

Management Audit for Primary Health Care Facilities in Plateau State

*Lawan M U *Abubakar I S **Zoakah A I

*Department of Community Medicine Bayero University Kano and **Department of Community Health, University of Jos

Abstract

Background: The health care system in Nigeria has been developed at three levels, the extension of health care to all people has been an objective of all National Health Systems for many years since the Alma - Ata conference on Primary Health Care (PHC) in 1978. Decades after the take off of PHC in all parts of this country, the goal of health for all and beyond is still far from being attained.

Method: The management activities of Primary Health Care Facilities in Plateau State were investigated. A multistage sampling method was used to select 30 PHC facilities from 10 randomly selected LGAs out of the 17 Local Government Areas (LGAs) of Plateau State. All the heads, the secretaries and the chief matrons of the selected facilities were interviewed using self-administered structured questionnaires. Responses were scored using a dichotomous scale and categorized into poor, fair, good and excellent performances, and analyzed using Epi info 2.3.05 2003 statistical software.

Results: Out of the 90 workers interviewed, 68.9% were females and 85.6% were married. Seventy four point four percent of the respondents were between 30-44 years of age, and 43.3% of the workers worked at the Basic Health Clinics (BHCs) while 20% of them worked in Comprehensive Health Centre (CHCs). Up to 40% of the LGAs had poor management performance, while the remaining 60% performed only fairly.

Overall, PHC facilities in Langtang north did better in management of their facilities, while Shendam LGA scored least in management performance. In this study, no significant difference in scores of the various management activities between the LGAs was observed ($F=7.084$, $p > 0.05$). However, a statistically significant difference in scores of management activities between the various types of PHC facilities was observed ($F=2.81$, $p < 0.05$).

Conclusion: The management staff in most of the primary health care facilities lack resources at their disposal and this hinders the efficient and effective running of the facilities. Lack of transportation and poor maintenance of those available would seem to be the major constraint to the effective running of the health facilities.

Key Words: Management, Audit, Primary Health Care Facilities, Plateau State

Date Accepted for publication: 11th June 2009

Nig J Med 2009; 290 - 302

Copyright©2009 Nigerian Journal of Medicine

Introduction

The extension of health care to all people has been an objective of all National Health Systems for many years, and since the Alma - Ata conference on Primary Health Care (PHC) in 1978, countries have pursued this aim with greater vigour.¹

The health care system in Nigeria has been developed at three levels; the Tertiary Health Care which is the highest level, provides for special care in highly specialized hospitals, Secondary Health Care provided at the general and cottage hospitals consists of specialized services to patients referred from the primary care level and the Primary Health Care which consists of promotive, preventive, curative and rehabilitative services provided at the health centres.² In Nigeria, essentially four types of health centres are recognized; the Comprehensive Health Centre (CHC), the Primary Health Centre (PHC), Basic Health Clinic (BHC) and Health post.³ These centres serve as frontline facilities which are directly linked to the communities they serve, and are therefore the first port of call for any member of the community seeking health care.³

Decades after the take off of PHC in all parts of this country, the goal of health for all and beyond is still far from being attained. One very crucial factor in sustaining PHC is the ability of the health care providers at every level to manage the system. There must be continuous assessment to detect health and health related problems, set priorities, design strategies, and micro plan for each strategy. The implementation of intervention and the degree of success depends to a great extent on available resources and level of community participation.⁴ Past works have identified that poor management of in-adequate resources, lack of managerial skills at all levels, poor utilization of health

man power and in-adequate logistic and supervisory support are among key factors that infringe on the sustainability of PHC in Nigeria.⁵⁻⁷ All of these problems identified would be addressed if a continuous management audit is introduced and sustained within the system. This process can be used as a tool by which health workers with management functions can examine their successes and failures.

Management audit has not been a common practice in Nigeria, and there is thus general paucity of information on the subject matter. This study was therefore embarked upon to bridge the gap in knowledge as well as to provide ground for further research.

