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Citizen participation in the political economy of primary healthcare financing in Nigeria: a cross-sectional survey

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Received: 23 September 2024 / Accepted: 17 March 2025
Published online: 01 April 2025

Abstract

Background The longstanding financing challenges in Nigeria's health sector which have resulted in undesired health outcomes, have necessitated the investigation of factors responsible for the apparent gap in fiscal prioritization. An earlier study shows that there is low citizen influence on healthcare financing in Nigeria, thus impacting gaps persist regarding the scale and drivers of citizen participation.

Method This study utilized a modified two-sided stakeholder model to assess citizen engagement in primary healthcare financing. A survey was conducted among 400 citizens and civil society organizations (CSOs) to gauge experiences, perceptions, priorities, and participation levels in advocating for enhanced primary healthcare financing.

Result Descriptive analysis uncovered significant challenges faced by Nigerians in accessing basic healthcare, with a strong collective desire for universal health coverage. Healthcare emerged as a pivotal consideration in evaluating political leaders, although it is not universally viewed as the government's primary concern. Chi-square tests revealed correlations between age groups and participation levels, as well as preferred information sources. Notably, findings suggest limited awareness and involvement in health policymaking, particularly among youth, possibly linked to insufficient coordination between CSOs and the public.

Conclusions The study underscores critical gaps in citizen engagement within primary healthcare financing in Nigeria. Despite widespread desire for improved healthcare access and coverage, actual participation and awareness levels remain suboptimal. Addressing this requires enhanced coordination and communication strategies between CSOs and the public to amplify citizen influence on health policymaking and implementation.

Keywords Health financing · Citizen participation · Primary healthcare · Political economy analysis · Nigeria

1 Introduction

Nigeria's commitment to international agreements such as the Sustainable Development Goals and Declarations for Universal Health Coverage, which acknowledge citizens' entitlement to adequate preventive, promotional and rehabilitative healthcare services, aligns with the broader social contract existing between people and government in democratic systems [1]. This social contract underscores the government's obligation to safeguard the well-being and social security of its citizens. Health, being one of the fundamental pillars of human capital development, is regrettably failing in Nigeria, as the country continues to fall short in essential health outcome indicators [2].

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There is a consensus that primary healthcare holds the keys to improving most of Nigeria's health indices, especially through its integrated continuum of care system known as RMNCAH, reproductive, maternal, newborn, child, and adolescent health services [3]. However, in Nigeria, primary healthcare funding has been suboptimal, arguably due to the broader context in which health is not as high a priority as other public service sectors [4]. Despite successive political administrations' pledges to allocate 15% of the yearly budget to healthcare, as outlined in the Abuja African Union Declaration of 2001, the actual average proportion of the national budget directed towards health falls considerably short, standing at less than 6% [5]. Consequently, this deficit in healthcare funding poses a substantial threat to access to essential healthcare services in Nigeria. It also places a heavy burden on at least 70% of Nigerians who must deal with exorbitant healthcare expenditures that can have catastrophic financial consequences [6]. Due to the economic downturns following three economic recessions between 2015 and 2023, as well as the prevalence of multidimensional poverty affecting 63% of the population [7], many Nigerians cannot afford basic health services, and this limits access to care to only about 43% of the population [8]. Some of the primary health services include malaria, typhoid, family planning, hypertension, obstetric, and immunization services among others [9]. However, due to poor access to care, Nigeria records the highest cases of Malaria deaths despite the existence of highly effective treatment regimens [10]. Additionally, hypertension, which can be managed by prompt diagnosis, is a leading contributor to Nigeria's relatively low life expectancy [11]. UNICEF estimates that Nigeria's child mortality rate of 128 per 1000 live births and a maternal mortality rate of 576 deaths per 100,000 live births are some of the highest in the world [12]. However, these unfavorable health outcomes owe largely to the heavy reliance on out-of-pocket spending by citizens for these essential services [13].

