GOVERNANCE CHALLENGES IN PRIMARY HEALTH CARE DELIVERY IN DELTA STATE, NIGERIA: AN ASSESSMENT OF COMMUNITY PARTICIPATION
Gideon E. D. Omuta & Andrew G. Onokerhoraye

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PREFACE

This monograph is part of the on-going research of the *Centre for Population and Environmental Development (CPED)* on the research project titled *"Strengthening the Health System in Nigeria through Improved Equitable Access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region"* funded by *IDRC and WAHO*. The monograph examines the role of community participation in the PHC system in Delta State. The monograph is divided into five sections. First; the conceptual framework is presented. Then the methods and materials are summarized in section two. Section three summarises various dimensions of community participation in the PHC system in Delta State. The policy implications are examined in section four and finally, the concluding remarks are made.

We are particularly grateful to IDRC and WAHO as well as the *Think Tank Initiative (TTI)* for the support to CPED which has enabled the Centre to carry out the study and the publication of this policy monograph.

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INTRODUCTION

The veracity of any government's claim of commitment to national development and poverty reduction can be tested in its provision of quality health care for its population, particularly the poor and vulnerable groups, including those who live in the rural and inaccessible communities. Only a healthy population can contribute to the wealth and development of the nation. Up till the late 1970s, the health care delivery system in Nigeria, like other sub-Saharan African countries, was characterised by poor quality on the one hand, and remarkable and unacceptable differences in the provision and distribution facilities, on the other. In addition, all services were delivered through a vertical, hospital-based structure.

However, China had moved in a rather opposite direction, by adopting a bottom-up structure that was community-based. Furthermore, as against the prevalent curative approach, the Chinese model emphasised the prevention of common diseases, using appropriate technologies. There was, therefore, the need to streamline the various models for global application. Consequently, between 6th and 12th September 1978, at an International Conference on Primary Health Care, in Alma Ata, Kazakhstan, USSR, 134 countries advocated and endorsed the 'health for all' programme through the *Alma Ata Declaration*. The programme was to be driven by the *Primary Health Care (PHC)* system.

However, an evaluation of the programme, after thirty years, revealed that a proper definition of PHC, equity in delivery and empowerment, remained daunting challenges. As the Millennium Development Goals (MDGs) wind up there appears to be a renewed commitment to improving the health of women and children. The Primary Health Care (PHC) system has been the platform through which Nigeria has committed herself to the continuing provision of equitable access to health care.

The PHC concept stands on five principles, designed to work together and be implemented simultaneously to bring about better outcomes for the entire population. These are:

1. *Accessibility* (equal distribution): this is the first and most important key to PHC. Health care services must be equally shared by all the people of the

community irrespective of their race, creed or economic status. This concept helps to shift the accessibility of healthcare from the cities to the rural areas where the most needy and vulnerable groups of the population live;

2. *Health promotion*: involves all the important issues of health education, nutrition, sanitation, maternal and child health, and prevention and control of endemic diseases. Through health promotion individuals and families build an understanding of the determinants of health and develop skills to improve and maintain their health and wellbeing;
3. *Appropriate technology*: technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and for whom it is used; and
4. *Inter-sectoral collaboration*: to be able to improve the health of local people the PHC programme needs not only the health sector, but also the involvement of other sectors, like agriculture, education and housing; and
5. *Community participation*: this includes meaningful involvement of the community in planning, implementing and maintaining their health services. Through the involvement of the community, maximum utilisation of local resources, such as manpower, money and materials, can be utilised to fulfill the goals of PHC.

The emphasis of this paper is on community participation, which is one of the domains of governance in primary health care delivery. However, because of their cross-cutting nature, some components of other principles are embedded in the principle of community participation. These include emphasis on rural communities (*accessibility*); and health education and sanitation (*health promotion*). Our objective is to determine the role of community participation in the PHC system in Delta State. To achieve this objective the rest of the paper is divided into five sections. First; the conceptual framework is presented. Then the methods and materials are summarised. Section three summarises various dimensions of community participation in the PHC system in Delta State. The policy implications are examined in section four and finally, the concluding remarks are made.

CONCEPTUAL CLARIFICATIONS

Two concepts are interrogated, namely: governance and community participation. Governance is the dynamic political process through which decisions are made, conflicts are resolved, diverse interests are negotiated and collective action is undertaken. It is "the effective participatory, transparent, equitable and accountable management of public affairs guided by agreed procedures and principles to achieve the goals of sustainable poverty reduction and social justice" (CARE, ND: 1). The World Bank (2000) perceives governance as entailing the building of the capacity of government so as to facilitate effective policy making and implementation, strengthening regulatory mechanisms and ensuring transparency and accountability in conducting the business of government and service delivery. It is the exercise of economic, political and administrative authority to manage affairs at any level of jurisdiction (UNDP, 1997). Furthermore, governance is the ability of government to develop an effective, efficient and accountable public management process which is open to the participation of all stakeholders and which also strengthens rather than weakening the democratic structure (USAID, ND). Governance emphasises not only the efficiency and effectiveness of the public administration system, but also the imperative of ensuring that popular participation (inclusive representativeness) is strengthened so as to ensure the accountability of service delivery (Eno, ND: 344).

With particular regards to the health sector, governance provides the framework within which to establish systems of mutual accountability that are participatory, equitable and accountable, and that support interactions between and among communities, health facilities and the government. It improves health care delivery by providing the platform for bringing together communities, health care providers (both public and private), the government and other stakeholders in participatory systems that enable them to collaborate, negotiate, act, build consensus and take action to improve service delivery.

