International Journal of Innovative Research in Education, Technology and Social Strategies
Volume 1, Number 1, JULY 2015.

ANALYSIS OF IMPACT OF CROSS RIVER STATE COMMUNITY AND SOCIAL DEVELOPMENT AGENCY ON ENHANCED HEALTH STATUS OF RURAL COMMUNITIES

[1]Dr. O. K. Osonwa & [2]Bassey Anam
[1]Department of Sociology &
[2]Institute of Public Policy & Administration
University of Calabar.

Abstract
The paper examines the impact of the Cross River State Community and Social Development Agency on enhanced health status of rural communities. The agency was established in the State in 2009, to compliment Community-Based Poverty Reduction Projects (CPRP) initiative of the Federal government earlier established in 2000. The theoretical assumptions of Community Driven Development (CDD) approach is used to explain the relevance of the agency in improving the socio economic wellbeing of communities in the state and country at large. Ex-post facto research design is used in this study. Data for this study are obtained from primary and secondary sources. Primary data were obtained with the aid of a research questionnaire administered to 140 respondents drawn from rural communities in the State. Data obtained was analyzed using Pearson Product Moment Correlation Analysis. Result obtained shows that there is a significant relationship between the provision of health care facilities and enhanced health status of the people. The study therefore recommends, among other things the need to further improve and sustain the present Primary Health Care (PHC) system in the country.

Keywords: *Community, Social Development, Facilities and Enhanced Health.*

Background to the Study

In 2000, the Federal Government established the Community-Based Poverty Reduction Projects (CPRP) in seven pilot States of Abia, Cross River, Ekiti, Kebbi, Kogi, Rivers and Yobe for the purpose of partnering with these states to provide poverty alleviation projects in each of the states especially in the rural areas. The agency commenced operations in the state in 2001, and was saddled with the responsibility of providing basic amenities in selected communities. Such amenities are construction of classroom blocks, market stalls, bridges and culverts, mini water projects, provision of electricity and health centres (Offem, 2008).

According to World Bank (2012), CPRP seeks to a) test approaches and mechanisms for delivering poverty reduction interventions to marginalized groups through community nutrition and food security interventions and activities to assist street children, and b) test and build capacity, at national and district levels, for monitoring and evaluating poverty reduction programs. There are four project components. 1) Community based nutrition and food security will test a community-based strategy to strengthen the capacity of communities to achieve, on a sustainable basis, good nutrition, and food security, especially for children under five and pregnant and lactating mothers. 2) Interventions to assist street children will provide grants to nongovernmental organizations already working on street children issues to improve and expand their existing activities. 3) Poverty measurement and monitoring will support three districts to pilot poverty measurement and monitoring systems, aimed at monitoring household/individual as well as community level poverty. 4) Project management will establish various units for project implementation (World Bank, 2012).

The Cross River State Community and Social Development Agency (CRSCSDA) is the implementing Agency for the Community and Social Development Project (CSDP) in Cross River State (CRSCSDA report, 2014). The report further indicates that CSDP is a scale-up of the Community Based Poverty Reduction Project (CPRP) which was a pilot project implemented in 8 states of the federation. CPRP closed on March 31, 2009 while CSDP became effective on April 1, 2009. The Agency was established by a law of the State House of Assembly 2009 and is funded by the World Bank and Cross River State government. CSDP which is currently implemented in over 27 states of the federation is a collaboration of the World Bank, State and Federal Government of Nigeria towards poverty reduction. It utilizes the Community Driven Development (CDD) approach, a bottom-up development strategy which places the poor on the driver's seat of development by giving them a voice in decision making for development. It is a participatory and socially inclusive approach which allows the poor to identify, design, part-finance, implement, manage and own assets created towards poverty reduction (Anam, 2014).

An evaluation of the project will be to examine the extent to which it has to supported and empowered community-based institutions, foster participatory development, empower poor people by expanding their access to and control over fundamental assets such as capital, knowledge and technologies and also rehabilitate rural infrastructure to improve production conditions, access to markets and living conditions (Ebong, 1991). The study is specifically set to examine the impact of the project on enhanced health status of the people.

Statement of the problem

That life in rural areas is hard, rustic and sometimes inhuman cannot be overstressed. Many rural dwellers are traumatized by poverty, starvation and diseases. Their social and economic lives are characterized by inadequate access to employment opportunities, physical assets such as land/capital, reduced access by the poor to credit even on a small scale and insufficient access to market where the poor can sell goods and services. They have poor health, nutrition and sanitation. Housing is inadequate and there is little opportunity to change these conditions. There are a lot of inadequacies associated with primary health care delivery system (Adebayo, 2014).

