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(RESEARCH ARTICLE)

Level of community contribution toward the financing of health care services in Jigawa state

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Abstract

Community involvement in health related activities is generally acknowledged by international and national health planners to be the key to the successful organization of primary health care, comparatively little is known about its potential and limitations. Drawing on the experiences of Jigawa State, this paper reports on research undertaken to compare and contrast the scope and Extent of community participation in the delivery of primary health care in a community run and financed health post and a state run and financed health post. Unlike many other health posts in Jigawa these facilities do provide effective curative services, and neither of them suffers from chronic shortage of drugs. However, community-financing did not appear to widen the scope and the extent of participation. Villagers in both communities relied on the health post for the treatment of less than one-third of symptoms, and despite the planners' intentions, community involvement outside participation in benefits was found to be very limited.

Aim: This study assess the level of community contribution toward the financing of health care services in Jigawa state, Nigeria

Methodology: A cross-sectional descriptive research was conducted on the respondents. The study population comprised the entire eligible respondent in a case study of government hospitals in Jigawa state Nigeria within the study area, who were selected and agreed to participate in the study. Sample sizes of One Hundred (100), respondents were recruited using a multistage sampling technique. Data was collected using Questionnaire Data collected was coded, entered, and analyzed using the Statistical Package for the Social Sciences (SPSS) version 24.

Result: The cooperation within department and with other departments in cooperation with equals was very good were 65(68.4%), good were 17(17.9%), Ok were 10(10.5%), not so good were 3(3.2%) and bad were 0(0.0%) respectively. The cooperation within department and with other departments in cooperation with PWD was Very good were 50(52.6%), good were 25(26.3%), Ok were 12(12.6%), not so good were 5(5.3%) and bad were 3(3.2%) respectively.

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In this studied many of the respondents has Diploma with 38.9% as their highest education qualification working with the Jigawa State Healthcare. Therefore, there is need for the continuous education programme of the health workers in the facility for proper and effective conduct of operations.

Conclusions: The findings from this study will help to develop programs that can improve knowledge of community Health Financing and services provided by the health-care system and can reduce burden on government by providing other alternative.

Keywords: Community; Contribution; Financing; Health care services; Jigawa

1. Introduction

Both short-term and long-term strategies are needed to guarantee community- based participation in national, regional, and state health systems. One short-term approach is to develop and implement federal guidelines and mandates on a minimum range of health and human services for vulnerable and high-risk populations in each country. These directives will establish specific health services that a sick individual must receive from the health care system, even when the delivery of health services is largely the responsibility of regional or state governments. For example, the standards might stipulate that each sick client should have a complete physical examination (including complete history of presenting complaints), urinalysis, stool analysis, and haemoglobin and white blood cell. Clients who are able to should pay for these services, but no one should be denied services. This minimum set of services could reveal much about ill persons and their families regarding anemia, diabetes, hypertension, intentional and unintentional injuries, cancers, pregnancy-related conditions, and other clinical conditions common in developing countries. Through the threat of enforcement and sanctions, national standards could ensure that vulnerable clients receive these services. The medical and allied health professionals in each country would play a significant role in implementing this short-term strategy by developing pro bono programs and making participation in them a condition for initial licensure and license renewal. Mandatory programs that send newly qualified health professionals to serve one or two years in rural areas would help provide services to these isolated regions. Community participation in international health A second short-term strategy is for national, regional, and state health systems to assure external funding agencies that proposed projects reflect local priorities. Such assurances should include a complete description of how priorities were identified, the rationale for choosing the location of the project, specific information on the role of the target communities, and benefits to local residents. Funding organizations should have the authority to verify the involvement of target communities. Donor agencies should not replace direct community involvement with “briefing papers” or guided tours of target communities, and they should establish mechanisms for direct contact with future program recipients to ensure that their views are considered. A third short-term strategy is for the national, regional, and state health systems to implement a comprehensive outreach program for inhabitants of isolated areas. Health workers should visit these regions and provide services on a predetermined regular basis. Such visits will complement the efforts of community health workers (CHWs), who traditionally come from target locales.