Among others, CARE's experience shows that strengthened governance could produce the following results: more functional and responsive health systems; improved quality and service delivery; improved staff attitude; reduced discrimination; improved coverage and access, particularly in reaching

vulnerable groups like isolated, remote, rural and wet land communities; removal of barriers to health care seekers; improved oversight and management of health facilities, in terms of budgeting and provision of supplies; mutual trust and accountability; feeling of a sense of ownership of, and responsibility for, their own health and health systems; as well as holding governments and heath systems accountable for their responsibilities and commitments (CARE, ND: 2)

There, therefore, appears to be a seamless relationship between primary health care governance and community participation. This is because without local communities there would be no primary health care, and without health care services, local communities would experience huge health challenges. The primary health care system is, in fact, tailor-made for the community level (Florin and Dixon, 2004). It is now almost universally acknowledged by health care planners that community participation is central to the successful implementation of the primary health care system. (Abdulraheem, Olapipo and Amodu, 2012). As embedded in the concept of governance, it requires the participation of all stakeholders, including community members, nurses, health care providers and health workers, so that they could interrelate and interconnect to deal with the problems of the system.

Community participation is, therefore, of core significance in the success of PHC system. For this purpose, the 1978 *Declaration of Alma Ata*, in Article 44, defines community participation as: "The process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their own and the community's development" (WHO, 1978: 50). Article 46 of the *Declaration* further elaborated that: "There are many ways in which the community can participate in every stage of primary health care. It must first be involved in the assessment of the situation, the definition of problems and the setting of priorities. Then, it helps to plan primary health care activities and subsequently it cooperates fully when these activities are carried out" (WHO, 1978: 51).

Community mobilization and participation facilitate the common ownership of the project by the researcher, decision-makers and end-users. Adah, Ogbonna, Anga, Chingle, Ashikeni, Envuladu, Agaba, Audu, Bupwatda and Zoakah's

study of the comprehensive health care centre in Gindirin, (http://www.ajol.info/index.php/jjm/article/download/55093/43567) confirm that they involve encouraging the community, through their credibly accredited representatives, to take part in their health care planning, development and implementation. These enhance the integrity and enrich the quality of the work by: injecting grassroots information; integrating the indigenous knowledge system (IKS), or appropriate technology, that is in harmony with local beliefs, cultures and traditions; as well as monitoring the quality of service provided. Indeed, it is for the purpose of community participation that the National Health Policy in Nigeria (FMoH, 1987) emphases community engagement in the provision of PHCs, pursuant to the spirit of the *Bamako Initiative of 1987*. Community participation was institutionalized in Nigeria in 2003 through the creation of District Development Committee (DDC) and the Village Development Committee (VDC) (Abdulraheem, Oladipo and Amodu, 2012: 8). In spite of their strategic importance to the actualization of the goal of equitable access to, and utilization of PHC services, community mobilization and participation have not been strong components of the PHC system.

The quality and effectiveness of community participation can enhance, and be enhanced through knowledge transfer and knowledge brokerage (Onokerhoraye and Omuta, 2014). *Knowledge transfer* is the collaborative problem-solving between researchers (information producers) and decision makers or governance (information consumers), that is facilitated though linkage and exchange. Community participation can be facilitated by knowledge transfer because it involves interaction between decision makers and representatives of local communities. It results in mutual learning through the process of planning, producing, disseminating and applying research findings to governance (Onokerhoraye and Omuta, 2014: 4). Knowledge transfer enhances the quality and integrity of community participation because it provides a two-way continuous process through which experience is exchanged between the research community – information producers - (including inputs from local communities) and the community of potential users (governance).

Knowledge brokerage, on the other hand, links producers of information (researcher and the local community) and consumers of information (decision makers), thereby facilitating their interaction and engendering better understanding between them, so that they are better to appreciate each other's goals. It enhances the quality of service delivery by enabling governance and community to influence each other's input into the system. Thereby, knowledge brokerage forges new areas of mutual agreements, partnerships and relationships. It focuses on identifying and bringing together, parties (governance and local communities) that are interested in the issue of primary health care delivery; people or parties that can help each other develop evidence-based solutions. Knowledge brokerage goes beyond transferring the results of research (information) to organizing an interactive process between governance and communities.

The Delta State PHC research project provided for the integration of community participation. This is done by involving all stakeholders, particularly rural health care seekers and end-users of PHC services, in the implementation of the project. This involvement is achieved through: membership of the project management committee, on the one hand, and attendance and participation at all briefing and information-sharing meetings at which felt needs are articulated and prioritized, on the other. This enabled local communities to assume responsibility for their health and welfare, as well as build their capacities to contribute to policy on health through involvement in planning, implementing, monitoring, evaluating and above all, ensuring the sustainability of health interventions.

METHODOLOGY

The study is an aspect of the larger research project titled: "*Strengthening the health care system in Nigeria through improved equitable access to Primary Health Care (PHC): The case of Delta State, Niger Delta region*". Delta is one of the nine (9) states that make up the Niger Delta region. Information gathering adopted the multi-stage sampling procedure. Accordingly, nine local government areas were selected; three (3) each from the three senatorial districts, as follows: Ndokwa East, Aniocha North and Ika South from Delta North senatorial district; Ughelli South, Udu and Okpe from Delta Central; and Isoko North, Bomadi and Warri North from Delta South. Since the emphasis of the larger study was to look at

the challenges of accessibility in health care delivery, the selection of local government areas was purposive and designed to capture rural, isolated and wetland communities that are characteristically inaccessible and usually underserved. The choice of communities can be further justified by the fact that more than 90 per cent of the region is rural, with 94 per cent of the 13,329 settlements having less than 5,000 population (CPED, 2003: 236).

