Attitude to the formation of Community Health Committee in an oil bearing community in south-south Nigeria.

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ABSTRACT

BACKGROUND

Community participation in the running of health services has been identified as key to unlocking the potentials of primary health care in achieving health for all members of the community. This and the desire to entrench democratic practices in Nigeria explain why the revised national policy on health recommended the constitution of community health committees (CHC) in all wards and local governments in the country. This study assessed the attitude of health workers, and members of an oil-bearing community towards this recommendation.

METHOD

The study was carried out in Ogbogu, a small semi-urban, oil-bearing community in Rivers State, using a pre-intervention/ post-intervention study design. The attitude of members of the community, and the health workers in the community's health center were assessed before, and six months after the constitution of a CHC, using focus group discussions, key-informant interviews, and field observations as study tools.

RESULTS

The health workers knew the importance of the CHC, but refused the offer of assistance in the constitution of the committee, until they got clearance from their superior. But the idea was warmly received by members of the community. However, six months after the formal inauguration of the committee, the committee was only able to hold 2, out of their 6 scheduled meeting, with only 6, out of the 14 members of the committee, attending all the meetings. Most of the issues discussed during the meetings centered on the accountability of the money realized by the health center. Some members of the committee were frustrated by the committee's inability to effect its decisions, while the health workers felt the community members of the committee were unnecessarily interested in financial matters.

CONCLUSIONS

The attitude to the CHC was poor. Giving the committee the full powers to effectively utilize the human and material resources of the health center in achieving the health aspirations of the community is thereby recommended.

KEYWORDS: Community participation; Primary health care; Community health committee; Nigeria.

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INTRODUCTION

More than thirty years after the Alma Ata declaration, and 26 years after primary health care was made the cornerstone of Nigeria's health care system, by the 1988 national policy on health, primary health care remained largely unavailable in most parts of the

country[1]. Although part of the blame for this lies with very poor government funding[2], lack of community participation has also been consistently blamed[3]. This is because the primary health care philosophy represents a paradigm shift in health care delivery as it sees health not merely as a product of biomedical intervention, but also the outcome of social determinants[4].

Traditionally, the inputs of the community in the running of the health center sited to serve the community are provided through the Community Health Committee, sometimes called the Community Development Committee, to emphasize the inter-sectoral functions of the committee. This committee has members drawn from the segments of the community with enough influence to mobilize others in finding solutions to the health problems of the community[3]. Health according to the World Health Organization, is not merely the absence of disease or infirmity, but also encompasses the physical, mental and social well being of the individual. Thus, the Community Health Committee is not restricted to assisting the health workers to diagnose and treat illnesses, but is also involved in environmental sanitation, ensuring that foods are safe and available to all the households in the community, and generally ensuring that good policies and programmes are properly implemented for the benefit of all[5].

These enormous responsibilities explain the emphasis placed on the Community Health Committee in the subsisting Nigerian national health policy; an emphasis deepened by the urge to entrench democratic practices in the country6. Indeed, community participation in health has been shown to result in more democratic and socially accountable governments, and more self-reliant individuals who are willing to take greater personal responsibilities, for their own health and those of their families[7].

The subsisting national policy on health specifically recommends that 'each ward in every Local Government or area Council should establish a Ward Development Committee' that shall be responsible for the coordination of planning, budgeting, provision and monitoring of all primary health care services that affect residents of the Ward and other matters incidental thereto[6]. The attitude to this recommendation needs to be examined as studies indicate that though health workers can repeat the "right words" about community participation and community health committee, they often prefer to do nothing[8]. It has also been shown that community participation works best in communities with traditions of volunteerism[9]. This article assessed the attitude of health workers and members of the community towards the formation of a community health committee, in an oil bearing community, where volunteerism is almost non-existent[10,11].