1.1. Community participation and partnerships

Enabling the active involvement of the community in efforts to tackle the Health problem is a cornerstone of the District level Public Health Management. Drawing on the Primary Health Care Strategy, (WHO) endorsed at Alma-ata in 1978, the involvement of the community as active participants in the process rather than as passive beneficiaries is an important challenge (Handout et al., n.d.) The guidelines that follow are based on certain principles that are crucial to the successful evolution of a partnership with the community. The community and its representatives both formal and informal must be involved in all aspects of the programme from planning, to organization, to monitoring and to evaluation. The focus of activities should not be just providing packages of services but enabling and empowering the community to participate in decision-making and taking responsibility. The large range of untapped human and material resources in the community must be mobilized (Handout et al., n.d.).

The Public Health programme must not be compartmentalized but must become an integral part of all the ongoing health and development programmes. A major thrust should be to demystify the problem at community level; build confidence, skill and capability at community level to tackle the problem; and help community to identify the programme as their own The process should also be facilitated with a certain humility so that the health team is willing to learn from local experience, wisdom and culture. New approaches or alternatives can emerge if this ‘learning from the people’ and ‘working with them’ rather than ‘for them’ becomes a team commitment. ‘We need not only to persuade the people to accept the professional’s wisdom, but also the professional to understand the people’s wisdom (Handout et al., n.d.)

1.2. Partnership with the Community

It has now been demonstrated, throughout the world that when a community participates effectively in a health programme with full understanding and involvement then the achievements of that health programme are sustainable and long lasting Once the plans of the local health programme is drawn up by the District Level Public Health Managers by interactive dialogue with the local health committee and the local volunteers are trained then the programme must be organized and managed in close collaboration with the local committee and the volunteers. As part of the partnership with the community, the programme will consist of the following major components (Handout et al., n.d.)

1.3. Relations with the Government and Voluntary Agencies

There was a good cooperation between the project and government departments, particularly with the staff responsible for the PHCs. The relation with the government staff was considered very important and complementary in the work and also to ensure sustainability of the programme after the project ceases to operate. To help establish good rapport and liaison with the health staff, a series of meetings were held between the FPAI and the Government at different levels. Initial misunderstanding, especially at the field level, was gradually overcome, and the government health workers later recognized that the project supported their work. The arrangement worked well for both sides: the contraceptives required by the project were provided by the PHC, and the project helped the PHC with other medical supplies. Camps for immunization, IUD insertion and sterilization were organized jointly by the project and the government staff. In the early days of the project, the Government of Kamataka passed a formal order agreeing to its implementation. This has facilitated cooperation of the government departments responsible for development activities, such as the Block Development Office, Agriculture, Education, and Women and Child Welfare, and the LVGs. The project has made successful efforts in identifying non-governmental bodies of all kinds that could be helpful in keeping the project going and in expanding its activities. Useful working relationships had also been established with the state Adult Education Council, the Rotary Club, the Lions Club, the Indian Medical Association, etc. That helped organize many coordinated activities, notably health campaigns and camps to address special health problems. The project had also been effective in securing the cooperation of the local religious committees existing in most villages (Bhuiya et al., 1996).

The Alma-Ata Declaration of 1978 affirmed that health is a fundamental human right and encouraged the active participation of recipients of health services and communities in the planning, organization, operation, and management of health care systems. The right to health can be viewed as a right to health care and a right to conditions that promote good health. Community participation provides an opportunity for citizens to have a voice in ensuring the state meets their needs and to contribute to life-affecting processes, while building or rebuilding trust between the public and the health system (LeBan et al., 2014).

1.4. Principal Positive Contributory Factors

The existence of the population awareness project in the area undoubtedly facilitated an easy start of the project and shortened the length of the preparatory phase. The FPAI had acquired considerable knowledge of the area, the people and their customs, perceptions and needs, and their potential for organizing themselves to improve their situation. Harmonious relationship among the different ethnic and religious groups in the political sphere assisted the development of a community spirit. The relocation of the community welfare workers from taluk headquarters to the villages strengthened the relationships between the project and the communities, and enabled the project staff to become more familiar with local needs and problems. The incorporation of modern ideas into traditional forms of entertainment provided a convenient way for the project to get its ideas across to the community (Bhuiya et al., 1996).

