CENTRE FOR POPULATION AND ENVIRONMENTAL DEVELOPMENT (CPED)

CPED-Research For Development News

Vol. 5. No. 1 June 2014

A Bi-Annual Publication of the Centre for Population and Environmental Development

CPED Develops a Framework for Research Knowledge Transfer to Policy Makers

About CPED ②

Also in this issue

4 Editorial Policy of Research for Development News (CRDN)

5 Editor's Note

This Publication is supported by the *Think Tank Initiative Programme* initiated and managed by the *International Development Research Centre (IDRC)*

About CPED

The Centre for Population and Environmental Development (CPED) is an independent, non-partisan, non-profit and non-governmental organization dedicated to promoting sustainable development and reducing poverty and inequality through policy oriented research and active engagement on development issues. CPED started as an action research group based in the University of Benin, Benin City, Nigeria in 1985. The action research group was concerned with applied research on sustainable development and poverty reduction challenges facing Nigeria. The research group also believed that communication, outreach and intervention programs, which can demonstrate the relevance and effectiveness of research findings and recommendations for policy and poverty reduction, especially at the grassroots level, must be key components of its action research. In order to translate its activities more widely, the Benin Social Science Research Group was transformed into an independent research and action Centre in 1998. It was formally registered in Nigeria as such by the *Corporate Affairs Commission in 1999.*

The establishment of CPED is influenced by three major developments. In the first place, the economic crisis of the 1980s that affected African countries including Nigeria led to poor funding of higher education, the emigration of academics to advanced countries which affected negatively, the quality of research on national development issues emanating from the universities which are the main institutions with the structures and capacity to carry out research and promote discourse on socio-economic development. Secondly, the critical linkage between an independent research or think tank organisation and an outreach program that translates the findings into policy and at the same time test the applicability and effectiveness of the recommendations emanating from research findings has been lacking. Finally, an independent institution that is focusing on a holistic approach to sustainable development and poverty reduction in terms of research, communications and outreach activities is needed in Nigeria. CPED recognises that the core functions of new knowledge creation (research) and the application of knowledge for development (communication and outreach) are key challenges facing sustainable development and poverty reduction in Nigeria where little attention has been paid to the use of knowledge generated in academic institutions. Thus, CPED was created as a way of widening national and regional policy and development debate, provide learning and research opportunities and give visibility to action programmes relating to sustainable development and poverty reduction in different parts of Nigeria and beyond.

The vision is to be a key non-state actor in the promotion of grassroots development in the areas of population and environment in Africa. The overall mission is to promote action-based research programs, carry out communication to policy makers and undertake outreach/intervention programmes on population and environmental development in Africa.

CONTENTS

- About CPED 2
- Editorial Policy of CPED's Research for Development News (CRDN) 4
- Editor's Note 5
- CPED develops a framework for research knowledge transfer to policy makers 6
- Brief Reports on other CPED Activities 18

EDITORIAL TEAM

Professor Andrew G. Onokerhoraye	Editor
Dr. Johnson Dudu	Member
Engr. Job Eronmhonsele	Member
Professor Peter Odjugo	Member
Ms. Otto Iroroturi	Member

Editorial Policy of *CPED's Research for Development News (CRDN)*

CPED's Research for Development News (CRDN) is the official publication of the Centre for Population and Environmental Development (CPED). Through this medium, CPED seeks to reach out to relevant policy makers and other stakeholders on key issues concerning development in Nigeria in particular and other parts of Africa in general.

Vision: *CRDN* seeks to inform, educate and report development issues and challenges as well as the progress in the research and outreach activities of the Centre for the consumption of policy makers, other stakeholders and the reading public in its quest to promote sustainable, holistic and grassroots development.

Mission Statement: To provide a medium for drawing the attention of policy makers, other key stakeholders and the general public to the issues and challenges of development and the policy response needed to promote equitable development.

Core Values: The two core values of *CRDN* are derived from those of CPED. The first relates to the fact that the universal ideals of intellectual and academic freedom is promoted and respected by CRDN. In this respect CRDN will remain an independent, professional and development news letter. Secondly, CRDN is a non-partisan newsletter which is not associated with any political party or organization. However, when the need arises, CRDN in its publication of CPED's research, advocacy and outreach activities will address key political issues that have considerable impact on development, especially at the local level.

Editorial Board: The Editorial Board of CRDN shall be made up of CPED's Executive Director, two professional staff of CPED and two other members from outside CPED comprising mainly of CPED Fellows.

Editorial Policy: While CRDN will report on any development issue and the various activities of CPED, CRDN will, as much as possible, focus on a particular development theme in one edition. The theme to be addressed in a subsequent edition shall be announced for the benefit of contributors in advance.

Adverts: There shall be created in every issue, a space for advertisement. The cost of the advert placements shall be determined by the Editorial Board.

Manuscript submission: Persons interested in contributing to any edition of CRDN are welcomed to do so. Manuscripts should be original with a maximum length of five pages typewritten with double-line spacing and accompanied with biographical sketch of the author which must not be more than fifty words. Each article should be typed on A4 paper with a margin of one inch round. Manuscripts already published elsewhere shall not be accepted.