METHODOLOGY

Study site: The study was carried out in Ogbogu, an oil-bearing community in the Ogba/ Egbema/ Ndoni Local Government Area (ONELGA) of Rivers State, with a projected population of 9,793 people, made up predominantly of subsistent farmers. The community has a good network of tarred internal road, regular electricity supply, and piped-borne water; most of them provided and maintained by the either the oil companies operating in the community, or government agencies like the Niger Delta Development Commission (NDDC).

The community's health care center which was one of the ten functional primary health care centers, out of the 22 in the local government area, was built and equipped by the major oil company oil in the area, donated to the community, but managed by the local government council. However, service utilization has been very poor, except for its immunization services, as only 408 out-patients were seen in the health center, in 2008.

Study Design

The study was carried out over a six month

period, using a pre-intervention/ post-intervention design. The interventions include the constitution of a functional community health committee; community needs assessment, and the guided implementation of various interventions, according to the identified needs. The attitude of members of the community, and the health workers in the community's health center towards the formation of community health committee were ascertained using focus group discussions, key-informant interviews, and field observations. These study tools were also used after six months to assess the experience of committee members in the running of the community health committee.

Data Collection

The in-depth interviews and focus group discussions were held with key members of the community development committee, the youth and women associations, as well as the staff of the health center. They were used to collect information on the knowledge, attitude, and experience of the respondents with the community health committee. The discussions were held separately for each of the stakeholders, conducted in Pidgin English and the local language, recorded using notes and audiotape, and then analyzed; all using the standard method[12].

The activities of the community health committee after its inauguration were also examined particularly the regularity of scheduled meetings, the attendance of members to the meetings, and the issues discussed during the meetings. The records kept at the health center within the study period were also examined.

Ethical Considerations

The approval to undertake the study was sought and obtained from the Ethical Review Committee of the University of Port Harcourt Teaching Hospital, Port Harcourt, as well as from the Primary Health Care department of the Rivers State Ministry of Health, and of the Ogba/ Egbema/ Ndoni Local Government Area. Informed consent was also sought from all the respondents. Only those that gave their consent participated in the study.

RESULTS

The health center had 10 trained staff, only 2 of whom were indigenes of the community. The health workers had an average post-qualification experience of 5.78 years. They were trained at the School of Health Technology without the recommendations of their respective native communities, but were able to get the sponsorship of their local government councils for the training.

The community health committee had members drawn from such community structures as the community development committee, youth association, women association, council of chiefs and elders, and prominent opinion leaders. The members had an average age of 47.54 +/- 7.5 years, with at least secondary school education, and were mainly either self-employed or civil servants.

The health workers knew the importance of the Community Health Committee, the NPHCDA's guidelines on its composition, and the recommendations of the revised national policy on health for the constitution of the committee; but refused the initial offer of assistance in the constitution of the committee, insisting on getting clearance from the local government PHC Coordinator, and the State's Director of primary health care.

On their parts, members of the Ogbobu community Development Committee were not aware of the recommendation for the constitution of a community health committee, but warmly welcomed the idea. They had thought that their interaction with the health workers ends with collaborations for national immunization days and other community outreach programmes. They saw the constitution of the committee as an opportunity to extend the control of the community to the health center. According to the Chairman of the CDC: "it would be good to form the community health committee if it would give the community an eye into what

happens in the health center. Health workers in the health center have received a lot of things from the oil companies without giving account to the community".

However, six months after the formal inauguration of the community health committee, the committee was only able to hold 2 (33.33%) of the 6 scheduled meeting, with only 6 (42.86%) out of the 14 members of the committee, attending all the meetings. Most of the issues discussed during the meetings centered on the accountability of the money realized from the seed drugs and ambulance donated to the health center by the NDDC. The committee also worked on memoranda to the NDDC and the oil companies operating in the area, soliciting for additional resources for the health center. Nothing was discussed on improving the level of utilization of the health center, or the pricing of services and products in the health center, as identified during the community needs assessment.