The United Republic of Tanzania has been implementing health sector reforms using a Sector Wide Approach for the past 10 years. One of the objectives is the delegation of responsibilities for service delivery from the central level to Councils and communities in line with the Government policy of Decentralization by Devolution. Devolution of powers is aimed at improving quality of health services, transparency, accountability, and legitimacy by broadening participation of health services users in decision making. Several institutions crucial for the improvement of access to health care and quality of services delivered have since been created at local government and community levels. A major objective of these structures is to ensure greater participation of communities in planning and budgeting processes, as well as in the implementation of programs to improve access to health services and the quality monitoring of services delivered at the local level. This paper assesses how far communities have been empowered through their participation in the established health governance structures (boards and committees) and the implications on health services delivery (Cross et al., 2010).

Tajikistan inherited a health system from the former Soviet Union which was comprehensive but inefficient. It remains highly specialized, centralized with emphasis on curative and in-patient care with an oversupply of hospitals and

specialized doctors. The bias towards in-patient care has resulted in less emphasis on primary care and there is little experience available in Tajikistan on how to design, plan and implement activities in the areas of health prevention and health promotion, and on how to integrate these activities at the Primary Health Care (PHC). Members of local communities are hardly ever involved in health and health service management. Since 2002, the Ministry of Health has embarked in a health reform agenda and sees family medicine development as a key element. The Swiss Agency for Development and Cooperation is assisting these efforts among else through project Sino. Since 2007, project Sino has worked out a model for community development and health promotion which is briefly presented below (Cross et al., 2010)

2. Methods and materials

2.1. Research design

Cross-sectional descriptive research was conducted

2.2. Research setting

Jigawa state

2.3. Study Population

Study of government Hospitals in Jigawa state Nigeria. A total of 100 community members and their care givers were selected

2.4. Sampling technique

A multistage sampling technique was used to select the study subjects from Twenty seven LGAs of Jigawa state and One Hundred respondent were recruited

2.5. Tool

Structured self-prepared questionnaire was used

2.6. Ethical considerations

The provisions of the HELSINKI declaration were respected (Shehu,et al., 2019). All privacy and confidentiality was also guaranteed during and after the data collection.

3. Results

The study result which was aimed at assessing the level of community contribution toward the financing of health care services in Jigawa state, Nigeria: a case study of government hospitals in Jigawa state Nigeria. A total of 100 community members and their care givers were selected.

Table 1 Socio-demographic characteristics of the respondents (n=100)

Variables	Frequency	Percentage
Gender		
Male	25	26.3%
Female	70	73.7%
Age in Years		
< 20	-	-
21-30	51	53.7%
31-40	12	12.6%
41-50	4	4.2%

> 50+	28	29.5%
Highest Education Level		
No formal education	-	-
Primary	-	-
Secondary	17	17.9%
Certificate	10	10.5%
Diploma	37	38.9%
Degree	22	23.2%
Masters	6	6.3%
PhD	3	3.2%

From table 1 shows above, it indicate that gender of the respondents male was 25(26.3%) while female was 70(73.7%) respectively. Majority of the health personnel in this studied are female with 73.7%. The age of the respondents ranges from < 20 years to > 50+ years. These present 21- 30 years were 51(53.7%), 31- 40 years were 12(12.6%), 41 – 50 years were 4(4.2%) and > 50+ years were 28(29.5%) respectively. The level of highest education of the respondents was secondary education 17(17.9%), Certificate was 10(10.5%), Diploma was 37(38.9%), Degree holders were 22(23.2%), Master was 6(6.3%) and PhD were 3(3.2%) respectively. In this studied many of the respondents has Diploma with 38.9% astheir highest education qualification working with the Jigawa State Healthcare. Therefore, there is need for the continuous education programme of the health workers in the facility for proper and effective conduct of operations.