The overriding objective of the study is to contribute to a body of evidence on the strengthening of the health system in Nigeria that can influence the development and modification and implementation of policy on equitable access to primary health care. Pursuant to this objective, the study seeks to address two major issues, namely: knowledge development and knowledge transfer, or knowledge exchange; already espoused in the conceptual clarifications. The specific objective of knowledge development is research aimed at generating policy-relevant evidence about access to primary health care in Delta State. The objective of knowledge transfer, on the other hand, is to provide an interactive platform between and among researchers, practitioners and policy makers in Delta State, for the purpose of facilitating a structured and systematic use of research evidence to influence the formulation of policy and programme implementation. It is a two-way continuous process in which research information is exchanged between the research community and the community of potential users. It is a collaborative problem-solving process. This approach creates a meeting point between policy makers and researchers as against the traditional research in which researchers and policy makers operate in different 'silos'.

Among other questions, the study sought to know the nature of the participation of key stakeholders, particularly decision makers, service providers, practitioners and health seekers/users in the primary health care delivery in Delta State. Furthermore, the study sought to find out if there is planned and systematic involvement of health care service providers and the local communities in the design, implementation and monitoring of health care programmes so as to enhance access to primary health care in Delta State. This (participatory) action research approach entails the inclusion of all stakeholders: researchers, users and policy makers right from the onset of the process of implementing the project.

The objective is to make the research results the joint product of all stakeholders. The expectation is that the 'co-ownership' of the research findings by researchers, policy makers, practitioners and users will facilitate their translation into policy.

The platform adopted in the study for integrating research and policy was to set up two (2) strategic committees, namely: the State Steering Committee (SSC) and the Project Management Committee (PMC). The State Steering Committee (SSC) was constituted of key policymakers that are statutorily linked with the implementation of projects designed to pursue and address issues of primary health care delivery. Therefore, pursuant to this objective, the SSC was constituted to include the supervising Permanent Secretary of the Ministry of Health (MoH), other Permanent Secretaries and all the Directors (of Departments) in the ministry. On the other hand, the Project Management Committee (PMC) was composed of representatives of policymakers; representatives of care providers; representatives of health care seekers/users; advocacy experts; activists; accredited representatives of such vulnerable groups as the poor, the women. The SSCs and SPMCs provided the framework for knowledge transfer from, and knowledge brokerage by, the core research team.

The following five (5) major structured questionnaires were designed and administered, namely: primary health care facilities survey; household questionnaire; questionnaire for PHC staff; health facility client exit survey; and primary health care users' questionnaire. Since the accent of the study is on community participation, the last instrument informed the body of the work reported in this paper. The emphasis of the users' survey is the degree and quality of public participation in the governance of primary health care. Among the issues that were interrogated were: who takes decisions about programming priorities; the involvement of local communities in PHCs; the type and level of community participation; communities' participation in health management committees; the frequency of meetings of health management committees; factors that make committees inactive; reasons why people are not interested in participating in committees; problems encountered in the implementation of PHCs; and perceived solutions to the problems observed. Research assistants were recruited from eligible members of the communities in which the facilities are located. They were trained on the administration of the survey instruments.

A pilot test was conducted after which the questionnaires were further fine-tuned for final production. Supervisors were also recruited and trained separately to monitor the research assistants and resolve all challenges that the latter might encounter. The field data were cleaned up and exported to SPSS for analysis and are presented in percentages.

In addition to the quantitative data, there was also a qualitative component. This component was implemented through focus group discussions (FGDs) and key informant interviews (KIIs). The population of the qualitative survey comprised PHC staff, and randomly selected key stakeholders in the localities, such as community leaders, users of primary health services, women and youths. The FGDs and KIIs were conducted in all the nine (9) local government areas. The objective of the qualitative survey was to determine the veracity of, and strengthen the quantitative data, particularly from the perspective of primary health care users. This paper is concerned with the quantitative data.

Because the study is entirely participatory, the involvement of local communities and key stakeholders did not end with the giving of information to researchers. Rather, after the collected field data were cleaned up, processed and analysed, the findings were presented to the representatives of the local communities for their review and feedback. Specifically, their perception of the major findings was canvassed. In addition, their opinion was sought as to what they considered to be the solutions to the perceived problems. In order to make them represent the opinion of all stakeholders, these assessments, reviews and feedbacks were further discussed with the Project Management Committee (made up of representatives of policymakers; representatives of health care seekers/users; advocacy experts; activists; accredited representatives of such vulnerable groups as the poor, the women) as well as the State Steering Committee (made up of key policymakers in the implementation of all projects designed to pursue and address issues of primary health care delivery), also for their perspectives on the findings and their suggestions for going forward. The final results were, therefore, the progressive integration of the inputs of all stakeholders. This is to ensure that the results were produced and owned by all stakeholders including decision makers. This inclusive approach is to ensure a platform for the smooth translation of the research findings into policy.

CHARACTERIZATION OF COMMUNITY PARTICIPATION IN HEALTH CARE GOVERNANCE IN DELTA STATE

The successful implementation of policies that promote equity and inclusion in primary care delivery entails a focus on human interactions at the local, micro level. It also entails the development of supportive institutional systems for funding, information, regulation and monitoring. The emphasis on community participation in health care delivery is a recognition of the need for a rights-based health system that addresses the systemic challenges encountered by vulnerable groups, particularly women, children, the poor and rural dwellers. It requires the ability to work with local communities and health care seekers/users in taking actions that are responsive. Below, some perspectives on health care governance and management of PHCs in Delta State are presented. The emphasis is on the inclusion and participation of the local people in the various aspects of the management of PHCs in the localities in which they are located. The responses of the relevant individuals or groups (users, staff and community members) are discussed below.

Who Makes Decisions About the Programming Priorities in the PHC Facility?