Some of the committee members who did not regularly attend the meetings were frustrated by the committee's inability to compel the health workers to completely account for the resources they received from government and the oil companies. Others felt frustrated by the inability of the committee to effect its decisions. According to the member representing the youths of the community "what is the need having the committee, when the health workers would insist on getting the permission of the local government before implementing any decision, even when the local government council in most times, are not interested?" But, the health workers felt the community members of the committee were too nosy, wanting to know everything that happen in the health center, especially financial matters, and even clinical issues.

DISCUSSION

The study shows a poor attitude to community health committee, not only amongst members of the community, but also amongst the health workers. This shows a poor attitude to a key recommendation of the revised national policy on health. Unfortunately, there are indications that this attitude is widespread in Nigeria[13, 14]. Several reasons have been put forward for this poor attitude, especially the lack of accountable leadership and equity priority – the two factors found in all poor developing countries that were able to make significant progress in the delivery of primary health care[15]. The local government system in Nigeria whose responsibility is to fund and manage primary health care has been noted to be the most corrupt in Nigeria, with leadership willing to embezzle all funds, including monies budgeted for the salaries of the workers[13]. The irregular payment of salaries has been shown to increase the tendency of health workers to compensate themselves with the revenues of the health facilities[13]. Little wonder, the health workers in the study facility had problems giving financial account to the community health committee, and actually tried to protect their direct relationship with the oil companies in the study community.

But, even as corruption is widespread in Nigeria, the situation in the study community and other oil bearing communities of the Niger delta is likely to be worse, considering the negative impact of the presence of the oil industry on the social environment of the communities. Several authors have indicated that the "divide and rule" employed by the oil companies in the Niger delta created in the indigenes, the desire to share in the wealth of the industry, fueling corruption amongst community leaders, whose main interest in service is personal aggrandizement, and not the interest of the whole community[10, 11]. It is widely acknowledged that community participation works best in communities with traditions of volunteerism, social solidarity, and politically supportive environment[9,16]; unfortunately, these are all lacking in the study community. This explains why members of the community health committee were more interested in how they could use the committee to win contracts for themselves, rather than working to improve access to quality care for all members of the community.

The problem of the community health committee is not entirely attitudinal, but also because the committee did not have enough powers to fully achieve its mandate. Although the revised national policy on health gave the committees the powers to plan, manage, monitor, and evaluate the primary health care system[6]; in practice, community health committees in Nigeria do not seem to have enough powers to accomplish their mandate. A study carried out in Kogi State, North-Central Nigeria concluded that though community participation has been institutionalized in the State, and were actively involved in some areas of health service delivery, they were not involved in areas critical to service improvement[13]. This is consistent with the viewed expressed by some members of the committee in this study who complained of not having the real power to make any difference, as the powers reside with the local government councils, who in most cases were not interested. This is not good enough, for community participation is acknowledged not to be just an intervention, but really about power and control[17]; therefore community health committees in Nigeria need to be granted full control of the health center under their jurisdiction. To do this would just be to legalize what already exists in numerous rural communities in Nigeria with few choices of primary health care services, where community members regularly make voluntary contributions to improve the quality of services provided in public health facilities in the communities[11]. This would not only help solve the accountability problem that has continued to bedevil the local government system in Nigeria, but would also encourage members of the communities to make further contributions for quality health services[11].

Granting the communities the full control of the health centers would also involve ceding the responsibilities for the evaluation, reward, and sanctioning of the health workers fully to the communities. This would assuage the frustration felt by members of the community health committee of their inability to control the health workers, and would firmly put the health workers at the disposal of the committee, in meeting the health aspirations of the community. The control would also help for stale the growing truancy of the health workers, especially as a lot of them do not work in their indigenous communities[1,13]. The study in Kogi State also revealed that community participation in the evaluation of health workers is significantly associated with greater productivity per staff, in providing inpatient deliveries, immunizations, and outpatient consultation[13].