Direct all correspondence and enquiries to:
The Editor,
CPED's Research for Development News;
BS-1 and SM-2, Ugbowo Shopping Centre,
P.O. Box 10085, Ugbowo Post Office
Benin City, Nigeria
Email address: Enquiries@cpedng.org

Editor's Note

Professor Emeritus Andrew G. Onokerhoraye, Ph.D., OON, JP
Editor

The Centre for Population and Environmental Development (CPED) is pleased to launch its *Research for Development News, with support from the Think Tank Initiative initiated and managed by the International Development Research Centre (IDRC). CPED's Research for Development News (CRDN)* series is published twice a year in June and December. The Series will report on the research, communication and intervention activities of CPED with the major aim of informing policy makers and other key stakeholders on development issues as well as informing key stakeholders on CPED's activities on research and intervention. In this respect the editorial policy of *CPED's Research for Development News* is to focus on one major development issue in each number of CRDN.

This June 2014 edition of CRDN is presenting progress and outcomes of CPED research projects with specific reference to the framework for disseminating research outcomes to policy makers.

Professor Emeritus Andrew G. Onokerhoraye
Editor,
June, 2014

Reports on CPED Research Activities

CPED research project on strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC) develops a framework for knowledge transfer to policy makers

CPED's ongoing project on primary health care has articulated a model for the transfer of research outcomes to policy makers in Nigeria and other parts of Africa as follows:

Generally, there is a spectrum of strategies for knowledge transfer and knowledge brokering. The six common ones which are being used in this study include: informing, consulting, matchmaking, engaging, collaborating and building adaptive capacity. Each of these strategies serves complementary functions and could be appropriate for different policy issues or for the same issue at different points in its evolution. The knowledge transfer and knowledge brokerage strategies of the primary health study in Delta State are based on the principle that personal contact between researchers and the potential users of research seems to be the most important route for research to enter policy and practice in Nigeria. This supports the assumption that research use is a social process where interacting stakeholders representing policy makers and researchers jointly examine research evidence through debate, interplay and exchange. The key organs in the knowledge transfer and knowledge brokerage of the primary health care study in Delta State comprise the *Centre for Population and Environmental Development (CPED), Project Management Committee* of the Primary Health Care Study, *Project Steering Committee* of the Primary Health Care Study in the Ministry of Health, Delta State, the *Executive Governor* of Delta State and *Project Steering Committee of the Primary Health Care Study in the Federal Ministry of Health*.

Centre for Population and Environmental Development (CPED): The Centre for Population and Environmental Development (CPED) is coordinating a range of tasks aimed at fostering better links between researchers and policy-makers. CPED is an independent, non-profit and non-governmental organization registered in Nigeria and dedicated to reducing poverty, inequality and environmental degradation through policy-oriented research and active engagement on development issues. In collaboration with civil society, the private sector and state agencies, CPED seeks to use the results of its research to influence development and implementation of policy that will promote equitable development and poverty reduction in Nigeria. CPED is currently one of the 24 IDRC *Think Thank Initiative* grantees in sub-Saharan Africa. CPED has experienced research staff that are imaginative, intuitive, inquisitive, and inspirational and who are capable of managing human intellect and helping to convert it into useful products or services. Over the years of action research and policy engagement, CPED has acquired considerable competence in dealing with policy makers including mediation skills, the ability to build teams, and considerable diplomacy, since people with very different goals and experience do not always work well together.

CPED's role as the coordinator of knowledge transfer and knowledge brokerage in the primary health care study in Delta State can be outlined as follows:

(i) Constitution of a health systems research team that will carry out CPED's coordinating role during the period of the implement - ation of the study;

(ii) Knowledge generation and critical appraisal of the primary health situation in Delta State which is being carried out through the research team using the agenda approved by IDRC and WAHO;

(iii) In Nigeria, healthcare is embedded in many social and political contexts; therefore, in addition to the knowledge of primary health care operations in Delta State that the research will produce, CPED is familiar with the broader health care pattern in Nigeria, in particular and other developing world, in general, its players, and controversies, as well as the political issues and public attitudes toward it. All of these factors influence decisions and CPED must be able to articulate them to policy makers;

(iv) **Packaging of research syntheses.** CPED will develop a range of materials designed to provide user-friendly access to complex research information on primary health care in Delta State. These materials will include executive summaries, cost/benefit breakdowns, press releases, posters, and so forth;

(v) Presentation and communication of the key and policy oriented findings to policy and decision makers and other stakeholders within Delta State and beyond;

(vi) Even when research influenced policy well, there is a need for follow-up research agenda. CPED will be involved in the post-policy period of the study to monitor its performance and sustainability;

(vii) CPED will convene meetings of other organs of the primary health care study's knowledge translation and knowledge brokerage activities;

(viii) **Fill research and policy gaps.** CPED will inform policy makers and other stakeholders about the neglected primary health policy issues in Delta State that ought to be addressed, and about deficiencies in available research. In general CPED will call for increased support for health systems research and policy-making on the basis of the findings of the study;

(ix) **Train policy-makers and researchers.** CPED will strengthen the capacity for knowledge translation by providing briefings and roundtable meetings that coach policy-makers to access and use primary health care information, and will also mentor junior researchers to understand the policy context of their investigations; and

(x) Monitor and **evaluate the impact of knowledge translation and knowledge brokerage activities.** CPED will monitor awareness of and attitudes toward its own activities, especially on the part of policy-makers, and other stakeholders, with particular attention to any influence on primary health policy change or practice.