Different cadres of personnel may make decisions on programming the priorities of PHC facility. All things being equal, however, the higher the status of the decision maker, the better the priority programming, and *vice versa*. The officers normally charged with this responsibility include: matrons/nursing officers, local inspection officers, chief supervisors/supervisors and heads of the community unit, in descending order of authority. The distribution of the involvement of these cadres of personnel in the programming of the priorities of the PHC facilities in the target LGAs is summarised in Table 1.

From Table 1, the study shows that 83 per cent of the people who made key decisions about the programming priorities of PHCs were Local Inspection Officers (LIOs) (44 per cent) and Matrons/Nursing Officers (39 per cent), who, in most cases were in charge of the facilities. The implication is that other stakeholders are involved in less than 20 per cent of the governance of PHCs with respect to the setting of priorities. The details, however, show that there were rather remarkable variations between and among the target LGAs.

Table 1: Percentage Distribution of Who Makes Decision about Programme Priorities in the Health Facility

LGA	Matron/ Nursing Officer	Local Inspection/ Officer (LIO)	Chief Supervisor/ Supervisor	Head of Community Unit	Total
Aniocha North	39	49	5	7	100
Bomadi	20	20	0	60	100
Ika South	77	11	6	6	100
Isoko North	41	29	6	24	100
Ndokwa East	57	35	4	4	100
Okpe	67	33	0	0	100
Udu	11	84	0	5	100
Ughelli South	29	46	7	18	100
Warri North	7	86	0	7	100
Average	**39**	**44**	**3**	**14**	**100**

Source: Fieldwork, 2014.

For instance, while on the average, local inspection officers set programme priorities in 44 per cent of the facilities in the surveyed LGAs, the figures were almost double in Warri North (86 per cent) and Udu (84 per cent). On the other hand, in Ika South LIOs set programme priorities in only 11 per cent of the facilities. Similarly, while overall, 39 per cent of programme priorities were set by matrons/nursing officers, the details ranged from as high as 77 per cent in Ika South to as low as seven (7) per cent in Warri North. Also remarkable was the observation that in 60 per cent of the facilities in Bomadi the head of community unit set programme priorities, compared to Okpe, where they were not (0.0 per cent) involved at all. Particularly noteworthy is the observation that provision is not made for local communities to be involved in the decisions concerning programming priorities in PHC facilities, as provided for in Article 46 of the *Alma Ata Declaration* (WHO, 1978: 51)

Participation of Communities (Local Content) in PHC Activities

Flowing from the conceptual contexts adopted for the study, is the fact that the greater the involvement of local communities in PHC activities, the more responsive will be the governance structure. Such participation enriches the management of the facilities, by bringing in the ideas, needs and perceptions of the communities. All things being equal, therefore, the higher the level of non-participation the less the local communities are carried along and the less the local content. Table 2 summarises the responses of PHC staff as to whether or not local communities participate in the PHC activities under their charge.Overall, the study shows a high level of public participation (67 per cent) was reported by the responding staff. Also noteworthy, was the observation that on the average, about one-third (33 per cent) of the respondents reported that their local communities did not participate in PHC activities.

Table 2: Percentage Distribution of PHC Staff Response to Whether Local Communities Participate in PHC Activities

LGA	**Yes**	**No**	**Total**
Aniocha North	71	29	100
Bomadi	44	56	100
Ika South	81	19	100
Isoko North	78	19	100
Ndokwa East	77	23	100
Okpe	75	25	100
Udu	39	61	100
Ughelli South	71	29	100
Warri North	71	29	100
Average	**67**	**33**	**100**

Source: Fieldwork, 2014.

The details, however, varied from 61 per cent of the respondents (local content) in Udu to 56 per cent of those in Bomadi, to only 19 per cent of those in the facilities in both Ika South and Isoko North reported the non-participation of communities in PHC activities.

Types of PHC Activities that Local Communities Participate in

The type of PHC activities that local communities could participate in include: planning and design; environmental sanitation; building of public toilets; monitoring of project implementation and building of permanent site, among others. Active participation of the local communities in the provision and/or maintenance of these facilities/infrastructure/activities has obvious implications for their quantity and quality. For instance, when local communities participate, they view these activities, as co-owners and would be more willing to increase their numbers, protect and maintain them. More specifically, for instance, less participation in sanitation has implications for the level on cleanliness of facilities and their appeal to potential users. Similarly, the lass participation in monitoring PHC activities and programmes, the less they will reflect local challenges. The responses to the types of PHC activities that communities participate in are presented in Table 3.

The study showed that three (3) activities engaged about 90 per cent of community participation in PHC facilities as follows: planning and design (31 per cent of all respondents); environmental sanitation (32 per cent) and building of public toilets (25 per cent). The Table further shows that virtually all the communities did not participate in the building of permanent sites. This is considered curious because many of the communities complained of the inadequacy of space for their facilities. As in all other variables, there were remarkable differences between and among the facilities surveyed in the target LGAs.

For instance, with respect to planning and design, compared to the overall average of 32 per cent, communities participated in 50 per cent or more of the facilities in three (3) LGAs as follows: Okpe (50 per cent), Ika Southe (51 per cent) and Ughelli South (57 per cent). However, in Ndokwa East communities participated in the planning and design of only five (5) per cent of PHC activities. With regard to environmental sanitation activities, compared to the overall average of 32 per cent of community participation, the levels in Udu and Ndokwa East were 66 percent and 61 per cent, respectively. Secondly, is the observation that local communities did not participate at all (0.0 per cent) in the environmental sanitation of the facilities in Bomadi

Table 3: Percentage Distribution of the Kinds of PHC Activities that Local Communities Participate In