Doubts however exist if the communities would do better than the local government councils in the management of the health facilities, considering the pervasive corruption in the country. Members of the community health committee in the study were even noted to pursue their own personal interests. But, such interests can effectively be subjugated by making available to members of the community, information about the resources that have been provided for the delivery of stated services, so that they can hold members of the community health committee accountable[13]. This is especially as feelers from several communities in Nigeria, still reveals that embezzlement of funds is not tolerated, especially when it involves funds specifically earmarked for social services in the community.

CONCLUSION

The attitude to community health committee was poor not only amongst members of the community, but also amongst the health workers. This has been attributed not only to the pervasive corruption in the country, but also due to the inadequate powers reposed on the committee. It is therefore recommended that the committee should be given full powers to effectively use the human and material resources in the health center in achieving the health aspirations of the community.

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REFERENCES

1. Asuzu MC, Ogundeji MO. Minimum standards for primary health care services nationwide in Nigeria. Report of a consultancy assignment for NPHCDA, Sept. 2007.
2. De Maeseneer J, van Weel C, Egilman D, et al. Funding for primary health care in developing countries. BMJ 2008; 336: 518 – 519.
3. Morgan LM. Community participation in health: perpetual allure, persistent challenge. Health Policy and Planning 2001; 16: 221 – 230.
4. Lawn JE, Rohde J, Rifkin S, Were M, Paul VK, Chopra M. Alma-Ata 30 years on: revolutionary, relevant, and time to revitalize. Lancet 208; 372: 917 – 927.
5. Zakus JDL, Lysack CL. Revisiting community participation. Health Policy and Planning1998; 13: 1 – 12.
6. National Primary Health Care Development Agency. Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria. Abuja. NPHCDA; 2004.
7. Tarimo E, Webster EG. Primary Health Care concepts and challenges in a changing world: Alma-Ata revisited: Geneva. World Health Organization. 1997 (WHO/ARA/CC/97.1).
8. World Health Organization, District Health Systems, Division of Strengthening Health Services The Challenge of Implementation: District Health Systems for Primary Health Care Geneva 1988.
9. Woelk GB. Cultural and structural influences in the creation of, and participation in community health programmes. Social Science and Medicine 1992; 35: 419 – 424.
10. Dokepsi AO. Emergence of the oil industry and the weakening of traditional values of the western Niger delta communities. Presented at the international conference on the Nigerian State, oil industry and the Niger delta held in Yenagoa, Bayelsa State, Nigeria on March 11 – 13th 2008.
11. Enweremadu DU. The vicious cycle: oil, corruption, and armed conflicts in the Niger delta. Presented at the international conference on the Nigerian State, oil industry and the Niger delta held in Yenagoa, Bayelsa State, Nigeria on March 11 – 13th 2008.
12. Araoye MO. Research methodology with statistics for health and social sciences. Ilorin. Nathandex publishers. 2003. 119-120.
13. Das Gupta M, Gauri V, Khemani S. Decentralised delivery of primary health services in Nigeria: Survey evidence from the States of Lagos and Kogi. Geneva. Development Research Group, The World Bank. 2004.
14. Abosede OA, Bakare OQ. Community participation in primary health care: 10 years experience between the "town" and the "gowns" in a peri-urban ward in Lagos State, Nigeria. Journal of Community Medicine and Primary Health Care 2008; 20 (1): 80 – 90.
15. Rohde J, Cousens S, Chopra M, Tangcharoensathien V, Black R, Bhutta ZA, Lawn JE. 30 years after Alma-Ata: has primary health care worked in countries? Lancet 2008; 372: 950 – 961.
16. Jacobs B, Price N. Community participation in externally funded health projects: lessons from Cambodia. Health Policy and Planning 2003; 18: 399 – 410.
17. Rifkin SB. Ten best readings on community participation and health. Afri Health Sci. 2001; 1: 43 – 47.