Project Management Committee

The Project Management Committee is constituted to promote the participation of all key stakeholders in the implementation of the primary health care study. The Committee is chaired by the Project's Principal Investigator and is composed of members of the research team that represent researchers; policy and decision makers that represent the Delta State Ministry of Health; health practitioners including medical doctors, nurses and other health professionals; representatives of the private sector involved in primary health care delivery; and representatives of users of primary health care services and community members. The main responsibility of the Committee is to collaborate with the research team to implement the research component of the project by making necessary input into its execution from the perspective of policy and decision makers, health practitioners/ professionals, and the users. Thus, the role of the Management Committee includes the following:

(i) Collaborating with CPED research team in knowledge generation and critical appraisal of the primary health situation in Delta State;

(ii) Ensuring that the perspectives of policy makers, practitioners and users of primary

health care services are reflected in the study and its findings;

(iii) Collaborating with CPED research team in the communication of the policy oriented findings to policy and decision makers and other stakeholders in Delta State; and

(iv) Participating in the monitoring and evaluation of the impact of knowledge translation and knowledge brokerage activities of the study.

One of CPED's Management Committee Meetings on Health Systems Project

Project Steering Committee in the Delta State Ministry of Health

The ultimate aim of knowledge translation and knowledge brokerage in the primary health care study in Delta State is to influence policy with its findings. It was, therefore, necessary to reach key policy and decision makers in the Delta State Ministry of Health right from the commencement of its conception and implementation. This was done through the constitution of Project Steering Committee. The Committee is composed of all the policy and decision makers in the Delta State Ministry of Health including permanent secretaries and directors as well as representatives of the research team and project management committee. The chairman of the Steering Committee is the Delta State Honourable Commissioner for Health who is represented by the Permanent Secretary in charge of the administration of the Ministry. The purpose of the Steering Committee is to promote the ownership of the project by policy makers. In this way, policy makers are part of the findings and policy recommendations and are in a position to articulate and implement such policies. The research proposal and protocol were reviewed and approved by the Steering Committee before the commencement of the study. The Steering Committee is expected to meet two or three times in a year during the period of the implementation of the project so that policy makers can be kept informed of the on-going project activities. The Steering Committee initiative is expected to be a permanent, dedicated, professional mechanism operating in the Delta State Ministry of Health

and serviced by CPED. It will serve health researchers by harvesting, synthesizing, re-packaging, and communicating the policy-relevant evidence of their studies – and in user-friendly terms that lay persons will understand. It will serve policy makers by expressing their policy needs in the form of questions that can be investigated scientifically.

One of Steering Committee Meetings at Asaba on Health System Project in Delta State

Reaching the Executive Governor of Delta State with the findings and policy recommendations of the Project

The likelihood for the speedy acceptance and implementation of the findings and recommendations of the project will be greatly enhanced if the Executive Governor of Delta State, who is also a medical doctor, is put in the study's picture. While the Project Steering Committee will ultimately report to the Executive Governor, CPED through the Project Research Team and the Project Management Committee is making another direct contact with the Executive Governor so that there can be another channel of communication on the study to him. The first contact with the Executive Governor was made at the commencement of the study and more progress reports will be presented to him before the final report is made available to him at the end of the study.

National Project Steering Committee in the Federal Ministry of Health

The findings and policy recommendations of the primary health care study in Delta State are expected to influence policy at the national level. The last comprehensive study of primary health in Nigeria, which covered three states, Bauchi, Lagos and Kogi, was carried out about ten years ago. The present study in Delta State will provide contemporary information on the patterns and challenges of primary health care in the country. It is in this context that the Federal Ministry of Health is involved in the present study in terms of the utilisation of the policy recommendations for

national primary health care planning and implementation strategies. The Federal Ministry of Health's involvement is promoted through the *National Project Steering Committee,* based in the National Primary Health Care Development Agency (NPHCDA) Abuja. While the National Project Steering Committee is being regularly briefed on the project activities and results, its primary role is to review the findings and recommendations of the Delta State study for their adoption at the national level.

A group photograph of CPED, WAHO and FMOH staff after a meeting in Abuja on Health Systems Project in Delta State

Strategies to enhance evidence-informed health policy making in Nigeria

Despite the current challenges associated with evidence-informed health policy making in Nigeria, they are not insurmountable. The experiences of the on-going knowledge translation and knowledge brokerage strategies in the implementation of the primary health care study in Delta State have the potential of contributing to addressing some of these challenges. A number of strategies to enhance evidence-informed health care policy making in Nigeria are outlined below for the attention of researchers, policy makers and funders (*Iqbal* and *Tulloch*, 2012).