In addition to exposure to financial risk that restricts access to health in Nigeria, alarming health performance indices are equally traceable to how health financing, as a pillar of the health system, limits the performance of other critical health supply pillars such as infrastructure, human resources, and health commodities, which all rely on the availability of financial resources [14]. A study reported that only one out of five primary healthcare facilities is operational, primarily due to significant infrastructural deficiencies [15]. Similarly, a significant exodus of healthcare professionals from Nigeria's healthcare system can be attributed to substandard working conditions, notably insufficient compensation, and a lack of essential equipment [16]. Furthermore, frequent shortages of vaccines, medications and other medical supplies also play a crucial role in contributing to inadequacies in healthcare provision in Nigeria. Given the indisputable importance of health financing, health reformers are increasingly inclined to investigate the factors that drive health financing policymaking, particularly through political economy lenses. On this, Weger and colleagues emphasized the relevance of citizen participation in grasping the political calculations that influence healthcare financing and prioritization in general [17].

2 Citizen participation and health financing in Nigeria

Citizen or public participation is defined as the involvement of an affected population in decision-making processes [18]. In a recent study examining the political economy landscape surrounding one of Nigeria's pivotal financing mechanisms for primary healthcare, namely the Basic Health Care Provision Fund (BHCPF), the Campos and Reich framework for political economy in health financing was used [6]. The study indicated that political stakeholders exerted the most substantial influence on both the design and execution of the fund. Surprisingly, the stakeholders of the citizens, represented by civil society health reformers in the study, were found to have the least impact on the development and implementation of the fund. Whereas citizen or community participation is gaining increasing relevance in strengthening health systems globally [19–21]; being generally associated with positive health outcomes as it provides room for accountability and localized solutions designing and feedback [22–24]. In the area of health policymaking, citizen participation is known to align policies with lived experiences of citizens, provide legitimacy to the policymaking process, and act as the 'lever' needed for radical policy change [17].

Similarly to other democratic nations of the world, Nigeria's health system is not entirely lacking in citizen participation. In fact, systemic citizen participation in health systems in Nigeria dates to 2001 with the establishment of the ward health system (WHS) as part of efforts to devolve primary healthcare from national to subnational governance systems based on WHO recommendations [25, 26]. The WHS is in line with the position of a political ward as the lowest entity in Nigeria's geopolitical stratification. The wards are led by elected councilors and are made up of smaller villages or settlements [22]. The ward health system incorporates the ward health committee (WHC), which is composed of representatives from various community groups, including village health committees, women's associations, and youth groups [27]. Subsequent policies, such as the 2014 National Health Act, the operational guidelines of the BHCPF, and the 2020 National Strategic Health Plan, have further defined and solidified the roles of ward health committees (also known as ward development committees).

These committees are now responsible for tasks that include identifying and prioritizing community health needs, designing and planning solutions to address these needs, generating demand for health services within the community, mobilizing local resources, and overseeing the financial management of healthcare facilities. Notably, the operational guidelines of the BHCPF stipulate that the chairperson of the health committee serves as a cosignatory for the facility's bank account, emphasizing the community's involvement and oversight in healthcare financing and management [28]. However, this system has been challenged on claims of poor representation and incapability of committee members to fulfil their given mandate [28].

In general, the impact of the WHS is largely limited to governance at the community level. Conversely, health financing policymaking which encompass aspects like budget allocations and the regulation of health payment methods (such as out-of-pocket payments, mandatory health insurance, voluntary health insurance, or tax-based health insurance), often lacks in public participation [29].

Notwithstanding, budgetary prioritization is intricately complex, therefore compounding the issue of citizen participation. Globally, initiatives such as polls, referendums, elections, public hearings are other means governments have been used to systemically engage citizens in establishing relative importance of different policy priorities. Other less-systemic means of citizen participation include citizen-led townhall meetings, advocacy walks, protests, social media campaigns, civil disobedience, letter-writing campaigns, storytelling, music, fine arts and so on [30]. Where such organic mobilization is not easily obtainable, for instance, in the case of developing democracies such as Nigeria, citizen involvement tends to be channeled through non-governmental health reformers, such as civil society organizations (CSOs) and community groups. Although civil society plays a role in advocating for health financing priorities, its impact within the broader context of decision making is considered to have limited influence due to the lack of broad legitimacy and sheer weight of the general citizenry [6].

