

Achieving Community Participation in Primary Health Care Service Delivery: What Should We Do?

About CPED Policy Brief

CPED Policy brief series is designed to draw attention of stakeholders to key findings and their implication as a research project is conducted. Actionable recommendations for policy influence and results utilization are also presented.

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Introduction

The term 'community participation' is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs. Community members are often perceived as consumers and yet are a potential resource that could be tapped into so as to strengthen health systems. The Delta State Government and other providers of primary health care services need to articulate strategies of empowering and involving communities to ensure ownership and sustainability of primary health care programmes. Community participation should not be limited to cost sharing only but should also include other aspects of the primary the health systems including the delivery of services. In scaling up community involvement there is a commitment to mobilize energy and voluntarism in a manner that is difficult for formal health services to match, and to achieve results in groups that formal services struggle to reach. The Delta State Ministry of Health therefore need to create an enabling environment for responsible and constructive community involvement, facilitate the emergence of community-based organizations and support actions, initiate and facilitate efforts in rural communities of the state. Innovative concepts on how buy-in by communities can be enhanced need to be employed. An example of this could be selling a stake of the health system, by outsourcing an income generating and self- sustaining part of the system to communities, such that this results in a mutually beneficial relationship between the health systems and the community it serves. This policy brief proposes an

BACKGROUND

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 Organisation (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, modification and implementation of policies on equitable access to health care with specific focus on the primary health care component.

The primary focus of this policy brief therefore is to outline the actions that need to be taken to improve the situation based on the findings of the project, for the attention of the Delta State government and other providers of primary health care in the state.

METHODOLOGY

Data was collected from all Primary Health Centres in nine Local Government Areas in Delta State using facility audit questionnaires, interviews with health service providers, Community health workers and community stakeholders in the communities where these PHC facilities were surveyed.

Focus group discussions and key informant interviews were held with various stakeholders on their assessment of PHC services in their respective communities.

action strategy for engaging communities in the promotion of primary health care services in rural communities of Delta State.

Key Findings on Nature of Community Involvement in Primary Health Care Facilities in Delta State

The findings of the survey of primary health care facilities in Delta State show that community involvement is quite limited in the management and delivery of primary health services in different parts of the state as outlined below:

- It was discovered that key decisions about programming priorities were largely made by the Local Inspection Officers and staff of the primary health centres mainly the Matron and Nursing Officer who in most cases were in charge of these centres. It was obvious from the findings that other stakeholders were not actively involved in influencing the pattern of primary health care and delivery. However, it was pointed out by some of the PHC staff interviewed that in some situations communities in which their primary health centres were located did participate in the activities of the primary health centres such as planning, environmental sanitation, building
- of toilets and monitoring of project implementation. The intensity and regularity of the involvement are quite limited.
- It was also found that some primary health centres had different types of committees in which the community members participated and these included community/village committees, ward committees and youth or women committees. The most common was the Health Management Committees. However, these committee rarely meet as most of them have not met for over three years.
- The reasons for the poor participation of the community members in management committees and other activities of the primary health centres in their locality include poor awareness by the people and lack of motivations by those who should normally promote their participation.
- The Delta State Government and the various Local Government Authorities that own and manage these primary health centres have not taken decisive steps to promote community involvement in the delivery of services which could have brought positive impact on the provision and utilization of primary health care services in different parts of the state.

Policy Recommendations

Based on the findings of the nature of community involvement in primary health care provision, there is need for the articulation of a strategic framework for the promotion of the participation of community members and users of primary health care services in different parts of the state particularly in the rural areas. The proposed strategy in this actionable recommendations focuses specifically on the involvement of community members and users on the delivery of maternal and child health care in which the empowerment and participation of women of child bearing age is a key component. This strategy focuses principally on the provision of technical skills to the women of childbearing age as well as mothers' groups, and lay birth attendants for better home-based maternal and child healthcare. This is to be achieved by introducing a number of packages which have proved successful in the literature and which we encourage the providers of maternal health care in both the public and private sectors to adopt. They include:

- *Community-based birth preparedness package:* This package is designed to mobilize key stakeholders and women of child bearing age to promote changes in the behaviour of families in the communities. This entails engaging volunteers to counsel the mothers and families during home visits as well as during the community group meetings.
- *Community-based newborn care package:* This package focuses on the service delivery component including home visitation as well as community mobilisation to enhance skills on community case management of infection, home-based care of Low Birth Weight (LBW), and birth asphyxia as well as orientation to mothers' group and lay birth attendants.
- *Community-based infant and young child feeding package:* This package addresses the counselling

component on early breast feeding, exclusive breast feeding, extended breast feeding, complementary feeding and food diversification empowerment of the stakeholders and users of maternal and child health care facilities.

- *Community-based integrated management of childhood illness package:* This is a package which has a service delivery component such as the delivery of commodities as well as community participation and the promotion of positive health behaviours and enhancement of skills for home-based management of pneumonia and diarrhoea as well as orientation to mothers about the programme in the community.

The implementation strategy proposed has three major stages as follows:

Stage One: This stage will focus on activities such as;

- i) The women's groups will identify and prioritize maternal and neonatal health problems at the community level;
- ii) Orientation of the women on participation in the project;
- iii) Exploring attitudes of the women toward pregnancy and maternity;
- iv) Learning what the women know and do about maternal and neonatal health problems;
- v) Encouraging women to think about what other women in the community know and do in relation to maternal and neonatal health problems;
- vi) Identifying challenges associated with access to maternal and child health care;
- vii) Prioritizing the problems of maternal/child health in their community.

Stage Two: This stage entails planning together by defining strategies and actions to resolve the problems identified by the women's groups. The planning process may include;

- i) Presentation of problems by the women. In this way the women's groups will learn about the problems of maternal/child health and will know why they are priority problems;
- ii) Identifying barriers to solving the problems. Here, the women's groups will understand what a barrier is and will identify barriers to solving the problems of maternal/child health;
- iii) Identifying strategies and realistic, concrete actions. Again the women's groups will identify strategies and realistic, concrete actions which will help to lessen or overcome the barriers of maternal/child health.

Stage Three: This stage focuses on organizing training sessions on the intervention packages. These include;

- i) Community-based birth preparedness package;
- ii) Community-based newborn care package;
- iii) Community-based infant and young child feeding package;
- iv) Community-based integrated management of childhood illness package.

Conclusion

Achieving community participation in health service delivery in resource-limited but a high disease burden setting as it is in the rural areas of Delta State is not a simple task. In many parts of the rural areas of the state the perception of the general population is often that of a grossly inefficient formal health sector that has simply failed to deliver. Additionally, community members may seek remuneration for participation in health service

delivery, a stance that is not often sustainable in poorly resourced rural communities as it is in Delta State. Furthermore, health service personnel may not be willing to involve laypersons in the execution of health programmes, an act that they may view as a dilution of their own expertise. The onus is on health planners to devise appropriate and context-specific ways in which to achieve sustainability by keeping lay people motivated in community

participation in health programmes while at the same time keeping in mind the limitations of cost-containment. The rationale for proposing participatory community-based interventions in Delta State is based on the fact that many maternal and neonatal deaths occur at home, and could potentially be avoided by changes in antenatal and newborn care practice and better understanding of health problems.

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 was 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.

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