Encouraging Nigerian policy makers to become better users of evidence

Governments at various levels in Nigeria need to establish norms and regulations that support the development and use of research evidence. There is increasing recognition of how health system constraints impede progress in scaling-up service delivery. Therefore support for evaluative and operational research should be part of the norm for researchers and funders of health systems. One key factor in promoting the use of rigorous evidence in health policy is to build the capacity of practitioners to find, assess and incorporate rigorous evidence in their work. In this respect, government and funders should support various seminars and courses designed to empower key policy and decision makers on the use of evidence in policy making and implementation. Skills in using evidence may be improved through training and development programmes for policy makers and other policy agents. Educating administrative officials who can then introduce new decision-making approaches to their agency is one important way to effect systemic change.

The importance of capacity development among policy makers and other stakeholders in the Nigeria

health sector cannot be over stated. This is a major factor that has the potential of boosting the interest in the transfer and uptake of research evidence into policy and practice as it will positively influence governance and leadership, resources (human, material and financial), communication and quality of research. It is already a well established fact that skills training could help policy makers and their aides not only identify research evidence that has policy relevance but also distinguish research of high and low methodological quality. Targeted, evidence-based training of policy and decision makers in charge of the health systems; national, regional, state and local officers of the health ministries; staff and consultants involved in public health issues within the health ministries; political/legal advisers on health related matters; and programme/project managers under the health ministry, could provide a powerful means for influencing how research is used and how policy issues are framed in larger legislative and administrative settings in Nigeria.

Need to build strong long-term relationships between Nigerian policy makers and researchers, while maintaining objectivity in reporting results

Establishing institutional links between researchers and decision makers is necessary in order to improve the communication and utilization of research in Nigeria. Policy makers can be better encouraged to use evidence in their decisions when they have closely partnered with researchers in all steps of the research design and have benefitted from feedback from the field to tackle unanticipated implementation roadblocks. The institutional links between researchers and decision-makers influence at what levels and at what stages of decision-making processes research results can be fed in as well as demanded for. Research institutions such as CPED can be an important link. This requires the support of researchers, research funders as well as decision makers. Researchers and policy makers can jointly disseminate the lessons from research programmes and their evaluations to other policy makers so that they can benefit from these dual perspectives. Such collaborative processes can encourage evidence-based decision-making at different levels of government. *Governments* in Nigeria as in other developing countries are often the biggest funders and implementers of social programmes, and working with them offers the chance to influence policies in different sectors of the economy. We must emphasize that working with governments can however involve long and cumbersome bureaucratic approval processes, a significant risk of projects being discontinued when the civil servants who championed the programme are transferred, and wide variation in the skills and enthusiasm for change among civil servants. There is also the possibility of civil servants trying to influence researchers to effect changes in research programme design or in the publication of results to accommodate political pressure.

Removing the barriers that limit partnership between researchers and policy makers in Nigeria

In building a stronger culture of evidence-based policy making, there is a need to work towards eliminating the barriers that reduce partnerships between researchers and policy makers in Nigeria. There are many barriers to such partnerships, but it is important to promote them as not only do policy makers benefit from close interaction with researchers, but researchers also have much to gain from such partnerships. First, policy makers understand well the pressing issues facing their constituents, the local context and what the primary constraints on programme options are, and they can therefore guide academics to the most relevant research questions, and also give them a sense of the difficulties that new programmes may encounter. Second, researchers are reliant upon their implementing partners for the smooth implementation of any of their research programmes. A close feedback loop between researchers and policy makers ensures that any challenges are addressed quickly and effectively so that programmes do not fail due to avoidable implementation problems. Third, when policy makers see the researchers contributing positively by providing evidence from existing research and giving feedback on programme design, they are more likely to be motivated to support considerations of future research.

The development and improvement of dissemination strategies of research results

A major strategy to improve the relationships between researchers and policy makers in Nigeria is the development and improvement of dissemination strategies of research results. This should focus primarily on how to package research

results to be easily understood by and applicable for decision-makers. Actively involving knowledge brokers can be part of a dissemination strategy. The dissemination strategy can be designed and implemented by researchers as well as research funders.

Establish and support policy research organizations such as think tanks to promote use of evidence in policy

Supporting research organizations so that they are dedicated to supporting evidence use in policy is essential to effective use of evidence in policy making in Nigeria. Such research organisations if properly funded will be able to collate, summarize and package research evidence relevant to policy concerns and present this in a timely fashion to policy makers. Such knowledge brokers are primarily intended to act as bridges between policy- and decision-makers on the one hand, and researchers on the other.

Promote networking

Institutions for health policy should be established so that they can train students who would then go on to assume posts in health-related ministries, departments and agencies. This would enhance research-related capacities of government institutions and can facilitate academics' access to policy processes.