To put in perspective how citizen participation may shape health financing, an American historian Beatrix Hoffman (2008) documented how social movements impacted government prioritization of healthcare financing in the twentieth century USA, emphasizing the roles of collective action in shaping the political economy of healthcare financing [31]. According to Beatrix, early efforts to expand social health insurance in the 1940s through the Wagner–Murray–Dingell bill failed due to lack of grassroots mobilization [32–34]. Much like how social movements played a pivotal role in influencing healthcare prioritization in the 1960s, Beatrix Hoffman's account illustrates a more recent example in Portland in 2021. In this case, a referendum led to the adoption of universal health coverage. To achieve this, health reformers organized impactful street shows that depicted the necessity of universal healthcare, and organized rallies where supporters passionately voiced their concerns against the existing healthcare system and expressed their strong backing for the new initiative [31, 35–37].

Nigeria, on the other hand, recently recorded one of the lowest budgetary proportions to healthcare in 2023, way lower than its West African counterparts Ghana and Cape Verde. While the lack of political will among political stakeholder is established to result in low budgetary prioritization [32, 33], poor citizen participation is equally a known driver [34]. In which case, evidence points to the negative impact of high illiteracy and poverty rates in dampening citizen participation [35].

The present study also draws inspiration from the study by Weger et al. on the dynamics of priority and participation between Dutch citizens and government stakeholders on healthcare [17]. De Weger et al. discovered that government stakeholders tend to have a more structured approach to setting health priorities, while citizens determine health priorities based on their "holistic experiences and perceptions". In this vein, our study seeks to provide a descriptive account of experiences, perceptions, levels of participation, and prioritization related to health financing, particularly in the context of primary healthcare, as perceived by citizens and CSOs in Nigeria. By exploring these aspects, our aim is to gain insight into how citizens and civil society engage with health financing issues and how these factors influence their priorities in the Nigerian healthcare landscape.

3 Methodology

3.1 Survey instrument

In our study, we employed a cross-sectional design, utilizing a survey questionnaire that covered four key domains: demographics, experiences, perceptions, and participation in healthcare matters within Nigeria. The demographic section included gender, age, monthly income, and education. Respondents' experiences were examined by surveying the facilities where they accessed care, the affordability of health services, and their current payment methods, such as out-of-pocket expenses

or health insurance. Perception was assessed through three questions: preferred health service payment methods, prioritization of health, and perceptions of the government's prioritization of the health sector. Finally, participation was evaluated based on respondents' involvement in advocacy activities to improve health financing, their sources of information on the health sector, and their knowledge of key health financing policies in Nigeria.

To ensure the validity of the survey questions, we subjected them to a content validation process with three external experts in the field of public health, all holding at least a master's degree in public health. This yielded a content validity index (CVI) of 0.84 which was accepted with minimal corrections based on Davis (1992) [36] recommendation for content validity. The questions were uploaded to the Cognitio survey platform (cognitoforms.com) and initially served 50 participants to test the reliability of internal consistency. The Cronbach alpha for each of the three dependent dimensions ranged from 0.796 in experiences (3 items) to 0.829 in perception (4 items) and 0.881 in participation (3 items). This range is acceptable based on extant reliability measurement practice [37].

3.2 Data collection

The survey for citizens or non-CSO respondents was sent out through an independent publicist who used social media platforms (WhatsApp, Facebook, Emails, and Twitter) to disseminate the link which was formatted to only receive responses from respondents who reported to be resident in Nigeria. In attempt to also capture less-digitally reached respondents, in-person data collection was conducted in the residential communities around the universities of Abuja and Calabar in the federal capital territory and the cross-river state, respectively. The two states were chosen through a vote of states in the northern and southern hemispheres of Nigeria. In the Northern hemisphere balloting, the federal capital territory was selected out of 19 states and the capital territory while in the Southern hemisphere balloting, Cross River was selected out of 16 states. The federal capital territory belongs to the north-central geopolitical region while Cross River belongs to the south-southwest region of Nigeria. Supplementary data collection was carried out in communities close to the universities to avoid insecurity liabilities for students who collected the data. Furthermore, due to the supplementary nature of the data set from these states, the study did not situate the sampling or responses within the states or their respective regions in order to maintain the universality of the majority of the data which were obtained from residents throughout the country.