Methodology

Study area:

Plateau State is located in the North central zone of Nigeria. It is bounded to the north and east by Bauchi and Taraba States, and to the south by parts of Nassarawa State. It also shares border to the west with parts of Nassarawa and Kaduna States. The state has an estimated 2005 projected population of 2,059,587 based on the 1991 National Population Census.⁸ The chief occupation of the rural population of Plateau State is farming while most of the urban population of the State are civil servants. Plateau State has a modest number of fairly distributed health facilities. It has a Teaching Hospital, a Specialist Hospital, nine General Hospitals and about twenty (20) PHCs in each of its seventeen (17) Local Government Areas (LGAs).

Study design:

A descriptive, cross sectional design was used to study the management activities of PHC facilities in Plateau State.

Study population:

The study population were the heads of the PHC facilities in Plateau State (Medical Supritendants, Community Health Officers and other Personnel in-charge of the PHC facilities), Hospital Secretaries for the facilities, and the Chief Matrons or their equivalent where deemed fit.

Sampling and data collection techniques:

A multistage sampling method was used to select the study subjects; Ten (10) of the 17 Local Government Areas (LGAs) were first selected by balloting, and then three (3) districts were randomly selected from each of the selected 10 LGAs by balloting giving a total of 30 districts. At the third stage, one (1) PHC facility was randomly selected from each of the 30 selected districts by balloting.

Finally, from each of the 30 selected facilities, the head of the facility, the secretary and the chief matron were interviewed. Overall, 90 subjects from the selected facilities were interviewed using self-administered closed-ended questionnaires.

The questionnaire consisted of six parts. Sections 1, 2 and 3 sought information on socio - demographic features of the workers, activities related to the personnel of the health facilities, and planning and organization activities of the management of the facilities, while sections 4, 5 and 6 elicited questions on resources available to the health facilities, district and public related activities and control systems of the health facilities respectively.

Data analysis:

Data generated were collated and analyzed using the Epi info 3.2.05 2003 statistical software. Responses to questions under each activity were scored using a dichotomous scale, one (1) for 'Yes' and zero (0) for 'No' answers respectively. This arrived at 5 points each for 'personnel', 'resources' and 'district/public activities' and 6 and 7 points for 'planning and organization' and 'control system' activities respectively, giving a cumulative sum of 28 points per subject. Total scores per LGA was therefore calculated as 9 by 28 points which equals 252 points. LGAs that scored 63 points were adjudged as having poor performance while those that scored 64-126 points and 127-189 were adjudged as having fair and good performance respectively, while those who scored 190-252 had excellent performance.

Analysis of variance (ANOVA) was used to determine any significant difference in scores between LGAs and between types of facilities. A confidence interval of 95% was used and a p-value of 0.05 was considered significant.

Results

Ninety health workers were interviewed in all. Table 1 shows the socio-demographic features of the study subjects. Majority of the Respondents for this study were in their forth decade of life, followed by those in their fifth decade (26.7%). There were more females (68.9%) than males (31.1%) among the respondents. Most of them (85.6%) were married. Majority of the respondents (73.3%) were Christians, with 52.2% having over ten years working experience. Up to (43.3%) of the respondents selected for this study worked in Basic Health Clinics, (36.7%) in Primary Health Centres, while one fifth were from Comprehensive Health Centres.

The management activities of the facilities examined are as summarized in table II. Comparing performance on the various management activities however, health facilities in Langtang north performed best (27 points) with regards to planning and organization activities, followed by facilities in Mangu LGA which scored 24 points. Health facilities in Mikang and Shendam LGAs scored least on planning and organization activities. All the LGAs scored highest on planning and organization activity. Langtang north spearheaded on activities related to personnel with 20 points, followed very closely by facilities in Mangu LGA. Again, facilities in Mikang and Shendam LGAs scored least under this activity. Health facilities in Jos south and Langtang north turned out having the best of resources, while Bassa and Shendam LGAs had the least resources at their disposal. Up to 80% of the LGAs scored lowest activities in district/public activities compared to all other activities. Between LGAs however, Langtang north was ranked second to Mangu with scores of 18 and 17 for Mangu and Langtang north respectively. Bassa LGA scored least for this activity. On the other hand, control activities were general found to be poor in all the LGAs. However, Langtang north had the best control system in place, out of all the 10 LGAs examined, followed by Mangu LGA. Facilities in Mikang and Shendam had the worst control systems.