Table 2 Level of community contribution toward the financing of health care services

Variables	**Frequency**	**Percentage**
Is a job description for each member of staff availableat your facility?		
a. Yes	90	94.7%
b. No	5	5.3%
Does your facility have weekly working schedules forthe staff?		
a. Yes	95	100.0%
b. No	-	-
Do you have staff meetings with all people working atyour facility?		
a. Yes, meetings take place every week	80	84.2%
b. No	15	15.8%
Do you use guidelines for decisions about whichmedical treatment to give?		
a. If Yes: We use guidelines given to us by the Ministry.	78	82.1%
b. We developed our own guidelines.	2	2.1%
c. We have a diagnosis-therapy-scheme.	4	4.2%
d. We use Standard Treatment Guidelines.	6	6.3%
e. No	5	5.3%
How do you document the visits of your patients? (allapplying answers).		
a. Patients have health cards.	72	75.8%
b. We use OPD slips.	17	17.9%

c. Our facility keeps records of patients.	6	6.3%
d. We don't have a documentation system.	-	-
How often do the following specialists visit your health facility?		
a. Every weeks.	33	34.7%
b. Never.	22	23.2%
c. Always there	40	42.1%
How are finances organized at your institution?		
Our patients pay a service fee for registration, whichcovers…		
a. Ordinary consultation	9	9.5%
b. Medicaments	56	58.9%
c. Other	30	31.6%
Do you have schemes for patients below the povertyline?		
a. Yes	65	68.4%
b. No	30	31.6
Is the budget you have at your disposal (only oneanswer):		
a. More than sufficient	15	15.8
b. Sufficient	26	27.4
c. Insufficient	10	10.5
d. By far insufficient	44	46.3

From table 2 above, indicates member of staff available at your facility Yes were 90(94.7%) while Nowere 5(5.3%) respectively. Jigawa State health facility have weekly working schedules for the staff said Yes were 95(100.0%) while No were 0(0.0%) respectively.

The staffs meetings with all people working at your facility of which say yes were 80(84.2%) while No were 15(15.8%) respectively. Use of guidelines for decisions about which medical treatment to give said, If yes: We use guidelinesgiven to us by the Ministry were 78(82.1%), we developed our own guidelines were 2(2.1%), we havea diagnosis-therapy-scheme were 4(4.2%), we use Standard Treatment Guidelines (STG) were 6(6.3%) and No responses were 5(5.3%) respectively.

The visits of your patients document was made from Patients have health cards was 72(75.8%), we use OPD slips was 17(17.9%), our facility keeps records of patients was 6(6.3%) and we don't have a documentation system was no response. The specialist's visit your health facility every weeks was 33(34.7%), never was 22(23.2%) and alwaysthere as visitor was 40(42.1%) respectively.

Our patients pay a service fee for registration, which covers ordinary consultation was 9(9.5%),medicaments was 56 58.9%) and others was 30(31.6%) respectively. Schemes for patients below the poverty line which said yes were 65(68.4%) while No were 30(31.6%). The budgets you have at your disposal are more than sufficient were 15(15.8%), sufficient were26(27.4%), insufficient were 10(10.5%) and by far insufficient were 44(46.3%).

Table 3 Challenges that Jigawa government hospital's face

Variables	Frequency	Percentage
How is the cooperation within your department and with other departments?		
i. Cooperation with superiors		
Very good	50	52.6%
Good	25	26.3%
Ok	12	12.6%
Not so good	5	5.3%
Bad	3	3.2%
ii. Cooperation with subordinates		
Very good	55	57.9%
Good	20	21.1%
Ok	12	12.6%
Not so good	8	8.4%
Bad	-	-
iii. Cooperation with equals		
Very good	65	68.4%
Good	17	17.9%
Ok	10	10.5%
Not so good	3	3.2%
Bad	-	-
iv. Cooperation with PWD		
Very good	50	52.6%
Good	25	26.3%
Ok	12	12.6%
Not so good	5	5.3%
Bad	3	3.2%

From table 3, shows that how is the cooperation within your department and with other departmentsin cooperation with superiors was Very Good were 50(52.6%), Good were 25(26.3%), Ok were 12(12.6%), Not so good were 5(5.3%) and Bad were 3(3.2%) respectively. It was revealed from thisstudies, the cooperation within department and others departments with superiors is very good and cordial. The cooperation within department and with other departments in cooperation with subordinateswas Very good were 55(57.9%), Good were 20(21.1%), Ok were 12(12.6%), not so good were 8(8.4%) and bad were 0(0.0%) respectively.