The survey link for civil society advocates for health was distributed through WhatsApp platforms of civil society coalitions based in Nigeria, such as the Joint Learning Agenda for Universal Health Coverage in Nigeria and the Meaning Adolescent and Youth Engagement Working Group. Members of the civil society were surveyed along with citizens in this study based on the relationship previously established by Alawode et al. in the beneficiary politics of BHCPF in Nigeria [6]. In addition, the civil society component of the survey could help describe the level of alignment and coordination between the citizenry surveyed and CSO representatives, in the hope of identifying potential gaps in the advocacy for health financing in Nigeria.

3.3 Sampling technique

The sample size of 384 was obtained through the sample size determination table provided by the University of Connecticut based on Cochran's formula for cross-sectional studies of populations above one million such as Nigeria [38]. This is expressed in the following formula:

$$N = \frac{Z^2 P\,(1 - P)}{d^2}$$

where N = minimum sample size; Z = sample statistic corresponding to 95% confidence interval = 1.96; P = proportion of adult population in Nigeria = 0.51; d = precision (corresponding to effect size) at 95% confidence interval = 0.05. The adult population in Nigeria is defined as all residents of Nigeria who are at least 18 years old at the last population projection.

Substituting the values into the above formula,

$$\text{our minimum sample size is } = \frac{1.96^2 \times 0.51 \times (1 - 0.51)}{0.05^2} = 384$$

Therefore, N, the minimum sample size for this study is 384. However, the study collected 400 responses after one month of data collection between May and June 2023.

3.4 Data analysis

Data was collected for a period of one month and cleaned using Microsoft Excel and analyzed using IBM SPSS for both descriptive and inferential statistics, respectively. The objective of the descriptive analysis was to generally understand the demography, experience, perception, and participation of the respondents, as well as to compare key variables for alignment and coordination between the general citizenry and civil society respondents. Inferential statistics were used to assess the relationships among key variables such as the level of participation of citizens, preferred channels of information, and age categories.

3.5 Ethical considerations

The study obtained ethical approval from the Health Research Committee of the Federal Capital Territory Human and Health Services Secretariat, with approval number FHREC/2023/01/96/30-05-23. In addition to that, the survey was programmed to accept only responses from anyone who was at least 18 years old at the time of filling out the survey. Whilst we obtained informed consent from all individual participants included in the study, the data was anonymized to protect respondents from breach of privacy and limit the influence of identity-linked bias in their responses. All other guidelines of the Federal Capital Territory Health Research Committee for health and social sciences survey were duly followed.

4 Results

4.1 Citizen survey

A total of 400 responses were collected –348 from citizens and 52 from members of CSOs. Among the citizens (non-CSO respondents), 248 filled out the survey links while 50 respondents each were surveyed at the federal capital territory and Cross River communities. Table 1 shows that more women and young people between the ages of 18 and 35, took the survey. Furthermore, 45% of the respondents earn less than 30,000 Naira (USD 65) 2023 national minimum wage, although most of the respondents have had undergraduate or postgraduate educational experience. Despite the economic status of most of the respondents, many of them use private clinics to access primary healthcare services such as malaria, followed by other points of care such as local pharmacy stores or traditional vendors (Table 2). However, only 12% reported using government-owned primary healthcare centers. The vast majority (85%) reported that they got health services at unaffordable amounts even as the same proportion of respondents reported to be paying out-of-pocket for primary healthcare.

In terms of perception and personal prioritization of healthcare as a public sector, an overwhelming majority of 99% agreed that primary healthcare should be available to all citizens regardless of their socioeconomic status, and the best way to achieve this aspiration is a mix of free health insurance and compulsory health insurance (48%); this was followed by a preference for compulsory health insurance (36%), which was significantly ahead of out-of-pocket spending (14%). A decisive majority of respondents (84%) chose health as one of their top three sectors by which they could assess and elect a government, but this could not be matched by their perception of government prioritization of health in the last four years. In fact, most reported that health has not been a priority for the Nigerian government at all, while 43% cumulatively chose between the top 5 and top 7 priorities.