Enabulele (2013) maintained that the trio must now face squarely a new reality that the primary health care system in Nigeria is not just working. It's abysmal performance remains not just a source for concern, but also the basis for outbreak of diseases in Nigeria. The most plausible way to address the problem with the nation's primary health care system is to start from the root, by building and equipping standard health care facilities in rural communities. The extent to which the Cross River State Community and Social Development Agency has played significant role in improving the health status of community dwellers is examined in this study.

Source of Data and Methods

Ex-post facto research design is used in this study. Ex-post facto is systematic empirical enquiry in which the scientist does not have direct control of independent variables because they are inherently not manipulable. Data for this study are obtained from primary and secondary sources. Primary data were obtained with the aid of a research questionnaire. The questionnaire which was designed using the four-point ranking scale from Strongly Agree (SA), Agree (A) to strongly Disagree (SD), Disagree (D), was administered to 140 respondents drawn communities who have benefited from the Cross River State Community and Social Development Agency health project. Data obtained was analyzed using Pearson Product Moment Correlation Analysis.

Literature and Theoretical framework

Experts have submitted that efforts to reduce rural poverty in the past tended to focus on increasing the income and food security of rural poor people (Odigbo & Adediran, 2004; Tyson, 2005; Offem, 2008). Increasingly, there has been a greater emphasis on the human and social factors that cause poverty. This broader understanding of the factors affecting poverty in rural areas has been reflected in many projects since the mid-1990s. Project design has stressed peoples' participation and empowerment, enhanced social capital, demand-driven development and a community-driven development approach.

According to Ebong (1991), Community-driven development (CDD) involves a degree of devolution of responsibility to communities for managing their development, including the design and implementation of projects. CDD programs operate on the principles of transparency, participation, local empowerment, demand-responsiveness, greater downward accountability, and enhanced local capacity. Experience has shown that when given clear and transparent rules, access to information, appropriate capacity, and financial support, poor men and women can effectively organize to identify community priorities and address local problems by working in partnership with local governments and other supportive institutions (Tyson, 2005).

It is a participatory framework which allows for participation of community members in the identification of felt need projects, design and implementation of such in their best interest. CCD empowers the poor. It encourages cooperation between citizens and their leaders to lift their community out of poverty. Using CDD, poor communities organize themselves, analyze their development needs and priorities, prepare project proposals to address their common problems, and compete for block grants to finance their own projects. Community members are also responsible for implementing and managing these projects.

According to World Bank (2012), CDD is denoted with five key characteristics as shown below,

1. A CDD operation primarily targets a community-based organization or a representative local council of a community. This community focus means that the essential defining characteristic of a CDD project is that the beneficiaries or grantees of implementations are agents of the community. Since the focus on small communities is so large the CDD normally targets small scale subprojects in the community.

2. In CDD operations, community or locally based representation is responsible for designing and planning the subprojects in a participatory

manner. Since the concentration on participatory planning is considerable in CDD operations, often the possible types of subproject investment options are very large with only a small list of subprojects that cannot be carried out.

3. The defining characteristic of CDD projects is that a transfer of resources to the community occurs and control of the resources is delegated to the community. The amount of transfer and control of resources will depend on the CDD implementations.

4. The community is directly involved in the implementation of the subproject. Often the participation of the community comes directly in the form of labour or funds. However, the community may also contribute to the subproject indirectly in the form of management and supervision of contractors or the operation and maintenance of the infrastructure when complete.

5. An element of community based monitoring and evaluation has become a characteristic of CDD subprojects. Most often it is social accountability tools such as participatory monitoring, community scorecards and grievance redress systems which allow for the community to ensure accountability of the CDD implementation.

In addition, the International Fund for Agricultural Development (IFAD) (2012) added that Community-driven development is a way to manage development, including the design and implementation of policies and projects, which facilitates access by poor rural people to social human and physical capital. CDD achieves this by creating the conditions for:

1. Enabling community organizations to play a broader role in the design and implementation of policies and programmes aimed at improving the livelihood of community members, particularly of the poor and marginalized people within those communities
2. Changing the organizational culture of the agents working for rural development and rural poverty reduction, and diversifying and shifting the power configuration that confronts rural communities in matters related to the communities' own socio-economic development
3. Emphasizing the importance of good local governance through a commitment to a long-term capacity-building processes
4. Maximizing the impact of public expenditure on the local economy at community level

This approach emphasizes that CDD refers to the way a policy or a project is designed and implemented, not to the content of a policy or project component. It is concerned with community-based civil society and private sector organizations and with decentralization.