Overall, PHC facilities in Langtang north did better in management of their facilities, and facilities in Mangu and Jos south LGAs follow suite in that order, while Shendam LGA scored least in management performance (Table 2). An analysis of variance showed no significant difference in scores of the various management activities between the LGAs ($F=7.084, p > 0.05$).

In this study, type of facility was found to be associated with management performance. A significant difference in scores of management activities between the various types of PHC facilities was observed ($F=2.81, p < 0.05$) (Table III).

Table 1: Sociodemographic Features Of Study Population

Feature	Freq (n = 90)	%
Age		
20-24	5	5.6
25-29	8	8.9
30-34	20	22.2
35-39	30	33.3
40-44	17	18.9
45-49	7	7.8
50-54	3	3.3
Sex		
Male	28	31.1
Female	62	68.9
Religion		
Christianity	66	73.3
Islam	24	26.7
Marital status		
Married	77	85.6
Single	9	10.0
Widowed	4	4.4
Experience (years)		
< 5	19	21.1
5 - 10	24	26.7
> 10	47	52.2
Place of work		
CHC	6	20.0
PHC	11	36.7
BHC	13	43.3
	30	

Table II: Management Performance by LGA

LGA	SCORES ON MANAGEMENT ACTIVITIES					TOTAL SCORES	REMARK
	A	B	C	D	E		
Bassa	14	12	10	9	12	57	Poor
Bokkos	15	13	12	10	14	64	Fair
Jos north	21	14	14	12	12	73	Fair
Jos south	20	16	15	14	18	83	Fair
Kanam	16	13	13	11	12	65	Fair
Langtan north	27	20	15	17	26	105	Fair
Mangu	24	19	12	18	24	87	Fair
Mikang	13	11	12	10	10	56	Poor
Pankshin	15	12	11	10	12	60	Poor
Shendam	13	11	10	10	10	54	Poor

$F_{(9,40)} = 7.08, p > 0.05$

- * A= Planning and organization activities
- * B= Personnel activities
- * C= Resources activities
- * D= District/public activities*
- * E= Control activities

Table III: Management Performance by Type of Facility

Type of facility (No.)	Scores					Total
CHC (6)	54	48	45	40	42	229
PHC (11)	61	42	39	35	34	211
HC (13)	70	52	52	51	49	274
(30)						714

$F_{(2,12)} = 2.81, p < 0.05$

Discussion

Achievement of quality in PHC requires the performance according to standards of proven interventions, i.e. the components of PHC that have the ability to produce an impact on morbidity and mortality.⁹ This is not without its constraints at primary health facilities which are generally difficult to manage in the face of inadequate team work, serious weaknesses in the development and implementation of action plans and inadequate technical and managerial support.¹⁰

In this study, most of the activities in the health facilities were found to be poorly planned and organized. Although the health facilities had defined goals, regular staff meetings and schedules of duties into achieving these objectives were lacking. Incentives such as acknowledgement of good work is also lacking. It is in records that reward improves performance. A reward system which gives incentives for working with communities, civil society organizations and other partners not traditionally recognized as necessary or valuable for health work is being advocated for PHC workers.¹⁰ This is to boost their morale and thus improve performance.

This study also revealed that most of the health facilities were ill equipped. This is a well-documented shortcoming of health facilities in the developing world that would lead to system failure and thus suggests a management weakness. Management is not only about making people do their jobs but it includes also providing people with adequate equipment with which to do their job. Primary health facilities deal with up to 80 percent of a country's health problems but receive as

little as 20 percent of its health resources. It is therefore necessary to shift resources towards the periphery, as this would lead to greater health impact on people.

