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RESEARCH ARTICLE

The Level of Community Involvement in Strengthening Primary Healthcare in Delta State, Nigeria: Are Improvements Needed?

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Abstract

The PHC is mainly tailored-made for the people at the community level. Therefore, it requires the participation of community members, nurses and health workers to interrelate and interconnect ideas that will eradicate health problems in their respective communities. However, over 35 years after the Alma Ata declaration of 1978 which states that "people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare", community involvement in PHC delivery has not been convincing. The objective of this paper is to investigate the level of participation/involvement of communities in Delta state, towards strengthening of PHC centres in their localities. The data analyzed were collected from the qualitative questionnaires given to health service providers in the PHCs. The results showed that participation of local communities in the governance of PHC delivery is still not satisfactory. Consequently, their contribution to the provision of some basic physical infrastructure like building permanent PHC site, building of public toilets, etc. is still at its low ebb. Attendance at health management committee meetings is also poor. One major recommendation in the paper is for awareness campaigns/sensitization to be given to the communities on the importance of PHC services.

INTRODUCTION

The well-publicized Alma Ata declaration on Primary Health Care (PHC) which was made in 1978 is meant to tackle the main health problems in communities by providing promotive, preventive, curative and rehabilitative health care services (World Health Organization-United Nations Children Fund, WHO-UNICEF, 1978). It is the first level of contact of individuals, families and communities with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of the continuing health care process (Alenoghena et al., 2004). Nigeria was among the 134 signatories to this priceless idea. Since then, Nigeria has made changes to her health systems by re-structuring the then status-quo. This to some extent have yielded some results especially from the view that primary health care centres are now obviously closer to the people in the country than before.

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;
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 utilization of local resources, such as manpower, money and materials, can be utilized to fulfill the goals of PHC.

It is vital to note that having an effective primary health care system in any society is a team effort that requires actions from key players within the health care system as well as members of the communities. Therefore, in strengthening the primary health care system, all hands must be on deck from all angles: the government, private and community.

The aim of this article is to find out the level of involvement of the community in PHC services in Delta state, Nigeria, especially those located in the rural areas, and possible ways be improve their participation.

Participatory development is the most important approach towards enabling communities to help themselves and sustain efforts in development work. Communities are no longer seen as recipients of development programmes; rather, they have become critical stakeholders that have an important role to play in the management of programmes and projects like healthcare delivery in their areas.

2. Conceptual Context

Many definitions of 'community' exist based on a vast body of sociological and anthropological literature and drawing on the politics of identity construction and social allegiance. The lack of a standard definition has proved to be an obstacle in effective participatory health programming, as different collaborators make contradictory or incompatible assumptions about community. There is often an implicit focus on the denominator of location, with the aim of organizing services or activities around population centres in order to maximize health coverage and equity. Yet, broader dimensions of community should be considered: who participates, why they participate, how they participate and how they are connected individually and collectively. In this sense, a useful definition of community is 'A group of people with diverse and dynamic characteristics, who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings' (MacQueen, McLellan, Metzger, Kegeles, Strauss, Scotti, Blanchard & Trotter).

Community involvement in primary health care is important because without local communities there will be no primary health care, and without health care services, local communities would experience huge health challenges (Florin and Dixon, 2004).

Therefore, one of the strong means to strengthen PHC system in Nigeria is through community involvement. For this reason, 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). Furthermore, Article 46 by way of elaboration states 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 consequently it cooperates fully when these activities are carried out" (WHO, 1978: 51). The primary health care system is in fact, tailored-made for the community level.

For the purpose of clarity, community participation in health could be defined along two fairly contrasting lines. It can be perceived as a movement in which the government and/or donors use community resources (i.e. land, labour, money) to meet the costs of providing health care. However, it can also be defined as a form of empowerment in which the community takes part in the decision-making process (Morgan, 1993).

Nevertheless, Community participation was institutionalized in Nigeria through the creation of District Development Committee (DDC) and the Village Development Committee (VDC) (World Bank, 2003). There is a large and growing body of evidence (Mike, 2010) that certain types of service delivery are enhanced with the active participation of the communities they serve. As end-users of the services, communities have a stake in ensuring that

services are well-provided, and are also well-positioned to monitor the quality of services. With the benefit of local information, they can assess the specific obstacles facing facilities in providing services and they can seek to ensure that facilities have the necessary infrastructure, supplies and staff motivation to provide the services they are supposed to provide. Some of this can be done through volunteer efforts, such as donations for buying supplies, but most of the benefits of community participation can only be harnessed if there are specific mechanisms in place to enable them to do so.

