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STAKEHOLDERS REACTIONS TO THE FINDINGS OF PRIMARY HEALTH CARE STUDY IN DELTA STATE

Policy Brief by

Centre for Population and Environmental Development, CPED

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Preface

This policy brief is the fifth in the series of communication to policy and decision makers on the on-going research project of the *Centre for Population and Environmental Development (CPED)* 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 policy brief series is designed to draw attention to key findings and their policy implications as the project is being executed. This edition presents a summary of the stakeholders' assessment reactions and assessment of primary health care based on the findings of the research as outlined in the interim report.

We are particularly grateful to IDRC and WAHO as well as the *Think Tank Initiative* for the support to CPED which has enabled the Centre to carry out the study and the publication of this policy paper. We also appreciate the corporation of the Delta State Government and other stakeholders within and outside Delta State in collaborating with CPED in the execution of the on-going research project so far.

Andrew G. Onokerhoraye
Editor

Stakeholders' Reactions to the Findings of Primary Health Care Study in Delta State

Introduction

This policy brief is based on the findings of an on-going research on *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region.* The project is funded by Canada's *International Development Research Centre (IDRC),* Ottawa and the *West African Health Organization (WAHO)*. The general objective of the research programme 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 policies on equitable access to health care with specific focus on the primary health care component. This policy brief presents the reactions of stakeholders to the findings of the study as presented to them in feedback meetings. As part of the participatory methodology of key stakeholders in this project the findings of the study were presented to key stakeholders comprising providers, users, women, youth, community leaders and other respondents and participants in the study for their comments and inputs. The synthesis of the stakeholders' reactions and contributions across the nine LGAs is presented below.

Stakeholder perspectives on the findings

Effectiveness of services: The common view of stakeholders is that PHC services were able to reduce or prevent some deaths and sickness of children by making immunization accessible to the children in their localities. Even traditional healers agreed that local immunization of children by the PHC system has been helpful in preventing deaths and diseases of children. There is agreement that female residents come to the primary healthcare centres principally for the health needs of their children. In this respect the stakeholders agreed that PHCs have made remarkable contributions to the health of the people in their localities.

Reliance of services on the skills of nurses/midwives: Stakeholders agreed with the findings that PHCs in the target LGAs are managed generally by nurses, midwives, and other allied healthcare professionals who are the only ones readily available. They observed that there are no permanent doctors in the PHCs which greatly affect the nature of health care services delivered.

Proximity of services: Stakeholders noted that while the accessibility of PHCs is adequate in some parts of many LGAs, in those localities where population is widely dispersed, access to PHCs is a major problem. They pointed out that PHCs should be viewed as an obligation of the government to the people, especially for those in the rural areas who may not be able to pay for hospital treatment.

Timing of services: Stakeholders noted that although PHCs are expected to operate a 3-shift schedule to cover a 24-hour period each day to save lives, prevent disease, and promote better health for local residents especially for those who may have limited resources for seeking care from private doctors or for travelling to the hospital, most of the PHCs do not open for 24 hours.

Facilities and essential amenities: Stakeholders agreed with the findings that most of the PHCs lacked electricity, water, and sanitation facilities. They noted that the environments of PHCs are dirty, uncomfortable, or uninviting to patients. Stakeholders described that the environment of many PHCs as unattractive, poor, and badly kept. In addition, they pointed out that some PHCs need new floors, windows, beds, nets, and even seats suitable for public use. They lamented that some of the PHCs have no mosquito netting and that newborns are exposed to bites if they are not properly covered. Some of the stakeholders explained how daunting it was to deliver babies in the middle of the night with only kerosene lamps as a source of light and how inconvenient it is for new mothers to wait until water is brought to them from their homes before they can shower after delivery. They also expressed concern that the PHCs have no oxygen or equipment to resuscitate patients and no incubators for premature babies.

PHCs equipment: Stakeholders agreed with the findings on PHC equipment and expressed concern about the general lack of basic primary healthcare equipment which is frustrating and discouraging to people who need care. They complained that the government's inability to provide PHCs with basic medical equipment and supplies discouraged many residents from continuing to seek care in most of the available PHCs. Stakeholders pointed out that PHC facilities needed to have a laboratory, x-ray equipment, labour rooms, beds, and netted windows. They pointed out that some of the PHCs lacked the equipment to examine pregnant women properly such a vacuum extractor, forceps, sterile gloves, obstetric forceps, an obstetric table, and drugs essential for deliveries. Stakeholders reported that lack of transportation such as ambulance services at the PHCs interferes with their ability to respond to emergency health situations. They concluded that patients feel greatly disappointed when the PHCs do not have the essential drugs or equipment needed for their care.

Ambulance or other transportation: As pointed out in the research findings, stakeholders emphasized that lack of means of transportation has posed a great handicap to the operation of the PHCs, especially for reaching patients in emergency or critical health conditions in a timely manner. They acknowledged that lack of transportation for the PHCs and the residents pose a great handicap in their ability to respond to residents' primary health care needs. Stakeholders pointed out that most of the LGAs do not have sustainable public transportation or taxi services and thus, responding to emergencies is difficult even in simple cases that nurses and midwives can handle. Even those people who have their own transportation are still hampered by security issues and bad roads, especially when emergencies occur during the night.

Resident doctors: Stakeholders agreed with the findings relating to the non-availability of doctors at least once a while in public sector PHCs. They pointed out that when patients visit the PHCs, they generally want to see a doctor and not a midwife and nurse because they believe that only a trained doctor will be able give them proper diagnoses. They noted that PHCs have mainly only nurses and midwives and many a time patients are not satisfied seeing only nurses or midwives.