LGA	Planning/ Design	Environ. Sanitation	Building Public Toilets	Monitoring Project Implement	Building Permanent Site	Total
Aniocha North	29	22	37	12	0	100
Bomadi	17	0	17	66	0	100
Ika South	51	21	28	0	0	100
Isoko North	47	22	20	8	3	100
Ndokwa East	5	61	13	13	8	100
Okpe	50	42	8	0	0	100
Udu	11	66	23	0	0	100
Ughelli South	57	27	16	0	0	100
Warri North	22	21	57	0	0	100
Average	**32**	**32**	**25**	**11**	**1**	**100**

Source: Fieldwork, 2014

While on the whole, an average of 25 per cent of the communities participated in the building of public toilets in the surveyed facilities, the details varied from as high as 57 per cent in Warri North, to as low as only eight (8) per cent in Okpe. The other remarkable observation with respect to the participation of communities in PHC activities was that while in five (5) of the nine (9) LGAs, communities were not involved in the monitoring of project implementation, communities participated in activities in 66 per cent of the facilities in Bomadi.

The Types of Committees Involved in Health Related Activities

The PHC system is dynamic. Consequently, the effectiveness of its activities depends, among other things, on the diversity of the sub-structures that provide the support base for the management and operations of its health and related activities. A number of committees have, therefore, been designed to provide this support, through regular meetings for the purpose of enriching local content, by supplying information and sharing of ideas from the health-seeking public and other stakeholders. Usually, the more diversified the committees, or the broader and more varied the involvement and input of the public/stakeholders, the greater the priorities and interests of the health care seekers will be captured and reflected. Consequently, the responsive the PHC facility services will be to the health needs of the public. Three (3) committees are particularly relevant. These are: community/village health management committees, ward health committees and youth/women committees, as outlined in the *Bamako Initiative, 1987.* Their distribution is presented in Table 4.

The study shows that community/village health management committees were the most common, accounting for more than half (54 per cent) of all the committees. This was followed by ward health committees, which accounted for 24 per cent. PHC facilities that had no committees and those that had youth/women committees, each accounted for 11 per cent. Between and among the committees, there were quite remarkable differences. For instance, regarding community/village health management committees, while the average was 54 per cent of all the committees, in Ndokwa East they accounted for 95 per cent of the committees. Other LGAs where this type of committees accounted for the vast majority are: Okpe (88 per cent), Isoko North (86 per cent) and Warri North (72 per cent). At the other extreme, the survey showed that none of the PHC facilities in Bomadi had community/village health management committees. With respect to ward health committees, while on the average, they accounted for 24 per cent of all the committees, the details also showed variations. For instance, while this type of committee accounted for an overwhelming 93 per cent of all the committees in Udu, Bomadi had none (0.0 per cent) Other LGAs with very few ward health committees were Okpe (4 per cent) and Ndokwa East (5 per cent). Two other remarkable observations on Table 4 are that: in Ughelli South, the most common type of committees were the youth/women

committees, which accounted for 43 per cent of all. Finally, Table 4 showed that Bomadi had no type of committees at the time of the survey.

Table 4: Percentage Distribution of the Committees Engaged in Health-Related Activities.

LGA	None	Community/ Village Health Management Committees	Ward Health Committees	Youth/ Women Committees	Total
Aniocha North	0	41	37	22	100
Bomadi	100	0	0	0	100
Ika South	0	53	28	19	100
Isoko North	0	86	11	3	100
Ndokwa East	0	95	5	0	100
Okpe	0	88	4	8	100
Udu	0	7	93	0	100
Ughelli South	0	41	16	43	100
Warri North	0	72	21	7	100
Average	**11**	**54**	**24**	**11**	**100**

Source: Fieldwork, 2014.

Frequency of Meetings of PHC Management Committees in 2013

It is one thing to have health management committees and it quite another for the committees to be functional. This is because a dormant committee is not better than having no committee. The survey, therefore, sought to determine the functionality of the committees by asking the PHC staff in charge of the facilities to specify how frequently they met in the year preceding the survey (2o13). It was considered that quarterly meetings were ideal in order to keep abreast of all developments. The responses are presented in Table 5.

Perhaps the most remarkable observation from the study was that in almost one-third (30.33 per cent) of the PHC centres surveyed, no health management committee meetings were held in 2013. Particularly noteworthy was the

observation that almost one-half (48 per cent) of the centres in Ndokwa East, Okpe and Ughelli South held no health management committee meetings in the year preceding the study. The survey showed that only 22.56 per cent of PHC centres performed optimally, having held health management committee meeting four times in 2013. However, this average masked the great variations that existed between and among the LGAs. Thus, while 57 per cent of the centres in Udu held such meetings, in the centres surveyed in Ndokwa East, none (0.0 per cent) held such meetings. Other LGAs that performed above the average were: Aniocha North (33 per cent), Isoko North (32 per cent) and Warri North (25 per cent).

On the other hand, Okpe was the other LGA that performed very poorly (6 per cent). Table 5 also shows that 10 per cent of the surveyed centres held meetings thrice in 2013, with the details varying from 22 per cent of the centres in Ika South, where such meetings were held, to Warri North, where none (0.0 per cent) of the centres held such meetings.

Table 5: Percentage Distribution of Health Management Committee Meetings in 2013 in PHC Centres

LGA	Once	Twice	Thrice	Four Times	None	Total
Anioca North	46	0	8	33	13	100
Bomadi	0	56	11	11	22	100
Ika South	26	22	22	22	8	100
Isoko North	26	5	11	32	26	100
Ndokwa East	38	10	4	0	48	100
Okpe	12	17	17	6	48	100
Udu	0	10	10	57	23	100
Ughelli South	11	17	7	17	48	100
Warri North	0	38	0	25	37	100
Average	**17.67**	**19.44**	**10**	**22.56**	**30.33**	**100**

Source: Fieldwork, 2014.