3. Methodology

This study is an aspect of the larger research project titled: "Strengthening the health care systems 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 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. 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.

Since the accent of the study is on community participation, the questionnaire for the PHC staff informed the body of the work reported in this paper.

4. Results and Discussion

The results and findings from the relevant respondents are presented below.

4.1 Participation of Communities (Local Content) in PHC Activities

Table 1 summarizes the responses of PHC staff as to whether or not local communities participate in the PHC activities under their charge. Overall, 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. The percentage of those local communities who are not participating in PHC activities is still quite high and especially for Udu LGA which accounts for 61 per cent in that category.

Table 1: 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.

4.2 Types of PHC Activities that Local Communities Participate in

Community members were involved in various health and development activities in the PHC centres to ensure the wellbeing of the citizenry. The activities undertaken at any point in time depended on the existing needs at a particular point in time. Community members were engaged in self-help and it was customary to find such gestures without proper mobilization.

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. The responses to the types of PHC activities that communities participate in are presented in Table 2.

The study showed that three (3) activities recorded 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 2 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.

Table 2: Distribution of the Kinds of PHC Activities that Local Communities Participate In

LGA	Planning/ Design (%)	Env. Sanitn. (%)	Building public Toilets (%)	Monitoring Project Implementation (%)	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.

4.3 The Types of Committees Involved in Health Related Activities

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 3.

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 while the youth/women committees accounted for 11 per cent.

Table 3: Distribution of the Committees Engaged in Health- Related Activities.

LGA	None (%)	Comm. / Village Health Mgt. 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.

4.4 Frequency of Meetings of PHC Management Committees in 2013

It is one thing to have health management committees and another for the committees to be functional. This is because a lukewarm 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 (2013). It was considered that quarterly meetings were ideal in order to keep abreast of all developments. The responses are presented in Table 4.

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).

Table 4: 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.

4.5 Major Factors 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 summarized in Table 5.

From Table 5, the 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. Across the target LGAs, illiteracy/ignorance accounted for 23 per cent while lack of adequate finance recorded 22 per cent as the major reasons for poor community participation in committee meetings.

Table 5: 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

4.6 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 6.

From the point of view of the perception of community members, Table 6 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 6: 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.

4.7 Funding and Awareness as Ways to Enhance Community Participation

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

In Table 7, the study shows that financial rewards which accounted for 47 percent, and awareness creation which accounted for 33 per cent, were the major factors that can boost community participation in PHC activities. Also from Table 7, community mobilization (20 per cent) would also be an influential factor to enhance community participation in PHC activities.

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. Also, 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.

Table 7: Distribution of Perception of What Could Be Done to Enhance Community Participation

LGA	Create awareness and enlightenment (%)	Financial reward	Mobilization of community	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

5. Conclusion and Recommendations

Community participation emerged as one of the main principles of primary healthcare rooted in the Alma Ata declaration of 1978: "people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare". More than 35 years after the declaration, community participation is still not impressive and convincing.

The study in Delta state showed that participation of local communities in the governance of primary healthcare delivery is still not satisfactory. Consequently, their contribution to the provision of some basic physical infrastructure like building of permanent PHC site, building of public toilets, etc. is still at a low ebb. Attendance at health management committee meetings is also poor. Indeed almost one-third of the facilities surveyed did not hold such meetings in the year preceding the study.

However, some of the recommendations to improve the poor state of community involvement in primary healthcare delivery in Delta state are depicted below.

i. Funding of the PHC system should be significantly improved and should be captured in the financial budgets of the LGAs in Delta state. There should be some funds set aside for stipends to members of the management committee whenever they meet. This will act as incentive.
ii. Awareness campaign and sensitization of the communities on PHC services and its importance to the people should be intensified. Capacity building and empowerment of communities through orientation, mobilization and community organization as regards training, information sharing and continuous dialogue, will no doubt further enhance the utilization of PHC services by rural populations.
iii. Community members who are above the poverty level and are well-to-do, should be willing to use their personal income and/or materials to help in providing some of the basic necessities in the PHC centres. They should not depend on the government for everything.

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