

Performance Evaluation of the European Union Micro Health Project in Niger Delta Region, Nigeria

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Abstract

The study was a performance evaluation of the European Union Micro Health Project in Niger Delta Region, Nigeria. The objectives were to describe the personal characteristics of the respondents, determine the frequency of use of the health facilities, the adequacy of infrastructural facilities and determine the extent of performance of the health services providers in the study area. The respondents were the beneficiaries of the health services and were selected using the multistage sampling techniques from which 300 (70-male; 230-females) were selected. Primary data were obtained using a structured questionnaire and recorded responses during Focus Group Discussions (FGDs). Descriptive statistics and probit and logit outcome models were used to analyse the data. The major findings showed that majority of the respondents were in their active age, and were more of female sex. The primary occupation to majority of the respondents was crop farming, as well as belonged to varied organisations. The finding also showed that patronage was low and infrastructural facilities were inadequate. The study therefore recommended that beneficiaries participation in all the project cycle and adequate funding of development projects would go a long way in enhancing its performance.

Keywords: Performance, Evaluation, Healthcare, Niger Delta

I. INTRODUCTION

The Niger Delta region of Nigeria is endowed with natural resources, mostly oil and gas which accounts for more than 85% of the national Gross Domestic Product (GDP), services about 95% of national budget and generates over 80% of the nations' wealth (Ebegbulem et al, 2013). Ironically, the wealth notwithstanding the region is still poor. The poor state of the region is largely attributed to hostile exploitation of natural resources and state policies that rendered the environment desolate and sub-changed the inhabitants of their rights to natural resources and livelihood. According to Egbebullem et al, (2013), devastation of the ecology by role exploration has made farming and fishing the main

livelihood activity of the rural population a wasteful venture.

Oil exploration activities in the Niger Delta has become a threat to the livelihood sources, physically, economically, politically and socially respectively (Egbe, 2012). Economically, the rural people are threatened as the aquatic lives disappear, the vegetation destroyed and the biodiversity and income from farming activities diminishes. The presence of oil companies in an area is accompanied with a socio-cultural dislocation and disorientation of the young people that plunge them into moral decadence.

The poor status of the region despite its huge contribution to national wealth attracted the attention of foreign development partners, the likes of United Nations and the European Union. The development was perceived as a step towards effectiveness and efficiency of programmes while hitherto have eluded previous programmes and projects executed by various tiers of government in Nigeria.

Etteng (1998) perceived the situation in Niger Delta as a characteristics of contemporary Nigerian feud-capitalist social formation, a region with immense wealth and poor. Faleti (2012) describes the Niger Delta situation as a disturbing paradox, a blessed but yet wretched region lacking in virtually everything that could help make living worthwhile. The European Union is involved in the execution of social development programmes to reduce poverty, mitigate social tension and crisis and help improve the living conditions of the rural and sub-urban communities. These they do through the execution of community-based micro-projects as a contribution towards the achievement of the Millennium Development Goals (MDGs) such as micro health projects. For the Niger Delta region, the micro-health project was aimed to address the poor health status of the region. Gwatkin et al (2003) believed that since the people are poor, they therefore have greater need of health facilities.

The European Union micro health project constituted 23% or 239 of 1,912 been the total projects executed under the Mpp6 programme and distributed among the six states of Abia-98, Akwa-Ibom-50, Cross-River-71, Edo-54, Imo-98 and Ondo-67 respectively. It is hoped that with the completion of these projects as sited in different rural

communities the health condition of the people will improve. However, that was not the case. Health centres are meant to handle primary health care services and reduce the influx to the secondary and tertiary health facilities for ailments such as malaria, antenatal and post-natal cases but the large number of cases in these facilities is a proof of a missing link. The missing link is between the benefactors and the beneficiaries of the micro health project in the inability to evaluate the project to ascertain effectiveness, and that this study is design to do.

II. PURPOSE OF THE STUDY

The purpose of the study is to evaluate the European Union micro health project in the Niger Delta region. Specifically, the study tends to:

1. describe the personal characteristics of the beneficiaries of the health project.
2. ascertain how frequent he beneficiaries use the health care services provided in the study areas.
3. determine the adequacy of the infrastructural facilities provided at the health centres in the study areas.
4. determine the extent of performance of the health services providers in the study areas.