The cooperation within department and with other departments in cooperation with equals wasVery good were 65(68.4%), Good were 17(17.9%), Ok were 10(10.5%), Not so good were 3(3.2%)and Bad were 0(0.0%) respectively. The cooperation within your department and with other departments in cooperation with PWD was Very Good were 50(52.6%), Good were 25(26.3%), Ok were 12(12.6%), Not so good were 5(5.3%)and Bad were 3(3.2%) respectively.

Table 4 Viable recommendations for better community participation

Variables	**Frequency**	**Percentage**
We organize meetings with the community leaders todiscuss health issues.		
Yes, approx. times a year	90	94.7%
No	5	5.3%
We give presentations about healthy behaviour to thegeneral public at the village.		
Yes, approx. times a year	95	100.0%
No	-	-
We visit families in the villages to give advice on healthylifestyle.		
Yes, approx. times a year	60	63.2%
No	35	36.8%
We give health education for children at school.		
Yes, approx. times a year	76	80.0%
No	19	20.0%
We ask the community to give feedback on our services.		
Yes, approx. times a year	83	87.4%
No	12	12.6%
We promote our services in our service area.		
Yes, approx. times a year	90	94.7%
No	5	5.3%
We assess the health needs of the community.		
Yes, approx. times a year	60	63.2%
No	35	36.8%
Do you think the Public could help you to improveyour services?		
a. inform the villagers about the services we offer.	20	21.1%
b. inform the villagers about health risks.	23	24.2%
c. inform the villagers about the national healthprogrammes.	10	10.5%
d. give medication to the needy villager.	30	31.6%
e. takeover some of our services.	2	2.1%
f. control the quality of our service.	4	4.2%
g. do awareness raising.	6	6.3%
How significant is health for the communities you areworking with? (Only one answer!)		
a. Health is very important for those, more than any other issue.	30	31.6%
b. Health is important to them, but it competes with otherissues.	48	50.5%
c. Health is not so important to them, other issues come	17	17.9%

first.		
d. Health is not at all important for them, they do not think about it.	-	-
What health services do people predominantly use?		
a. Public health service	20	21.1%
b. Private health service	12	12.6%
c. Traditional healers	48	50.5%
d. Quacks	15	15.8%
How do you reach out to the community?		
a. We organize health camps	20	21.1%
b. We go to schools	15	15.8%
c. We go to PHCs	48	50.5%
d. We go to self-help groups	12	12.6%
It is just about time that Community got recognized by the government.		
Yes	80	84.2%
No	15	15.8%
Community can do much better work than governmentemployees.		
Yes	70	73.7%
No	25	26.3%
Communities should be a substantial part in allnational health programmes.		
Yes	80	84.2%
No	15	15.8%
Can Public and government institutions work together well?		
Yes	80	84.2%
No	15	15.8%
They can work together well on national or state level.		
Yes	64	67.4%
No	31	32.6%
They can work together well on the basis (PHC level).		
Yes	75	73.7%
No	20	26.3%
How can community participation help to improve the public health system in rural areas?		
a. inform villagers about their rights	12	12.6%
b. control work absenteeism (MO, MPW)	22	23.2%
c. motivate public health personnel	31	32.6%

d. pressure public health system for better performance	20	21.1%
e. make public health system aware of community needs	10	10.5%
H o w can Public in general help to improve the publichealth system in rural areas?		
a. inform villagers about their rights	10	10.5%
b. Motivate public health personnel	26	27.4%
c. Pressure public health system for better performance	15	15.8%
d. Make public health system aware of community needs	12	12.6%
e. help community to complain about missing infrastructure /health service	12	12.6%
f. Fight corruption	20	21.1%
What are the obstacles Public have to face now when they want to cooperate with the Health?		
a. distrust by government officials	10	10.5%
b. shortage of funds	42	44.2%
c. funds only available for specific areas	23	24.2%
d. laws and regulations	20	21.1%