In this vein, Community-based and -driven development projects have become an important form of development assistance, with the World Bank's portfolio alone approximating $7 billion. CRSCSDA is one of such development agency established to foster the goals of CDD. The primary objective of the study is to improve the livelihoods and living conditions of rural communities in general and of the most vulnerable rural households and particularly those headed by women and further sustainably increases access by poor people to improved social and natural resource infrastructure services. According to the programme blueprint, the key performance indicators for the project are as follows:

i. Increased number of poor people (of which 70% are women) with access to social services.
ii. Increased number of poor people with access to natural resources infrastructure services.
iii. Increased percentage of participating Local Government budgets that incorporate Community Development Plans (Nwoabi, 2012).

Specifically the programme seeks to, empower communities to plan, part finance, implement, monitor and maintain sustainable and socially inclusive multi-sectoral micro projects, facilitate and increase community-LGA partnership on Human Development related projects, increase the capacity of LGA's, State and Federal Agencies to implement and monitor CDD policies and interventions and leverage the capacity of LGA's, State and Local Government resources for greater coverage of CDD interventions in communities (CRSCSDA, 2014).

By 2014, the agency had approved and funded 247 Community Development Plans (CDP) comprising 673 multisectoral micro projects as at date. Out of this, 523 micro projects are completed and put to use by beneficiary communities. These micro projects have far-reaching effect on the fight against poverty, the CRS seven point Agenda, the attainment of the MDGs and Federal Government vision 20:20:20. Over the years Agency has worked assiduously to improve the living standard of beneficiary communities across the state using the Community Driven Development (CDD) approach (CRSCSDA, 2014).

There is some evidence that such projects create effective community infrastructure, but not a single study establishes a causal relationship between any outcome and participatory elements of a community-based development project. The study is

Specifically set to examine the impact of the project on enhanced health status of the people.

Data analysis, result and discussion of findings

A hypothesis was developed to guide this study. In its null form, the hypothesis stated that there is no significant relationship between the provision of health care facilities by CRSCSDA and enhanced health status of the people. Here, both the independent and dependent variables are continuous in nature. This permitted the use of Pearson product moment correlation analysis for its test as shown in table below.

Table 1

Result of Pears Correlation analysis of the relationship between the provision of health care facilities and enhanced health status of the people.

Variable	X	SD	∑ X ∑ Y	∑ X^2 ∑ Y^2	∑XY	rxy
Provision of health care facilities	18.06	3.81	2527	47625		
					50823	0.136*
Enhanced health status of the people	19.95	5.33	2795	59587		

*P < 0.05, df = 138, critical t = 0.135

In table 12, the calculated r value is 0.136. This is found to be greater than the critical r value of 0.135 at 0.05 level of significance with 138 degree of freedom. This led to the rejection of the null hypothesis while the alternate is retained. The interpretation of this result is that there is a significant relationship between the provision of health care facilities and enhanced health status of the people. The result shows a positive correlation with the report of the State agency. The agency reported that as at 2014, about 58 health centres have been constructed and furnished where 1052 persons are receiving medical treatment. This is no doubt significant in enhancing the health status of the people.

Discussion of findings

Ekwuruke (2007) underscored the importance of health care delivery services when he stated that the general health of a member of any society can be seen as part of an interrelated set of conditions, which have to do with his capacity to adjust to his immediate environment and to utilize it to his optimum advantage. However, more is yet to be achieved. There is still high level of vulnerability to diseases and other

health related challenges in rural areas in Nigeria. The Nigerian rural communities are still noted for their high degree of poverty (World Bank, 2012). They have poor health, nutrition and sanitation.

Enabulele (2013) identified that, one of the critical problem facing primary health care system is the inability of the various strata of governments to distinguish whose responsibility it is to oversee primary health care. In most states, primary health care facilities are nothing to write home about. Where they exist, most lack medical equipment. The frustrating aspect of it all is that a majority of the primary health care centres do not have diagnosis equipment to clinically discern outbreaks of diseases, mostly communicable diseases. Therein lies the problem with Nigeria's health system.

Faced with such problems, health seekers in rural communities are challenged not just with the issue of cost but also the quality of service. Similar to the challenges above is that many of them would be ultimately referred to secondary or tertiary health facilities far removed from their domain. Still, government can address these gaps in rural communities in providing sustainable service in primary health care. The fact that primary health care centres in villages have been reduced to mere complaint centres about ill-health has not helped matters (Enabulele (2013). He acknowledged further that, with close supervision from National Primary Healthcare Development Agency (NPHCDA), the agency intends to reorganise primary health care through the full implementation of the Midwives Service Scheme (MSS) and SURE-P programme.