Also the study showed that while across the target LGAs 19.44 per cent of the centres held biannual committee meetings, the details varied from as high as 56 per cent in Bomadi, to Aniocha North where no such meetings (0.0 per cent) were held. Finally, Table 5 shows that although 17.67 per cent of the PHC centres held committee meetings once in 2013, none (0.0 per cent) of the centres in Bomadi, Udu and Warri North held such meetings, while in Aniocha North 46 per cent of the centres held such meetings. Ndokwa East (38 per cent), and both Ika South and Isoko North each which recorded 26 per cent, also did better than the average.

Major Reasons Inhibiting Adequate Participation of Communities in Committee Meetings

Recognizing its significance in the management of PHC activities, the survey sought determine the factors militating against adequate public participation in health management committee meetings of PHCs; thereby making them inactive. This will point to the policy issues that should be addressed. The responses by the respondents are summarised in Table 6.

The most major reason for the poor community participation in health committee meetings was lack of awareness, which accounted for 55 per cent of all responses. PHC staff claimed that many community members did not know what roles they were expected to play in the health management committees. The severity of this factor varied from a vast majority of 81 per cent of the responses in Isoko North, to 32 per cent in Aniocha North. Other LGAs where lack of knowledge severely hampered the participation of local communities were Ughelli South (73 per cent) and Udu (66 per cent). Across the target LGAs, illiteracy/ignorance accounted for 23 per cent as the major reason for poor community participation in committee meetings.

Table 6: Percentage Distribution of the Major Factors that Inhibit the Committees From Being Active

LGA	Lack of adequate finance	Lack of awareness	Illiteracy/ ignorance	Total
Aniocha North	39	32	29	100
Bomadi	11	56	33	100
Ika South	28	53	19	100
Isoko North	5	81	19	100
Ndokwa East	23	45	32	100
Okpe	50	38	12	100
Udu	20	66	14	100
Ughelli South	7	73	20	100
Warri North	14	50	36	100
Average	**22**	**55**	**23**	**100**

Source: Fieldwork, 2014

However, the details showed that this factor was cited by 36 per cent, 33 per cent and 32 per cent of the facilities in Warri North, Bomadi and Ndokwa East, respectively. The LGAs where illiteracy/ignorance had low affect on community participation were Udu (14 per cent) and Okpe (12 per cent). The third major cause of poor participation committee meetings was lack of adequate finance. Generally, attendance at committee meetings implies sacrifice of time that could have been used for some income-yielding activities. When this sacrifice is uncompensated, attendance becomes unattractive after one or two meetings. On the whole, the problem of lack of financial incentives for attending committee meetings accounted for 22 per cent of all responses; while the details varied from as high as 50 per cent in Okpe, to as low as five (5) per cent and seven (7) per cent in Isoko North and Ughelli South, respectively. Finally, apart from Okpe, (where lack of finance accounted for 50 per cent of all responses) the lack of awareness is the single most major reason for poor community participation in all other LGAs.

Perceptions of the Causes of Poor Participation in PHC Activities

As against the views expressed by PHC staff, the study sought to know the people's (users) perceptions of the cause of poor community participation. Although the factors were almost the same as those indicated by PHC staff, there were very remarkable differences in the accent placed on them. The results are presented in Table 7.

From the point of view of the perception of community members, Table 7 shows that ignorance and lack of awareness of the role of local communities in health management committees is the most overwhelming factor inhibiting their involvement in PHC activities.

Table 7: Percentage Distribution of the Perception of Why People Were Not Involved in Their PHC Activities

LGA	**Lack of awareness and ignorance**	**Lack of finance**	**Lack of time due to farming activities**	**Total**
Aniocha North	49	19	32	100
Bomadi	100	0	0	100
Ika South	98	2	0	100
Isoko North	100	0	0	100
Ndokwa East	64	30	6	100
Okpe	63	37	0	100
Udu	77	23	0	100
Ughelli South	77	23	0	100
Warri North	79	21	0	100
Average	**79**	**17**	**4**	**100**

Source: Fieldwork, 2014

This factor alone accounted for 79 per cent of all responses. The study showed that while this was the sole factor (100 per cent) in Bomadi and Isoko North, it accounted for 49 per cent of the responses in Aniocha North. As noted elsewhere

in this study, lack of adequate finance (to organise PHC activities and provide some incentives for participation) was the second most important perceived problem for not being involved in their activities. The details showed that although none of the respondents (0.0 per cent) in Bomadi and Isoko North cited finance as an inhibiting factor, it accounted for 37 per cent and 30 per cent of the responses in Okpe and Ndokwa East, respectively. It was only in Aniocha North (32 per cent) and Ndokwa East (6 per cent) that 'lack of time due to farming activities' was mentioned.

Internal Structural Management Problems

A number of infrastructure and supplies must be provided by the system and should be functional before the good governance of prompt provision and delivery by PHC facilities can be ensured. They influence the quality of service that can be delivered to the health care seeking public. These include: adequate equipment and personnel/good management structure; adequate housing and sanitary environmental condition; and adequate supply of drugs, staff and laboratories, among others. For instance, if PHC staff are not adequately accommodated, particularly in rural communities, their attitude to work will be affected. Poor attitude produces poor output, which in turn negatively affects users' perception, and ultimately, utilization. Similarly, lack of laboratories would mean that basic tests cannot be run. Finally, the lack of basic drugs would affect the utilization of PHC facilities and services. In developing countries, these facilities are more deficient in the rural than in urban areas. PHC staff were, therefore, asked to enumerate which of these posed challenges in the management and governance of the facilities under their care. The responses are presented in Table 8.