Conclusion

The justification for knowledge translation and knowledge brokering in Nigeria is based on the recognition that evidence from research when available could contribute to rational policy decision-making; and that clarifying the information needs of policy-makers could help direct research. The lack of knowledge brokers is acute in Nigeria, where the relatively inefficient researcher–push approach is common. Nigeria is characterized by few independent think tanks that can take the initiative of knowledge translation and knowledge brokering. One of the main complaints of policy makers in Nigeria is the queue of advocates for various results and experiences, sometimes conflicting or confusing, seeking the attention of the policy maker. In this context, CPED's knowledge translation and knowledge brokering initiative in the primary health study in Delta State is an interesting and attractive idea that is establishing a permanent brokerage available to influence policy for primary health care research, and for influencing the research agenda in turn. It would provide a single, or at least predominant, conduit of evidence to policy makers and is thus more likely to command their attention than the current fragmented approach. It should also serve to strengthen the relationship between the research and policy communities and hence a move towards a stronger culture of evidence-based policy and policy-relevant research in Nigeria. CPED believes that the knowledge brokering approach is the most appropriate way to institutionalize the use of evidence in primary health care and recommends the need to support and learn from the brokerage approach over the next few years to overcome the long-standing barriers to amalgamate research and policy and therefore promote more policy-relevant research in the country.

Users' assessment of the quality of primary health care services in Delta State

The findings of the on-going research on primary health care in Delta State with specific reference to users' assessment of the quality of primary health care services is summarized as follows: The results of the discussions in focus group and key informant interviews are outlined briefly under the following three major themes that dominated the discussions as follows: (1) conduct of health staff and professional care, (2) PHC facilities and the availability of required drugs, and (3) waiting time before treatment.

Conduct of staff and professional care

There were various positions expression by respondents and participants with respect to the conduct of staff and the professional care they receive from PHCs in their locality. Among the factors known to influence how patients experience of health care services are responsiveness and empathy on the part of health personnel. These might be outwardly displayed in the attitude of health workers. Generally, the respondents in the PHC study perceived the attitude of the various categories of health workers to be good but some

feel very strongly that some staff in public PHC facilities are not helpful to patients when they visit the centres. The focus group participants reported that staff in public PHC show varying attitudes. While some PHC staff members are reported to be polite others are perceived as being overly very insensitive to patients. Often they pointed out that most male staff are less harsh whilst most female staff tended to be harsh towards youngsters who visit, especially those with sexually transmitted diseases. Many of the participants and respondents emphasized the insensitivity of PHC staff in public facilities towards patients who needed urgent attention as well as general laxity in dealing with patients waiting for attention. Differences were noted between private and public health services such that private facilities treated patients better than in public facilities. According to some participants, rudeness is expressed by being shouted upon in public PHC facilities compared with those in private PHCs which tend to be generally friendly. Some of the participants noted that PHC staff tend to discriminate between patients according to their status or influence. The higher the perceived status of the client, the better the service provided compared with clients from low income background that often receive poor attention. Some participants acknowledged that a few PHC health staff show respect and compassion towards their patients but many especially in the public PHCs do not. Other PHC staff are said to be insensitive to particular problems of patients. Many of the respondents and participants pointed out that consultation with health staff tend to be brief with no thorough examination except for discussions around the patient telling what is wrong with him/her and then given medication on the basis of those reports. The problem of diagnostic practice is seen to be related to the failure of health staff to examine the patients thoroughly before they can determine treatment. Some respondents said that sometimes prescriptions were written even before examinations were done which was discouraging. They argue that this may be a reflection of the inadequate health staff and limited experience of those posted to rural areas.

One of the participants in a focus group discussion compared visiting a public PHC facility in their locality with visiting a traditional health care facility as follows:

> *"If I go to a traditional health care facility I am sure that I will be treated very friendly from the onset. When you knock at the door of the traditional healer you are immediately offered a seat, and thereafter one will be examined after reporting the health problems that one is having. After some examination, the traditional healer will say what is wrong with one's health. I do not have to explain what is wrong with me as the traditional healer will tell me after his/her examination. Unlike at the public PHC facility, where one is asked what is wrong and why you have that pain. ......how am I supposed to know why I have pains as if I am a doctor? I think they treat people better in traditional health care facilities than in public primary health one. This explains why many people prefer to visit traditional healers rather than visit public primary health centres..."*

Another focus group participant reported as follows,

> *"At the PHC clinic, the greetings come out more as threats rather a welcome'. You are not offered a place to sit before questions are thrown at you such as "are you attending school, what is your age and level of education, are you working and all that in front of other patients. They are not even writing anything down." "I should point out, however, that "at a private PHC facility they take good care of patients. You are given a chair on arrival, and then you will be given a bed later. The staff often speak to patients politely. The helpers show happiness and respect on their faces and they also greet patients. At the private health centre there is more privacy. The staff tell you your problems while you are in the examining room. The staff show compassion and understanding, when telling him or her what you feel."*

CPED staff conducting a focus group discussion in one of it's research project.