Meetings were organized with the community leaders to discuss health issues said Yes, approximatelytimes a year were 90(94.7%) while No were 5(5.3%) respondents respectively. Presentations was given about healthy behaviour to the general public at the village said Yes, approximately times a year were 95(100.0%) while No were 0(0.0%) respondents respectively. Visitation of families in the villages to give advice on healthy lifestyle said Yes, approximately timesa year were 60(63.2%) while No were 35(36.8%) respondents respectively.

Practitioners give health education for children at school said yes, approximately times a year were76(80.0%) while No were 19(20.0%) respondents respectively. The community people give feedback on our services rendered said Yes, approximately times a yearwere 60(63.2%) while No were 35(36.8%) respondents respectively.

The public could help you to improve your services to inform the villagers about the services we offerwere 20(21.1%), to inform the villagers about health risks were 23(24.2%), to inform the villagers about the national health programmes were 10(10.5%), to give medication to the needy villager were30(31.6%), to takeover some of our services were 2(2.1%), to control the quality of our service were4(4.2%) and to do awareness raising were 6(6.3%) of the respondents respectively.

The significant of health for the communities you are working with health is very important for those,more than any other issue were 30 (31.6%), health is important to them, but it competes with other issues were 48 (50.5%), health is not so important to them, other issues come first were 17(17.9%) and health is not at all important for them, they do not think about it were 0(0.0%) of the respondentsrespectively. Health services do people predominantly use to public health service were 20(21.1%), to Private health service were 12(12.6%), to traditional healers were 48(50.5%) and the quacks were 15(15.8%)of the respondents respectively.

The healthcare personnel of Jigawa State health facility reach out to the community at organized health camps were 20(21.1%), go to schools were 15(15.8%), at the Primary Health Care's (PHCs) were 48(50.5%) and go to self-groups were 12(12.6%) of the respondents respectively. Time that Community got recognized by the government in health facilities across the state said Yes were 80(84.2%) while No were 15(15.8%) of the respondents respectively. Community can do much better work than government employees said Yes were 70(73.7%) while No were 25(26.3%) of the respondents respectively. Communities should be a substantial part in all national health programmes said Yes were 80(84.2%)while No were 15(15.8%) of the respondents respectively. The public and government institutions should work together well in collaborations said Yes were 80(84.2%) while No were 15(15.8%) of the respondents

respectively. They can work together well on national or state level indicates that Yes were 64(67.4%) while No were 31(32.6%) of the respondents respectively.

Community participation help to improve the public health system in rural areas shows that inform villagers about their rights were 12(12.6%), control work absenteeism (MO, MPW) were 22(23.2%),motivate public health personnel were 31(32.6%), pressure public health system for better performance were 20(21.1%) and make public health system aware of community needs were 10(10.5%) of the respondents respectively.

Public in general help to improve the public health system in rural areas revealed that inform villagersabout their rights were 10(10.5%), Motivate public health personnel were 26(27.4%), Pressure public health system for better performance were 15(15.8%), Make public health system aware of community needs were 12(12.6%), help community to complain about missing infrastructure /healthservice were 12(12.6%) and Fight corruption were 20(21.1%) of the respondents respectively.

The obstacles Public have to face now when they want to cooperate with the health revealed in this studies distrust by government officials were 10(10.5%), shortage of funds were 42(44.2%), funds only available for specific areas were 23(24.2%) and laws and regulations were 20(21.1%) of the respondents respectively.