When asked if the respondent had participated in any advocacy to improve health financing for healthcare in Nigeria, the response fell short of the level of personal prioritization reported because only 20% had actively participated in such activity. Social media was widely chosen as a means of getting health-related information, and this was followed by sensitization programs (19%) and television (14%). Lastly, to assess the knowledge of the respondents about existing health insurance programs, about half of the respondents (46%) knew that the national health insurance scheme was even more popular than the basic healthcare provision fund (9%) or the tertiary student health insurance program (TSHIP) even though 95% of the respondents had a tertiary education experience.

4.2 Relationships of key variables among citizens (non-CSO respondents)

Using cross-tabulation and chi-square test to assess key variables that are important for coordination and mobilization between citizens and CSOs, a significant relationship between age group and level of participation were observed ($p < 0.05$, $\alpha = 0.05$, 95% CI) as well as between age group and medium of information ($p < 0.005$, $\alpha = 0.05$, 95% CI). (See

Table 1 Demographic characteristics of the citizen survey (N = 348)

Variable	Sample size (n)	Frequency (%)
Gender		
Male	154	44
Female	194	55
Age		
18–35	288	83
36–49	35	10
50–69	25	7
Monthly income (Naira)		
< 30 K	156	45
30–40 K	55	16
50–99 K	66	19
100–199 K	41	12
= / > 200 k	30	8
Education		
Primary & secondary	16	5
BSc	249	72
Postgraduate	82	23
None	1	0

Table 3). Additionally, participants aged 18 to 35 years were more inclined to get health policy-related information through social media (60%) while those between 36 and 49 through television programs (34%), community sensitization programs (26%) and social media (22%). Participants aged 50 years and older reported a marked preference for television (68%).

4.3 Civil society survey

As analyzed in Table 4 below, 52 respondents with equal numbers of men and women took the civil society survey. Most (61%) had spent more than 5 years in health advocacy. Similar to the result of the citizen survey, CSO respondents perceived that health had not been a priority for the government of Nigeria in the last 4 years (2019–2023). Lastly, their most utilized means of passing health information to citizens are through community sensitization programs (38%), followed by social media (23%), radio (15%) and peer interaction (14%).

As shown in Fig. 1 above, the three most-utilized platforms for sharing information by the surveyed civil society actors are sensitization programs (38%), social media (23%) and radio programs (14%), respectively. Whereas the three most used mediums of accessing information by the surveyed citizens are social media (52%), sensitization programs (19%) and television (14%).

5 Discussion

This study corroborates previous studies that have affirmed the high proportion of out-of-pocket expenditure in Nigeria and its attendant impact on the economic survival of individuals as well as their decisions to seek health services in the first place [39–41]. Although Nigerians generally aspire to universal health coverage, this is evident in the overwhelming majority who reported that primary healthcare should be accessible and available to all persons without socioeconomic barriers. In fact, a similarly overwhelming majority (84%) consider health to be one of their top three priority sectors when electing or evaluating a political leader. Unfortunately, government's fiscal prioritization of health between years 2019 and 2023 which is a political term in Nigeria, did not meet the priority expectations of Nigerians.

In March 2022, the President of Nigeria signed the new national health insurance authority act (NHIA) 2022 into law [42]. The law makes health insurance mandatory for all Nigerians through employment benefits, existing government initiatives such as the basic healthcare provision fund, the tertiary student health insurance scheme, and a new funding mechanism called the vulnerable groups fund [43]. This policy framework aligns moderately with the choice of majority

Table 2 Descriptive table analysis of the citizen survey (N = 348)

Variable	Sample size (n)	Frequency (%)
Facility used		
Govt PHC	43	12
Govt secondary facility	49	14
Govt tertiary facility	29	8
Private clinic	128	37
Others	99	28
Payment method		
Out of pocket	308	88.5
Health insurance	40	11.5
Ease of payment		
Affordable	40	11.5
Not affordable	308	88.5
UHC (PHC) aspiration		
Yes	346	99
No	2	1
Preferred payment method		
Compulsory insurance	48	14
Free insurance	134	39
Mix of compulsory and free health insurance	166	48
Individual's health priority		
Top 3	291	84
Top 5	25	7
Top 7	18	5
Not a priority	14	4
Perceived Govt. Priority		
Top 3	46	13
Top 5	78	22
Top 7	73	21
Not a priority	151	43
Participation status		
Active	69	20
Not active	279	80
Medium of information		
Television	48	14
Radio	13	4
Online News	22	7
Social Media	181	52
Sensitization programs	67	19
Peer interaction	17	5
UHC Initiative awareness		
NHIS/NHIA	161	46
BHCPF	30	9
TSHIP	14	4
NONE	135	39
Others	8	2