Another participant in one of the focus groups stated as follows:

"Some health staff at the clinic when one is ill even abuse the patient saying that "from the morning of the day one went to the clinic, you knew that you were not feeling well, why are you coming here now?" Then you will try to explain that the pain was not very bad by then, it only got worse later. Some rude health staff will say: "there is no such, there's no such...you cannot tell me a thing I have been a nurse for years, you know nothing. This attitude of health staff discourages people from these health centres...."

One other participant stated as follows:

"The nurses and midwives don't talk to patients well. May be they always have bad mood from home and put it on their patients. If she had a problem with her family, she becomes crossed with patients for no apparent reason. The nurse will just scold you even if you did nothing wrong. For example, you are on the queue and she says, 'next', while you are still deep in thoughts, she won't speak with you well. She will shout, 'why did you not come here?"

Another of the participants emphasized the attitude of health staff with respect to discrimination based on status within their communities as follows:

"They treat you depending on your background, i.e. it depends on the kind of family you come from; your appearance also contributes towards the whole thing. If you visit the clinic wearing nice clothes and jewellery they will give you first preference. If you come in tattered clothes, then things are different. It is painful to a sick

person who needs care because any person who is sick cannot have time to dress as if he/she is going to the market or party.."

"They look at the kind of person you are, if they don't like you, they won't give you the urgent attention. The nurses look at the surname. If one patient is related to her, the service is faster. "The nurses should not judge us because of where we come from or which families we are coming from. They should treat us in the same way, equally."

Another of the respondents emphasised the poor medical examination of sick persons during visits to health care facilities. According to the respondent:

"The nurses do not examine you; they just ask what is wrong with you and give you medication. You actually have to know what is wrong with you when you go to these places otherwise you will not be helped. People who complain about feeling pain in general and do not point to any specific place on their bodies cannot be helped. The medication you get is based on the patient's 'own diagnosis...."

Another participant reported along the same line as follows:

"When you are ill the first thing to do is to tell PHC staff what you are suffering from. They won't tell you what kind of illness it is, what causes it, and the functions of medicines they are giving you. They will only tell you that you must take 1 tablet 3 times a day. They do not tell you that a particular type of disease, you should not eat this and that.. " "They do not ask, they just take an injection and fill it up, then say undress the baby. They will then say you will massage the buttock on the way, while you are busy walking. They do not tell us what the function of that injection is. We take children to clinic 6 weeks after birth, and we are not told what it is for. At the clinic they do not tell us the reason for injecting us..." "We are often not satisfied with the outcome at the clinic, we just tell ourselves that God will heal us because the drugs they are giving us are just useless, they are not strong enough to cure patients. The nurses give us medication for other diseases, not for what we are really suffering from."

Availability of Facilities and Drugs

Generally, the participants in the focus group discussions reported relative good cleanliness of the PHC facilities. Basic amenities of health services such as clean waiting rooms are aspects often highly valued by patients. However, some participants and respondents complained of having small buildings as PHC centres that force them to queue outside sometimes in the sun or rain. There are no resting places and often chairs or benches for sitting are not adequate, people have to sit under tree shadows waiting for attention. Beds are only available for a few patients not more than two or three people at a time. Water was reported not to be available in many PHCs and consequently toilets are not functioning well. Overall most of the PHC environments are poor and not clean. The participants singled out the lack of drugs as a major challenge in public PHC facilities and this tend to discourage users from visiting them. Participants agreed that it is the government and not the PHC staff that should be held responsible for the lack of drugs in the PHCs. However some of the participants pointed out that even when drugs are available health staff do not have patience to explain the use of the drugs to them.

One of the focus group participants recounted her experience in the PHC in their locality as follows:

"The health staff generally do not explain how we should take the pills. At the health centre they give you medicines but they do not tell you the function of these medicines. All they tell you are take 3 teaspoons 3 times a day and keep out of reach of children. But at the private practitioner clinic they explain the function of the pill and guide you properly on how to use them ..."

Another focus group participant pointed out as follows:

"Sometimes the medicines we get from health centres help but most of the times they are useless. Sometimes you can clearly see that they have added water to the medicines. PHC medicines are too weak. You can give those medicines to a child with flu; he or she won't get better. Two weeks can pass without any change. "We want to believe that the medication that we are supposed to be given is used by the health workers for their own purposes" This problem of poor drug supply to patients do force most of us to take a child to the private PHCs where better drugs are provided"

A health staff in one of the PHCs also blamed the patients for not following the instructions given to them with respect to the use of the drugs and only for them to turn round to blame the health staff. He pointed out that

"... there was a time when I attended to a patient and gave him the prescriptions on how to take the medication; I had instructed him to take certain painkillers two times a day when he was sweating in an awkward way. It so happened that he took the medication many times within one day and not as I prescribed. He got worse in his condition, in which I was unnecessarily blamed for the failure of the patient to follow instructions."

The members of one of the focus group discussions concluded by making the following recommendation with respect to improving the drug supply situation in PHCs.