4. Discussion

It indicate that gender of the respondents male was 25(26.3%) while female was 70(73.7%) respectively. Majority of the health personnel in this studied are female with 73.7%. The age of the respondents ranges from < 20 years to > 50+ years. These present 21- 30 years were 51(53.7%), 31- 40 years were 12(12.6%), 41 – 50 years were 4(4.2%) and > 50+ years were 28(29.5%) respectively. The level of highest education of the respondents is secondary education was 17(17.9%), Certificatewas 10(10.5%), Diploma were 37(38.9%), Degree holders were 22(23.2%), Master were 6(6.3%) andPhD were 3(3.2%) respectively. In this studied many of the respondents has Diploma with 38.9% as their highest education qualification working with the Jigawa State Healthcare. Therefore, there is need for the continuous education programme of the health workers in the facility for proper and effective conduct of operations.

Member of staff available at your facility Yes were 90 (94.7%) while Nowere 5 (5.3%) respectively. Jigawa State health facility have weekly working schedules for the staff said Yes were 95 (100.0%) while No were 0 (0.0%) respectively. The staffs meetings with all people working at your facility of which say Yes were 80 (84.2%) while No were 15 (15.8%) respectively. Use of guidelines for decisions about which medical treatment to give said, If yes: We use guidelinesgiven to us by the Ministry were 78 (82.1%), we developed our own guidelines were 2 (2.1%), we havea diagnosis-therapy-scheme were 4 (4.2%), we use Standard Treatment Guidelines (STG) were 6 (6.3%) and No responses were 5(5.3%) respectively.

The visits of your patients document was made from Patients have health cards was 72 (75.8%), we use OPD slips was 17 (17.9%), our facility keeps records of patients was 6 (6.3%) and we don't havea documentation system was no response. The specialist's visit your health facility every weeks was 33(34.7%), never was 22 (23.2%) and alwaysthere as visitor was 40 (42.1%) respectively. Our patients pay a service fee for registration, which covers ordinary consultation was 9 (9.5%),medicaments was 56 58.9%) and others was 30 (31.6%) respectively. Schemes for patients below the poverty line which said Yes were 65(68.4%) while No were 30(31.6%). The budgets you have at your disposal are more than sufficient were 15 (15.8%), sufficient were26 (27.4%), insufficient were 10 (10.5%) and by far insufficient were 44 (46.3%).

Community participation help to improve the public health system in rural areas shows that inform villagers about their rights were 12 (12.6%), control work absenteeism (MO, MPW) were 22(23.2%), motivate public health personnel were 31 (32.6%), pressure public health system for better performance were 20 (21.1%) and make public health system aware of community needs were 10 (10.5%) of the respondents respectively. Public in general help to improve the public health system in rural areas revealed that inform villagers about their rights were 10 (10.5%), Motivate public health personnel were 26 (27.4%), Pressure public health system for better performance were 15 (15.8%), Make public health system aware of community needs were 12 (12.6%), help community to complain about missing infrastructure /health service were 12 (12.6%) and Fight corruption were 20 (21.1%) of the respondents respectively. The obstacles Public have to face now when they want to cooperate with the health revealed in this studies distrust by government officials were 10 (10.5%), shortage of funds were 42 (44.2%), funds only available for specific areas were 23 (24.2%) and laws and regulations were 20 (21.1%) of the respondents respectively.

Meetings were organized with the community leaders to discuss health issues said Yes, approximatelytimes a year were 90 (94.7%) while No were 5 (5.3%) respondents respectively. Presentations was given about healthy behaviour to the general public at the village said Yes, approximately times a year were 95 (100.0%) while No were 0 (0.0%) respondents respectively. Visitation of families in the villages to give advice on healthy lifestyle said Yes, approximately timesa year were 60 (63.2%) while No were 35 (36.8%) respondents respectively.

Practitioners give health education for children at school said yes, approximately times a year were76 (80.0%) while No were 19 (20.0%) respondents respectively. The community people give feedback on our services rendered said Yes, approximately times a yearwere 60 (63.2%) while No were 35 (36.8%) respondents respectively. The public could help you to improve your services to inform the villagers about the services we offerwere 20 (21.1%), to inform the villagers about health risks were 23 (24.2%), to inform the villagers about the national health programmes were 10 (10.5%), to give medication to the needy villager were30 (31.6%), to takeover some of our services were 2 (2.1%), to control the quality of our service were4 (4.2%) and to do awareness raising were 6 (6.3%) of the respondents respectively.