III. RESEARCH QUESTIONS

1. What are the personal characteristics of the beneficiaries of the health project?
2. How frequent do the beneficiaries use the health care services provided in the study areas?
3. How adequate are the infrastructural facilities provided at the health centres?
4. To what extent do the health services providers perform their duties in the health centres?

IV. HYPOTHESIS

There is no significant relationship between the personal characteristics of beneficiaries and the utilization of the health care facilities.

V. METHODOLOGY

The study was a survey that sought the opinion of respondents in a bid to answer the research questions. The beneficiaries of the European Union (MPP6) micro health project in the states of Ondo, Edo, Imo, Abia, Akwa-Ibom and Cross-River respectively. A multistage sampling technique was applied in selecting 300 respondents that constituted the sample.

First, the six states that benefited from the project were clustered into three zones based on period of execution. Zone one include Abia and Imo state, Zone two were Akwa-Ibom and Cross-River State, while zone three were Edo and Ono state. Three states (one from each zone) were selected-Imo, Akwa-Ibom and Edo and studied. Secondly, ten communities hosting the health project were randomly selected from each state, give a total of 30 communities. Thirdly, ten persons were substantially chosen from each community and gave a total of 300 respondents (100 males and 200 females), selected for the study.

Data gathered were both primary and secondary. The primary data were gathered using structured questionnaire, interviews, observations and Focus Group Discussions (FGDs). The secondary data were project reports and documentaries obtained at the coordinator’s office. Data collected were analysed using both descriptive and inferential statistics (Percentage, Mean and Binary Probit and Logit Outcome Models).

VI. RESULT AND DISCUSSIONS

A. Personal Characteristics of Beneficiaries of Health Care Services.

To a large extent, it is necessary to study respondents’ personal characteristics as it could influence research outcome. The variables considered include sex, age, marital status, educational attainment, primary occupation and membership of organization.

Table 1: Distribution of Respondents Based on Personal Characteristics

Variables	Frequency	Percentage
A Sex		
Male	70	23.33
Female	230	76.67
B Age range (years)		
20-29	50	16.67
30-39	140	46.67
40-49	55	18.33
50-59	40	13.33
≥ 60	15	5.00
C Marital Status		
Married		

	Divorced	25	8.33
	Single	30	10.00
	Widowed	50	16.67
	Separated	5	1.67
D	Educational attainment		
	No formal education	30	10.00
	6 years of formal education	40	13.33
	9 years of formal education	150	50.00
	< 9 years	80	26.67
E	Primary Education		
	Crop farming	165	55.00
	Fishing	30	10.00
	Trading	25	8.33
	Salaried	47	15.67
	Other activities	33	11.00
F	Membership of Organization		
	Social	60	20.00
	Cultural	50	16.67
	Religious	240	80.00
	Political	32	10.67
	Professional	20	6.67

Source: Field Survey, 2016

Table 1 showed more females than males (76.67% and 23.33%) utilize healthcare services provided at the health centres studied. The funding corroborated those of Awoyemi et al (2011) and Rasak (2013) on gender differences in the utilization of health care services. They found that women, being home makers and care givers were usually responsible for the health needs of their children. On age range of respondents, the study found that majority (46.67%) were within the range of 30-39 years. This range is believed to be the most active in female reproduction, hence the need for ante and post natal care services rendered by the health centres. Adu-Gyamifi and Abane (2013) shared this opinion when they said that people within the age range of 20-39 years mostly utilize local health care facilities.

On marital status, 63.33% were married, 16.67% were widowed, 10% were single, 8.33% were divorced while 1.67% had their marriages separated. Majority of the respondents were educated as 50% of them had about nine years of formal education, 26.67% spent more than nine years in school, 13.33% had basic/primary education while 10% had no formal education. On primary occupation, 55% engaged in crop farming, 15.67% earn salary, 10% were into fishing, 8.33% were traders while 11% were engaged in other activities for livelihood. The findings on primary occupation is a confirmation of the reports by World Bank (2008) and FAO (2010) that agriculture is the fulcrum upon which rural people livelihood rest.

