and Resources in Social Practice. In I. R Gough and J. a. McGregor (ed). Wellbeing in Developing Countries: New Approaches and Research Strategies. Cambridge. Cambridge University Press

White, S. C. (2008): But what is wellbeing? A framework for analysis in social and development policy and practice. *Paper for regeneration and wellbeing: Research into Practice.* Centre for Development Studies. University of Bradford, 24-25, April

WHO (1978): *Alma Ata Declaration on Primary Health Care*. Geneva. World Health Organisation

WHO (2006): *Constitution of the World Health Basic Documents, Forty-fifth edition, supplement*, October.

WHO (2010): *Promoting Health in the America.* The Pan American Health Organization. World Health Organization, Geneva.

World Bank (2000b): *World Bank Development report 2000/2001*. Attacking Poverty. Oxford and New York. Oxford University Press

- World Bank (2003): *Nigeria Poverty-Environment Linkages in the Natural Resources Sector*. Africa Environment and Social Development Unit.
- World Bank Institute. June (2005): World Bank Approves Funding for the West African Gas Pipelines in Benin. Ghana, Nigeria and Togo. *Press Release* No. *2005/181/AFR.*
- (2007a): *Nigeria Data Profil*e. World Indicators Database. World Bank, Washington, DC7