The study showed that inadequate equipment and personnel/poor management structure accounted for 55 per cent of all the problems by the staff in all the target LGAs. However, their severity varied from as high as 96 per cent and 89 per cent in Udu and Ughelli South, respectively, to as low as 17 per cent and 25 per cent in Okpe and Bomadi, respectively. By implication, Okpe and Bomadi are better equipped and have better management structures, while Udu and Ughelli South are the worst.

The study also confirmed internal variations. For instance, while these accounted for 50 per cent of all the problems in Bomadi, they accounted for only two (2) per cent and four (4) per cent of the problems in Udu and Ughelli, respectively.

Accommodation for staff and general environmental conditions were identified by 23 per cent of all respondents. As in most of the parameters, the details showed very remarkable differences between and among the target LGAs. While housing and environmental conditions were not mentioned at all (0.0 per cent) in Isoko North, and while they were mentioned by only two (2) per cent, seven (7) per cent and eight (8) per cent of the staff in Udu, Ughelli South and Ika South, respectively, they accounted for 67 per cent of the responses in Okpe.

Table 8: Percentage Distribution of the Problems Within the Management Structure of the Health Care System that are Being Encountered in the Implementation of PHC Services

LGA	Inadequate equipment and personnel/ management structure	Poor housing and sanitary environmental condition	Lack of drugs, and laboratories	Total
Aniocha North	51	22	27	100
Bomadi	25	25	50	100
Ika South	77	8	15	100
Isoko North	62	0	38	100
Ndokwa East	41	36	23	100
Okpe	17	67	16	100
Udu	96	2	2	100
Ughelli South	89	7	4	100
Warri North	43	36	21	100
Average	55	32	22	100

***Source*:** Fieldwork, 2014.

Okpe, therefore, had the worst accommodation and environmental conditions among the surveyed LGAs. Finally, Table 8 showed that lack of drug and poor laboratory facilities accounted for 22 per cent of all the identified problems. The

affected communities were, therefore, exposed to the danger using fake drugs that are sold by itinerant medicine sellers.

Other Problems

Among the other factors identified by PHC staff as problems or obstacles commonly encountered in the implementation of PHC services are: lack of light and water; lack of awareness on the use of PHCs; inadequate staff and illiteracy. Some of these, such illiteracy, awareness and drugs have either been discussed or are implied in response to earlier questions. Their mention here should, therefore, be seen as a confirmation of earlier findings and further emphasis.

With regards to infrastructure, some staff cited instances where they had to carry out some procedures (including suturing) using candles or lanterns, because of the lack of electricity and a functioning standby generator. Some time where the standby generator is functional there may be no money to buy fuel. In other cases, treatment had to carried out using unsafe water from unprotected wells. These deficiencies have obvious implications for the quality of service that could be rendered. This in turn, negatively affect the assessment of the PHC services and their utilization. The distribution of these other problems is summarised in Table 9.

The Table shows that infrastructural deficiency (lack of water and electricity) is the most major obstacle inhibiting the proper implementation of PHC services in the target LGAs. They accounted for 53 per cent of all the 'other' problems identified by PHC staff. The study showed that while infrastructural challenges accounted for 83 per cent, 75 per cent and 70 per cent of all the problems encountered in Ika South, Isoko North and Ndokwa East, respectively, they were cited by only 30 per cent and 32 per cent of the respondents in Udu and Aniocha, respectively.

Table 9: Percentage Distribution of Other Problems or Obstacles Being Encountered in the Implementation of PHC Services

LGA	Lack of light, water and drugs/ power failure	Lack of awareness of the use of PHCs	Inadequate staff	Illiteracy	Total
Aniocha North	32	44	17	7	100
Bomadi	50	33	17	0	100
Ika South	83	9	8	0	100
Isoko North	75	0	25	0	100
Ndokwa East	70	18	12	0	100
Okpe	54	25	17	4	100
Udu	30	66	4	2	100
Ughelli South	41	48	9	2	100
Warri North	43	45	14	0	100
Average	**53**	**32**	**14**	**1**	**100**

Source: Fieldwork, 2014.

The study also showed that as against the average of 32 per cent of the respondents who mentioned 'lack of awareness' as a major problem, 66 per cent cited it in Udu, while this was not a problem at all (0.0 per cent) in Isoko North. Inadequate staff was mentioned by 14 per cent of all respondents, while the details varied from 25 per cent in Isoko North to 4 per cent in Udu.

POLICY IMPLICATIONS

In accordance with the inclusive and participatory methodology for the study, the local communities in which the PHC facilities were located, were also involved in determining the policy implications. Their input was guided by some policy-oriented questions from the point of view their perception of the policy thrust of the study. The analysis of their responses to these questions revealed a number of policy deficits that must be addressed if the quality of service is to improve. Two are particularly noteworthy. They are: funding and health education. They are presented in Tables 10 and 11. However, though presented separately, their discussion will use both Tables simultaneously.

Funding

Respondents were asked what they thought could be done to enhance community participation in PHC activities.

Tables 10 and 11 show that among the three (3) suggestions made for enhancing participation (Table 10) and for making the committees more functional and effective (Table 11), funding was number one. While it accounted for 47 per cent of the reasons why there was poor community participation in PHC activities (Table 10), it accounted for 85 per cent of why health management committees were not active (Table 11). If the provision of financial benefit four (4) per cent (Table 11) is considered as a subset of inadequate provision of funds (85 per cent), then this factor accounted for an overwhelming 89 per cent of the reasons why committee meetings are poorly attended.

In both cases there were remarkable differences. For instance, compared to the overall average of 47 per cent who indicated that funding was the reason for poor community participation in PHC activities, the details varied from as high as 93 per cent in Ughelli South to 22 per cent in Warri North. On the other hand, compared to the average of 85 per cent that indicated that funding (excluding financial incentives) was the reason why health management committees were not active, the details varied from 100 per cent in Bomadi, Ika South and Isoko North, to 34 per cent in Udu. In other words, In Bomadi, Ika South and Isoko North, funding was the sole cause of the dormancy of health management committees.