The fact that patients asked few questions on the activities in the facilities may not necessarily show that all was well. Most patients at the primary level are mostly illiterate and may not know what to expect from the health facilities, also the attitude of the workers may be one that does not encourage questions from the patients. It therefore becomes pertinent that community health workers should listen carefully to people and concentrate on providing support rather than being prescriptive. Education of the public enlists their cooperation in many creative ways like in needs assessments, strategic planning and design of a user friendly health facility.

The transport systems in most health facilities were not well maintained. A review of African studies has shown that logistic problems lead to performance deficiencies and limit the quality of service delivery.⁹ Transport failure also ensures that the performance of isolated PHC workers is dependent on their limited knowledge and supplies. This calls for an upgrading of the curricula of community health workers who man these facilities. In addition to the usual health skills, they should be taught skills in financial management, general management and be taught to tap resources from the community. It will also hamper the health facility from carrying out its basic function of referring patients it cannot handle to secondary and the tertiary facilities.

With the introduction of PHC, Health Centre Committees were set up at almost every health facility but most were not told what their functions were nor empowered to carry out these functions and existed in name only, having no impact. But a few are involved in the active running of the health facilities, helping in advocacy and the Essential Drug Revolving Fund (EDRF) scheme mainly.

The facilities in Langtang north and Mangu LGAs are better managed than facilities in other LGAs because this facility though set up by the Teaching Hospital in conjunction with the LGA gets a lot of support from the community. Examples of support enjoyed by this facility from the community include utilization, and the existence of a functional facility development committee to name a few. Communities often have many hidden resources waiting to be uncovered and deployed for health development if only health workers could find ways to work more closely with them.

Conclusion and recommendations

The management staff in most of the primary health care facilities lack resources at their disposal and this hinders the efficient and effective running of the facilities. Lack of transportation and poor maintenance of those available would seem to be the major constraint to the effective running of the health facilities. There were also reports of shortage of equipment in a large number of health facilities.

Base on the above findings we recommend that:

1. Staff in charge of health facilities should be given some training in management.
2. Functional ambulances should be made available to all primary health care facilities in order to ease supervision of isolated PHC workers as well as referral of patients.
3. Equipment that are needed at PHCs and CHCs are basic and cheap, most patients are seen and taken care of at these centres with these equipment. It will therefore be more cost-effective to equip these centres and those handling the equipment be taught how to maintain them.
4. Staff members should be taught skills on how to work in and with other members of the community.

References

1. Flahault D, Roemer MI. Leadership for PHC; Levels, Functions and Requirements based on 12 studies. WHO, Geneva. 1986.
2. National Health Policy and Strategy to achieve Health for all Nigerians. Federal Ministry of Health. Lagos. 1994.
3. Fulop T, Roemer MI. Reviewing Health Manpower Development- a Method of Improving National Health Systems. WHO, Geneva. 1987.
4. Obionu CN. Defining and Packaging Relevant and Qualitative Health Services; Primary Health Centres what should they offer? Primary Health Care in Nigeria - The Journey so far; National Conference Proceedings. Abuja. 13th-16th April, 1999: 17-19.
5. Dokunmu OO. Primary Health Care Problems and Prospects. Primary Health Care in Nigeria - The Journey so far; National Conference Proceedings. Abuja. 13th-16th April, 1999: 14-16.
6. Ransome-Kuti O, Sorungbe AOO, Oyegbite KS and Bamisaiye A. Problems and Lessons learned in Implementing PHC at LGA in Nigeria. Strengthening PHC at Local Government level The Nigerian Experience. Academy press Ltd. Lagos. 1991:156-162.
7. AFRO. Evaluation of the Strategy for Health for all by the year 2000: The report of the World Health Situation. Vol 2. Brazzaville. WH. 1987.
8. Federal Ministry of Health. 1991 Populations by State and LGA. Nigeria Bulletin of Epidemiology. 1992; 2(3): 12-25.
9. Guson L, Magomi M and Mkangaa E. The Structural Quality of Tanzanian Primary Health Facilities. Bulletin of the WHO. 1995; 73(1): 105-114.
10. Kahssay HM. Health Centres the Future of Health depends on them. World Health Forum. 1998; 19: 341-347.