Medical support staff: Stakeholders agreed with the findings that most of the PHCs lacked support staff capable of educating the public and creating awareness of the services they offer. Some of the stakeholders complained that the PHCs do not have staff to do home visits, create awareness of their programmes, or educate them on available services or disease prevention. They noted that virtually all the PHCs do not have laboratory staff who can conduct basic tests which make nurses and midwives to rely on guess work to diagnose and prescribe drugs.

Essential drugs: Stakeholders supported the findings of the study that PHCs always have shortages of essential drugs and health care supplies, which limits the ability of the nurses and midwives to give the highest level of service to the population. They complained that the PHCs required them to buy drugs from outside vendors, which exposed them to the potential of purchasing fake or adulterated drugs.

Excessive cost of care: Stakeholders pointed out that in view of the lack of basic facilities and adequate personnel coupled with the shortage or non-availability of drugs, the cost of receiving health care in the PHCs is indeed high and in fact comparable to the cost of visiting secondary health centres in the urban areas.

Poor and irregular pay: Some stakeholders, especially staff of the PHCs reported lack of professional development and compensation to deserving employees, resulting in low employee morale and decreased productivity. They noted that lack of regular training and good reward system affected their attitude toward their work as well as their ability to do their work.

Unstable leadership: Many of the stakeholders pointed out that instability and selfish interests of local government leadership, and their interference with the objectives and performance of PHCs have enormous impact on the performance of PHCs. They noted that frequent changes in leadership often mean that the LGA chairmen are unsure in their positions and thus lose focus and indulge in practices to enrich themselves and their political godfathers. They pointed out that the leadership of the LGAs do not involve health administrators or providers in budgeting issues or allocation of funds for the health department. It was observed that the primary healthcare departments of the LGAs hardly have any plan, as every new leader comes with a different plan or no agenda at all. They also remarked that some national-level and state-level political leaders influence decisions at the local government level, causing the leadership to undermine essential community services, including PHC services. Many stakeholders pointed out that corruption among those in authority result in mismanagement of healthcare funds.

Healthcare professionals not involved in policy and budgetary decisions: The stakeholders pointed out that the LGA Chairman is the principal decision maker on healthcare and in many cases overrides the decisions of healthcare professionals. They observed that the absence of collaboration and consultation between the health department and the local-government leadership, which impacts the resolution of important healthcare issues and adversely affects service delivery. It was pointed out that proper resource allocation, budgeting, and PHC management are not practiced.

Stakeholders proposed solutions to the challenges faced by PHCs

Provide an effective PHC system with adequate health personnel: Stakeholders are of the strong view that a variety of qualified medical staff be employed in the PHC system to provide comprehensive PHC services. Generally, stakeholders perceived effective PHC from the standpoint of efficiency and effectiveness in meeting their needs rather than on the availability of physical infrastructure or staff who lack skills to help them. They pointed out that most of their health needs are beyond the expertise and training of nurses and midwives at the PHCs. They pointed out that they needed a doctor-run PHC system that would reduce the incidence of pregnancy-related deaths, heart attacks, stroke, and other diseases such as typhoid fever and malaria. They held the strong view that the PHC system cannot function effectively without

doctors. In addition a range of other health personnel should be engaged and exposed to regular training to update their professional skills.

Fund PHCs to effectively equip and maintain the facilities: Stakeholders suggested that adequate funds be allocated to the PHC system. They recommended better training and improved professional development for primary health staff, and the need for well maintained and well equipped health facilities.

Provide mobile clinics and ambulances to improve access and respond to emergencies: Stakeholders shared similar opinions on the solutions to the challenges and barriers people face in accessing PHCs. They suggested that a mobile clinic to reach out to those who are home-bound and very old people who are in great pain with arthritis and other age-related diseases should be provided in each LGA. They emphasized that the PHC system be provided with well-equipped ambulance services to respond to emergencies and save lives.

Professional relationship between traditional healers and the PHC system: On the issue of recognition and collaboration with traditional healers particularly birth attendants, views varied among different stakeholders. While some advocated that traditional healers should be permitted to provide services that the primary health care system does not offer, such as bone-setting for fractures and dislocations or care for snake and dog bites, others considered the involvement of traditional religion in healing as idolatry, according to the predominant Christian belief in most of the target LGAs. However, the traditional healers at the stakeholder meetings pointed out that greed on the part of the orthodox trained professionals is the key issue in isolation and disregard of traditional healing practice. They pointed out that in spite of the services traditional healers render to complement the services of the PHC system, they are still struggling for integration and recognition by the local health system.

Healthcare-provider attitudes: Many stakeholders complained of a poor attitude of some PHC employees, citing examples such as tardiness to work, leaving early, rudeness, delays, and a lack of a sense of urgency. These attitudes should change if PHCs are to make the required impact on the health of the people in rural communities.

Participants want to be involved in community-based research: Most of the stakeholders accepted the idea of community-based research such as the present study which involved key stakeholders in the implementation. They are happy that opportunity was provided for their voices to be heard in the report of the research project. Others were concerned about whether local primary health leadership would actually value and use their input to improve healthcare delivery. There was a general consensus that community-based research on PHC should be encouraged and that key stakeholders will participate as they have done in this study. Healthcare administrators and midwives/nurses agreed that a community-based research approach to healthcare can help nurses and midwives share their opinions about their challenges and strengths, as well as the feedback they receive from the people, which in turn will provide the PHC system with an opportunity to improve healthcare delivery for the people.

Conclusion

The summary of stakeholders' reaction to the findings of the study shows that they are quite conversant with the nature and challenges of primary health care delivery and utilisation in their communities. They also have incisive perspectives on how to improve the situation. The lesson is

that policy makers must seek the involvement and participation of stakeholders, especially users in the planning and delivery of primary health care services in Nigeria.