The policy implication that flows logically from these observations is the need to improve the funding of the primary health care system in Delta State. Although it has implications for all areas of operation of the system, with particular emphasis on community participation, improved funding will enhance community participation in at least the following ways: It will facilitate the convening of quarterly meetings of health committees, as required by the guidelines. It is expensive to organize such meetings, considering that space may have to be rented, where the facility(ies) do(es) not have enough. To hold such meetings four (4) times in a year, as ideally expected would be unaffordable to a majority of the facilities. Secondly, for meetings that last hours, refreshment may

have to be provided, because participants may have to forgo a meal. Thirdly and more importantly, 'a sitting allowance/transportation allowance' should be given to attendants, so as to compensate for the sacrifice of time and the cost of travelling to the meeting venue.

Table 10: Percentage Distribution of Perception of What Could Be Done to Enhance Community Participation

LGA	Create awareness and enlightenment	Financial reward	Mobilization of community members	Total
Aniocha North	32	49	19	100
Bomadi	45	33	22	100
Ika South	40	32	28	100
Isoko North	36	44	20	100
Ndokwa East	16	66	18	100
Okpe	33	38	29	100
Udu	32	50	18	100
Ughelli South	2	93	5	100
Warri North	57	22	21	100
Average	**33**	**47**	**20**	**100**

Source: Fieldwork, 2014

This is particularly so for those that are poor but will have to forego their livelihood for the day to attend such meetings. Also considering that most of the facilities are located in rural and remote, inaccessible/wetland communities, it is quite stressful to attend such meetings, because transportation infrastructure are either totally lacking or in very poor state. Such journeys are, therefore, made on foot or bicycles because public transport is either not available or where available, unaffordable. The proposed financial incentive will, therefore, encourage community members to attend and/or continue to attend health management committee meetings. Otherwise, after one or at most two meetings, they will cease to attend. This could be the reason why almost one-third of all the facilities surveyed did not hold any committee meeting in the year preceding the survey.

Awareness

Respondents were also requested to indicate what they thought could be done to make the health management committees more active.

In both Tables 10 and 11, the study shows that lack of awareness was the second most important cause of both poor community participation and the dormancy of committees. As with all the factors, there were also remarkable variations among the target LGAs. Thus, while the lack of awareness of the importance of health and the activities connected with its provision and delivery was the reason for poor community participation in 33 per cent of all the PHC facilities surveyed, the details varied from 57 per cent in Warri North to only two (2) per cent in Ughelli South.

Table11: Percentage Distribution of What Could Be Done to Make Health Management Committees More Active

LGA	**Provision of adequate finance**	**Create awareness of the importance of health**	**Provide incentives**	**Total**
Aniocha North	85	15	0	100
Bomadi	100	0	0	100
Ika South	100	0	0	100
Isoko North	100	0	0	100
Ndokwa East	98	2	0	100
Okpe	71	25	4	100
Udu	34	30	36	100
Ughelli South	86	14	0	100
Warri North	86	14	0	100
Average	**85**	**11**	**4**	**100**

Source: Fieldwork, 2014

The policy implication that logically flows from the lack of awareness is the need for health education, campaign, awareness and sensitization. The present dismal level of awareness is a strong indictment of the health educators in the surveyed facilities. The level of ignorance must be reduced. As a matter of urgency, therefore, the health education departments in the PHCs in Delta State, should be overhauled, with a view to ensuring that they are equipped to disseminate health information to host communities. A number of outlets already exist in our communities which could be used for this purpose. These include, but by means limited to: the ubiquitous town/village crier, age-grade and special-interest meetings (such as youth women's, traders' groups). Special general meetings could be convened for whole groups, or in the alternative, their leaders could be trained, who in turn train their members. Of course, formal information dissemination structures, such as schools, churches and mosques must be explored maximally. Accordingly, not only are students and pupils and church and mosque attendants to be equipped with knowledge on their importance, but more importantly, they should be encouraged to spread information on the varied services that PHC facilities offer and the need for local communities to participate in the design for the policies by attending health management committee meetings and participate in project monitoring and other activities.

CONCLUSION

The primary health care (PHC) system was conceived and designed to meet the health needs at the basic level. It is meant to be the health seeker's first entry point into the health care delivery system. This makes the local community its primary target and clientele, because it is customised for the community level. Indeed, the community is the *raison d'être* for the PHC system. The efficacy of the system should, therefore, be judged by the degree to which it responds to the health needs of the local people. One of the factors that determine the degree of its responsiveness is the quality of community participation in the management of the system and its facilities. It is through community participation that individuals and families assume responsibility for their own health. It also helps the community to develop its capacity to contribute to its overall development. This could be done through participation in various activities, such as environmental sanitation, building of public toilets and monitoring of project

implementation. More importantly, community participation enhances the quality of service delivery by attending committee meetings and contributing their inputs and suggestions at the village, ward and special interest group levels.

However, the study of Delta State showed that the participation of local communities in the governance of primary health care delivery has not been satisfactory. Consequently, their contribution to the provision of basic infrastructure, such as toilets, is minimal and their attendance at health management committee meetings is poor. Indeed almost one-third of the facilities surveyed did not hold such meetings in the year preceding the study. Two major reasons were adduced for poor community participation in primary health care governance in the Delta State, namely: inadequate funding and ignorance. Consequently, it has been proffered that the funding of the PHC system should be significantly improved and that there should be massive health education, campaign and sensitization of the communities, concerning the importance of health and the need for them to participate in primary health care activities in their localities.

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