NHIS/NHIA National Health Insurance Scheme/Authority, *BHCPF* Basic Health Care Provision Fund; T*SHIP* Tertiary Student Health Insurance Program

respondents, which is a mix of free and compulsory health insurance. However, considering the high rejection of an exclusive compulsory prepayment plan and the low knowledge of the new health insurance policy among other health financing policies and initiatives, there is a need for increased awareness creation on the benefits and implications of these policies.

Table 3 Relationship between age group versus participation status and medium of information

		Participation status n (%)		Medium of information n (%)						Total per Age group (N*)
		Active	Inactive	TV	Radio	Online News	Social media	Sensitization	Peer interaction	
Age group (years)	18–35	53 (18%)	235 (82%)	19 (7%)	9 (3%)	20 (7%)	172 (60%)	55 (19%)	13 (4%)	288
	36–49	5 (14%)	30 (86%)	12 (34%)	3 (9%)	2 (6%)	8 (22%)	9 (26%)	1 (3%)	35
	=/ > 50	11 (44%)	14 (56%)	17 (68%)	1 (4%)	0 (0%)	1 (4%)	3 (12%)	3 (12%)	25
	$\chi^2 = 10.233; p = 0.006; 95\%$ CI			$\chi^2 = 103.491; p = 0.002E\text{-}13; 95\%$ CI						

Table 4 Descriptive analysis table of the CSO survey (N = 52)

	Sample size (n)	Frequency (%)
Gender		
Male	26	50
Female	26	50
Years of advocacy		
1 year	2	4
2–4	18	35
5 and above	32	61
Government priority ranking		
Top 3	6	12
Top 5	10	19
Top 7	11	21
Health is not a priority	25	48
Medium of information used		
Peer interaction	7	14
Television	1	2
Radio	8	15
Social media	12	23
Sensitization programs	20	38
Online news	2	4
Others	2	4

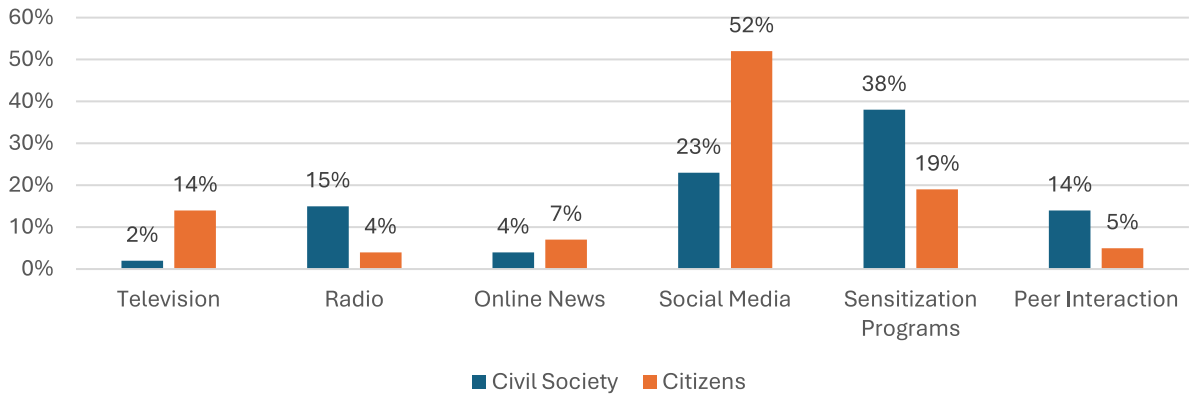

Fig. 1 Chart comparing the medium of information used by citizens vs. civil society advocates

The lack of adequate information is perhaps equally responsible for the very low level of active participation among the participants. Only one in five respondents among citizens has participated in any form of activity to engage policy makers for increased fiscal prioritization of primary healthcare in the last year. This accentuates the findings by Alawode et al. that beneficiary politics (citizens) have been the least influential in the implementation of a health financing initiative in Nigeria [6]. This pattern observed with the implementation of the BHCPF is arguably playing out with the implementation of the NHIA Act 2022 which after one year of existence is still lacking an operational guideline.