"As a solution to this problem of lack of medication the government should introduce fees for drugs. This will mean that we will get proper undiluted drugs."

Waiting time

Prompt attention has been shown to be a key dimension in surveys of community satisfaction with health services. Individuals value prompt attention because it might lead to better health outcomes, allaying fears and concerns that come with waiting for diagnosis and treatment. Prompt attention on its own is not a function of health improvement, but it is a dimension of patient satisfaction. The participants at the focus group discussions point out that the ideal total waiting time should be about one hour and patients expected to be seen quickly, attributing long waiting times to unnecessary delays. Some patients identified the dispensary and injection rooms as places likely to delay patients, so management will have to find out the causes of such delays and help minimize them. There was a general perception that at PHCs patients must have to wait for a long time until they are attended to and are even sometimes turned back if they come late in the queue. Long queues are also experienced on antenatal and postnatal days in the PHCs. The attitude of the health staff was reported by participants to be very poor in dealing with patients that needed urgent attention. There was also a problem of lack of waiting space. People wait under tree shades. At private practitioners the waiting time was very little.

One of the participants stated as follows:

"At the PHC we stand on the queue for a long time and we become tired. You will read every pamphlet on the wall until your eyes are painful." "At clinic the queue is always long because of free

services whereas at the private practitioner there is absolutely no queue due to high payments."

"At the health centres the queues are always long, especially where there are supposed to be free or lower cost of services whereas at the private practitioner there is absolutely no queue due to high payments."

Recommendations by participants to inform policy on improving the quality of PHC services

A large proportion of the discussants at the various focus groups pointed out that the quality of services in most of the facilities was acceptable while many argue that the situation is bad in their health centres. However, they all agreed on the need to improve the prevailing situation by implementing some recommendations which they have suggested. These recommendations which they believe will impact on the quality of PHCs services include the following:

(i) The range of drugs given was limited to mainly painkillers, vitamins and anti malarial. Consequently more drugs should be provided in the PHCs;

(ii) The staff were inadequate so the few available were overworked and tired affecting their performance. Efforts should be made to employ more staff in the PHCs;

(iii) The referrals were too many and costly, encouraging self-medication. They suggested having qualified medical doctors visit PHCs on specified days to reduce referrals.

(iv) There is the need to provide ambulances or vehicles in the PHCs especially to help transport referred cases.

(v) Some health workers were perceived as rude, unfriendly, unapproachable or impatient, or did not respect patients. They should be trained on how to handle patients because the attitude of health staff towards patients complicate their health challenges;

(vi) Favoritism was sometimes practiced to the chagrin of other patients. They advocated respect for all in respective of their social status;

(vii) There were no services in most PHCs on weekends. In certain facilities even medical assistants were not available over the weekends. The situation should change with the employment of more staff or the payment of weekend allowance;

(viii) Waiting times were longer, especially at the dispensary or when going for an injection. The suggested ideal total waiting time for seeking medical help should not be more than one hour; and

(ix) Health workers should be effectively supervised to reduce illegal charges.

Conclusion

Improving drug availability, interpersonal skills and professional care have been identified as the key priorities for enhancing perceived poor quality of primary health care services in different parts of Delta State. According to the participants in the qualitative surveys, there is urgent need for action on the part of provider and policy makers to remedy the situation. Patient satisfaction as a measure of health care is an important outcome measure. It is useful in assessing consultations and patterns of communications. If used systematically, feedback enables a choice between alternatives in organizing or providing health care. The efficacy of medical treatment is enhanced by greater patient satisfaction. It can also be taken as the proxy measure for the quality of health care. This policy brief is restricted to the views of the users of primary health services and it identifies various impediments in the delivery of primary health care services that may be important to the users but may appear trivial to healthcare personnel. Incorporating the views of the users in the management of primary health services will lead to fewer unsatisfied users. Policy makers and care givers should respect these patient preferences to deliver effective improvement of the quality of care as a potential means to increase the utilization of PHC services in Delta State in particular and other parts of Nigeria in general.

Other CPED Activities

Collaboration with other Nigerian research institutions to implement research projects

CPED was able to partner with development and policy researchers in ten (10) organisations, mainly knowledge-based NGOs and universities in the execution of research projects under the various research themes in the current strategic plan. The organisations partnered with include, *Intervention Council for Women in Africa (ICWA), Community Projects Against Poverty (CPAP)*, The *Centre for the Study of the Economies of Africa (CSEA)*, The University of Benin, Benson Idahosa University, Benin City, Delta State University, Abraka and Western Delta University, Oghara. Some of the researchers from these partner institutions and organisations who are associate research fellows of CPED have enriched the in-house research capability of CPED.