The significant of health for the communities you are working with health is very important for those,more than any other issue were 30 (31.6%), health is important to them, but it competes with other issues were 48 (50.5%), health is not so important to them, other issues come first were 17 (17.9%) and health is not at all important for them, they do not think about it were 0 (0.0%) of the respondentsrespectively. Health services do people predominantly use to public health service were 20 (21.1%), to Private health service were 12(12.6%), to traditional healers were 48 (50.5%) and the quacks were 15 (15.8%)of the respondents respectively.

The healthcare personnel of Jigawa State health facility reach out to the community at organized health camps were 20 (21.1%), go to schools were 15 (15.8%), at the Primary Health Care's (PHCs) were 48 (50.5%) and go to self-groups were 12 (12.6%) of the respondents respectively. Time that Community got recognized by the government in health facilities across the state said Yes were 80 (84.2%) while No were 15 (15.8%) of the respondents respectively. Community can do much better work than government employees said Yes were 70 (73.7%) while No were 25 (26.3%) of the respondents respectively.

Communities should be a substantial part in all national health programmes said Yes were 80 (84.2%)while No were 15 (15.8%) of the respondents respectively. The public and government institutions should work together well in collaborations said Yes were 80 (84.2%) while No were 15 (15.8%) of the respondents respectively. They can work together well on national or state level indicates that Yes were 64 (67.4%) while No were 31 (32.6%) of the respondents respectively.

Shows that how is the cooperation within your department and with other departmentsin cooperation with superiors was Very Good were 50 (52.6%), Good were 25 (26.3%), Ok were 12 (12.6%), Not so good were 5 (5.3%) and Bad were 3 (3.2%) respectively. It was revealed from thisstudies, the cooperation within department and others departments with superiors is very good and cordial. The cooperation within your department and with other departments in cooperation with subordinateswas Very Good were 55 (57.9%), Good were 20 (21.1%), Ok were 12 (12.6%), Not so good were 8 (8.4%) and Bad were 0 (0.0%) respectively. The cooperation within your department and with other departments in cooperation with equals wasVery Good were 65 (68.4%), Good were 17 (17.9%), Ok were 10 (10.5%), Not so good were 3 (3.2%)and Bad were 0 (0.0%) respectively. The cooperation within your department and with other departments in cooperation with PWD was Very Good were 50(52.6%), Good were 25(26.3%), Ok were 12(12.6%), Not so good were 5(5.3%)and Bad were 3 (3.2%) respectively.

5. Conclusion

The practitioners give health education for children at school approximately times a year were 76(80.0%). The community people give feedback on our services rendered said, approximately times a yearwere 60(63.2%). The public could help you to improve your services to inform the villagers about the services we offer were 20 (21.1%), the medication to the needy villager were30(31.6%), to takeover some of our services were 2(2.1%), to control the quality of our service were4 (4.2%) and to do awareness raising were 6(6.3%) of the respondents respectively. The significant of health for the communities you are working with health is very important for those,more than any other issue were 30 (31.6%), health is important to them, but it competes with other issues were 48 (50.5%).

The findings from this study will help to develop programs that can improve knowledge of community Health Financing and services provided by the health-care system and can reduce burden on government by providing other alternative

Recommendations

Based on the findings of the study, the following were recommended:

- Community participation help to improve the public health system in rural areas shows that inform villagers about their rights
- Public in general help to improve the public health system in rural areas revealed that inform villagers about their rights
- The obstacles Public have to face now when they want to cooperate with the health revealed in this studies distrust by government officials.

Limitations

Study participant might decide to withdraw from the study at any time in the course of this research;

Time, financial and logistic constraints

Compliance with ethical standards

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Disclosure of conflict of interest

As the Author; no any area of conflict of interest in the manuscript.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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