The recommendations put forth by the United Nations Research Institute for Social Development, in conjunction with Fowler Alan's working document on the roles of civil society in social development, underscore the critical importance of civil society actors in mobilizing citizens' interests through tailored engagement strategies. These efforts are seen as essential for achieving robust citizen participation and influence in the realm of public decision-making [44]. However, despite the marked consensus between civil society actors and the general citizenry on the issue of healthcare underprioritization by political leadership, it is evident that citizen mobilization remains insufficient in the context of health financing in Nigeria. This is in tandem with results from a qualitative study in Uganda where citizen participation was recorded as low, possibly due to inadequate representation and knowledge among others [45]. Conversely, a small sample

survey in Taita Taveta county, Kenya suggested greater level of citizen participation in the country's implementation of its integrated development plan for health, education and development sectors. According to the study, the county benefits from effective information and mobilization [46].

The gap in citizen participation in health policymaking in Nigeria is particularly pronounced among young people, who constitute most of the Nigeria's population and have played a pivotal role in some of globally renowned movements, including the #EndSARS movement against police brutality in 2020 [47] and the #NotTooYoungToRun movement advocating for increased youth political participation in governance in 2018 [48]. The study's findings reveal that this young population, despite their significant influence and presence, is not adequately mobilized through their preferred medium, social media. This raises a critical challenge that must be addressed. It calls for a concerted effort by health reformers and civil society actors to adapt their strategies and messages to effectively engage and mobilize diverse demographic groups, with a particular emphasis on harnessing the potential of youth engagement through social media channels.

Looking at the available data from a political economy standpoint, there appears to be presence of latent interest among citizens of Nigeria which has not translated into the required influence in shaping the nation's health priorities due to participation gaps.

6 Limitations

Although the study maintains a unique utility by theoretically equalizing the demand and supply ends of the existing political economy framework while providing insight on the experiences, perception, participation and coordination or mobilization within the beneficiary politics of primary healthcare financing in Nigeria, the authors acknowledge the underrepresentation of various demographics such as the uneducated, digitally excluded, and rural dwellers. This creates a room for future research to consider a much more context-specific data collection inclusive of subnational dynamics in how much influence the demand side is influencing health financing policymaking in Nigeria. Although the sample size used in this study is well supported by the University of Connecticut's tabular adaptation of the Cochran formula, the authors consider the sampled population too small to represent the adult population of Nigeria exhaustively. Future work on this topic should consider significantly increasing the sample size.

7 Conclusion

The authors attempted to quantify the level of citizen participation in health financing policymaking in Nigeria, albeit within the broad political economy context. The findings reveal that there is a grossly low level of citizen participation in health financing policymaking, likely due to inadequately tailored engagement by health reformers which limits the level of information among citizens. Therefore, health reformers in Nigeria are equipped with the impetus to employ tailored citizen participation that is based on evidence such as sociodemographic preferences. Also, this study can inform the political leadership in Nigeria how highly Nigerian citizens prioritize health and how that affect the perception of their performance in elected offices.

Acknowledgements The research team acknowledges the volunteer and advisory roles played by friends of the researchers in the data collection and analysis. Many thanks to Grace Nwaononiwu, Faith Adukwu, Joshua Owoyemi, Chibuike Odo, Marvellous Olatunji, Rachel Idim and Olaoluwa Olatunde.

Author contributions E.O.A. and O.O.A conceptualized and wrote the manuscript. E.O.A. supervised and provided funding while O.O.A. conducted the data analysis. All authors reviewed the manuscript.

Funding The study was self-funded by the research team.

Data availability Study data is available on request.

Declarations

Ethics approval and consent to participate The study obtained ethical approval from the Health Research Committee of the Federal Capital Territory Human and Health Services Secretariat, with approval number FHREC/2023/01/96/30-05-23. Informed consent was obtained from all individual participants included in the study.

Consent for publication Consent was obtained from all participants to publish the data from the study with the promise that all data are anonymized irreversibly before the commencement of analysis.

Competing interests The authors declare no competing interests.

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