Support for Training of young academics for higher degrees

Although CPED has a subsisting policy and programme of supporting the training of young researchers over the years, the number of those who benefitted from such support was limited. The period of TTI support to CPED which also manifested in the increased research funding and activities contributed to a remarkable increase in the number of young researcher that have been supported financially or are still being supported in their post graduate programmes at the Masters and Doctoral levels within and outside Nigeria. During the TTI support period, a total of 15 young researchers are beneficiaries of such financial support from CPED. The research interests of these young scholars being supported have been stimulated by their participation in the implementation of CPED research projects. They are focusing on different aspects of socio-economic development and poverty reduction in Nigeria. CPED experts at least two of the Ph.D. and four of the Masters graduates to return or take appointment in CPED depending of course on the ability of CPED to mobilise resources to facilitate their full and productive engagement.

Strengthening CPED's Communications Unit

Before TTI the communications and dissemination activities of CPED were integral parts of the Research Division. This suggests that communications and dissemination activities were tied to specified research projects. There was no communications policy and programme and the need for a separate unit to handle communications and dissemination in CPED did not arise. With TTI and its emphasis on policy engagement, it became necessary for CPED to give greater attention to the issue of governance on communications and dissemination. Consequently, the Communications' Unit was established and a Communications' Officer appointed. CPED's Communications' Officer benefitted from a mentoring and training programme on communications. Thanks to the TTI's Policy engagement and communication (PEC) support program to enhance the performance of the Unit.

CPED Communication Assistance making a presentation during a training organised for communication staff

Participation of CPED in externally organised workshops

CPED Staff participated in the following learning activities during the last six months.

Onokerhoraye, Andrew and Eronmhonsele, Job-TTI PEC Anglophone Africa Regional Peer Learning Workshop, Result for Development Institute, Comms Consult and TTI, Best Western Premier Hotel, Nairobi, Kenya, April 28th – 30th, 2014.

Eronmhonsele, Job – Think Tank-University Relations Meeting, Partnership for African Social & Governance Research, Boma Hotel, Nairobi, Kenya, March 31st – April 1st, 2014.

Onokerhoraye Andrew Roundtable: Strengthening research quality for policy engagement in Africa, Safari Park Hotel, Nairobi, Kenya May 19th and 20th, 2014.

Onokerhoraye Andrew -Think Tank and University relationships: finding the synergies, Safari Park Hotel, Nairobi, Kenya, May 21st and 22nd, 2014

Ikelegbe Augustine Amnesty- DDR and Peace Building in Sub-National Conflicts: Is the Peace Being Won in the Niger Delta? Presented at International Symposium on Peace, Governance and Security in Africa, Organized by University of Peace, Africa Program, at United Nations Conference Centre, Addis Ababa, Ethiopia, April 28th – 30th, 2014.

Ikelegbe Augustine – The Crises of the State and Governance: The Colonial Roots of the Nigerian Predicament, Keynote Paper presented at the Second Annual International Conference of the Department of Political Science, Ignatius Ajuru University of Education, Port Harcourt, 14th – 16th May, 2014.

Ikelegbe Augustine – Trends and Dynamics of Small Arms and Light Weapons Proliferation and Armed Violence in the South/South, Nigeria. Presented at the National Consultative Forum on Illicit Small Arms and Light Weapons Proliferation in Nigeria, Organized by the Presidential Committee on Small Arms and Light Weapons (PRESCOM), at ECOWAS Commission Auditorium, Abuja, 2nd – 4th, June.

Odjugo Peter – The 55th Annual conference of the Association of Nigerian Geographers on *"Geography And The Challenges Of Development In Nigeria"*. University of Maiduguri, held in UNIMAID Garden Park, Abuja April, 2014.

Odjugo, P. A. O. Impact of climate change on human health and development. A paper presented at the 55th Annual Conference of the Association of Nigerian Geographers held at the Department of Geography, University of Maiduguri, Maiduguri, Borno State, Nigeria, 7th – 11th April, 2014.

CENTRE FOR POPULATION AND ENVIRONMENTAL DEVELOPMENT (CPED)

Under the current five-year programme of work, CPED activities focus on four broad areas reflecting the objectives set for the five-year strategic plan period as follows:

- (i) Research;
- (ii) Communications and outreach;
- (iii) Intervention programmes; and
- (iv) Capacity Building of CPED and partners.

RESEARCH

Four research thematic areas will be targeted by CPED during the five-year period as follows:

1. *Growth with Equity in Nigeria*
2. *Conflict and Development in Nigeria's Niger Delta Region*
3. *Education and Development in Nigeria*
4. *Health including HIV/AIDS and Development in Nigeria.*

COMMUNICATIONS AND OUTREACH

Partnership development with public and private sector/civil society organisations

INTERVENTION PROGRAMMES ON SOCIO-ECONOMIC DEVELOPMENT

Beyond action and policy oriented research and its communications activities, our mandate entails implementing intervention activities in our identified areas of policy research during the five-year strategic plan period. In this context intervention programmes that benefit largely deprived grassroots communities and other disadvantaged people are being carried out.

CAPACITY BUILDING OF CPED AND PARTNERS

CPED believes that the strengthening partner organisations including community based organisations must be a key mechanism for the achievement of its mandate during the next five years. This also includes the strengthening of CPED to be able to fulfil its mandate during the strategic plan period.

Printed by: Eddy Graphics Int'l: 08023105069, 08037461187