Muhammed (2015) observed that so far, 2500 primary health care centres had benefited from the SURE-P programme through the conditional cash transfer system. In the same vein, for the communities, it is a win-win situation, as they are to benefit from both the MSS and SURE-P programmes. It is assumed that the two-pronged approach will take primary healthcare to greater heights. Even at that, primary health care in the country is still far off from meeting the yearning of health seekers in rural communities. Granted, NPHCDA immunisation programme has been cheered and applauded by close watchers, it must foreground its activities in building reliable and state-of-the-art primary health care facilities in rural communities and villages. Time has come to do away with primary health care centres that end up being just referral centres, with one nurse and just one hospital bed. It must start providing standardised primary health care facilities that address the health challenges in rural communities. In building such centres, it must do so hand in hand with the states and local governments.

While prevention of diseases through the administering of immunisation has become the critical focus of NPHCDA and his partners, health experts are of the view that such efforts should not just end there. Concerted efforts should be put in place to ensure standard primary health care facilities are built, and works towards stemming the tide of diseases in rural communities. They added that there should be a common ground among the NPHCDA, states and local governments in setting in motion a new way of combating outbreak of diseases and other health challenges in rural communities (Enabulele (2013).

Conclusion

The study was an attempt to analysis of impact of cross river state community and social development agency on enhanced health status of rural communities. The analysis of data and result obtain shows that there is significant relationship between the provision of health care facilities and enhanced health status of the people. Much as this is commended, much is still desired as most community dwellers do not have access to improved health services in the country. The study submitted that therefore that the most plausible way to address the problem with the nation's primary health care system is to start from the root; adopting the bottom- top approach, by building and equipping standard health care facilities in rural communities (Dele, 2006). Otherwise, government may just be applying cosmetic measures on a perennial disease, as the nation remains stuck in the middle of diseases. For primary health care to work, it must start with the provision of adequate medical facilities. That would be a time-tested guaranty that would reposition the sector for good (Enabulele (2013).

Recommendations

From the findings and discussions above, the study recommends as follows,

1. Construction of more Primary Health Care centers across the country, especially in rural communities where the vulnerability of disease is still very high.

2. Provision of adequate facilities in health care centers. Time has come to do away with primary health care centres that end up being just referral centres, with one nurse and just one hospital bed. It must start providing standardised primary health care facilities that address the health challenges in rural communities.

3. The provision of effective primary health care system in the country must be enhanced by the three tiers of government and not just seen as an exclusive responsibility of the local government areas. Effort must also be

made to effectively maintain and sustain health care facilities.

4. Medical practitioners and health workers must be trained and retrained, with complementary motivation on the job. This will enhance their performance and improved health care delivery system in the country.

References

Adebayo, S. (2014). ¡°CommunityDevelopment: Theories and Approaches.¡±Lagos: Alfa Press.

Anam, B. (2014). ¡°Understanding Community and Rural Development.¡± Calabar: Etheral Bliss.

Anam, B. (2014). ¡°UnderstandingCommunity and Rural Development: Cross River State Community and Social Development Agency (CRSCSDA).¡±Calabar: Etheral Bliss.

Dele, F. (2006). ¡°Towards full economics of scale in Nigeria.¡± Ibadan: Alpha Publishing House.

Ebong, M. (1991). ¡°Mobilization of resources for rural development in Nigeria.¡± Calabar: Wusen Press.

Enabulele, O. (2013). ¡°MakingPrimary Health Care Thrive in Rural Communities¡±. http://www.thisdaylive.com/articles/making-primary-health-care-thrive-in-rural-communities/162447/

International Fund for Agricultural Development (IFAD) (2012). http://www.ruralpovertyportal.org/topic/home/tags/community_driven_development

Nwoabi, G. (2000). ¡°Ruralresources farm business and rural development.¡±Ibadan: Routers Press.

Odigbo, M. & Adediran, D. (2004). ¡°Integrated approach to rural development: Issues of theoretical review¡±Nigerian Tribune July 12, 40.

Offem, I. D. (2008). ¡°Elementsof rural economics ¡±Ibadan: University Press.

Tyson, P. (2005). “Rural infrastructure in Nigeria.” Tell Magazine, August, 22, 26-27.

World Bank Report (2012). “Community-based Poverty Reduction Project.” Http://www.worldbank.org/projects/P040659/community-based-poverty-reduction-project?lang=en