B. Frequency of use of Health Care Facilities

Table 2: Distribution of Respondents Based on Frequency of Use

Responses	Frequency	Percentage
Frequently	64	21.33
Rarely	197	65.67
Never	39	13.00
Total	300	100.00

Source: Field Survey, 2016

Data in Table 2 was an indication that the supposed beneficiaries of the health project rarely make use of the facilities as 65.67% rarely use them, 13% never attended the health centres while only 21.33% used it frequently. During the Focus Group Discussions (FGD), the respondents blamed some factors for the situation. The findings showed that

their reasons for not utilizing the facilities corroborated those found by Oswald and Clewett (2007) and Dias et al (2012) that rural people were faced with the problems of cost of services, distance from home, transportations among others which grossly reduced their chances of accessing the health care facilities.

Hypothesis 1: There is no significant relationship between respondents’ personal characteristics and their utilization of health care services.

Table 3: Binary (Probit & Logit) Outcome Models of Health Services

Utilization	Probit Coefficient	Probability of Z score	Logit (r)	Probability of Z score
Sex	-0.241	0.257	-0.363	0.342
Age	-0.204*	0.007	-0.039	0.009
Marital Status	0.245	0.241	0.413	0.271
Educational attainment	-0.110	0.341	-0.181	0.392
Occupation	-0.181	0.299	-0.320	0.312
Membership of Organisation	0.091	0.490	0.209	0.396
Constant	0.123	0.868	0.226	0.863
Pseudo R ²		0.0649		0.0653
Correctly classified		83.91		83.91

Source: Data Analysis, 2016

Table 3 showed the outcome models of health care services in relation with personal characteristics of respondents. The Probit and Logit coefficient models when correlated with the variables such as sex, age, marital status, educational attainment, occupation and membership of organization did not show any significant relationship in all aside age. With the Probit and Logit coefficient of -0.204 and -0.039 and probability scores of 0.007 and 0.009 less than 0.05 critical value, age was found

to influence the utilization of health care services. The implication was, that as an individual advances in age, there is the tendency for health challenges, hence the hypotheses was accepted. The findings were at variance with those of Taylor et al (2005) and Nayamuddin and Manriguliani (2006) who found that educational attainment and membership of social organizations were strong tools in the mobilization, advocacy and effective participation in project planning, execution and implementation.

C. Adequacy of Health Care Facilities

Table 4: Respondents Assessment of Adequacy of Facilities

Facilities	Mean	Remark
Building	2.35	NA
Health personnel	1.45	NA
Electricity supply	1.25	NA
Laboratory	1.35	NA
Pipe-borne water	1.82	NA
Access roads	1.45	NA
Consulting rooms	2.01	NA
Out-patient wards	2.20	NA
Internal water linkages	1.65	NA
Soak-away pits	1.85	NA
Incinerators and placenta pits	2.32	NA
Pesticides treated nets	3.65	A
Laundry facilities	1.85	NA
Consumables	1.90	NA
Computer and its accessories	1.62	NA

Source: Field Survey, 2016

NA = Not Adequate, A = Adequate

Table 4 showed the respondents opinion on adequacy of physical infrastructures in the health centres as listed. The respondents were of the opinion that the European Union Micro Health project was marred with inadequate supply of necessary facilities. Among the facilities listed, it was pesticide treated nets with mean value of (3.65) that was adequately supplied. Other necessary facilities such as buildings (2.35), electricity (1.25), laboratory (1.35), pipe-borne water (1.82) and access roads (1.45) were

inadequate. Also, in short supply or total absence were consulting rooms (2.01), out-patient wards (2.20), internal water linkages (1.65), soak-away pits (1.85), incinerators and placenta pits (2.32) and most importantly health personnel (1.45) among others.

The inadequacy of these necessary facilities was identified to have affected the acceptability and patronage of the project as expressed by the respondents during Focus Group Discussions. The

findings corroborated those of Abdulraheem et al (2012) and Adesiji et al (2012) who found that the problems constraining rural people from patronizing

health centres were among others inadequate infrastructural facilities.

D. Performance of Health Care Services

Table 5: Respondents’ Assessment of Health Care Services Provided

Variables	Mean	Rank
Functionality of health centre	1.62	Low
Availability of necessary drugs	1.59	Low
Affordability of drugs	1.69	Low
Punctuality of personnel to duty	1.68	Low
Prompt attention given to patients	1.58	Low
Adequate care given to children	1.86	Low
Adequate treatment given to the aged	2.00	Low
Improvement on safe delivery by women	1.77	Low
Regular awareness on health matters	1.81	Low
Effective ante and post natal care	1.81	Low
Functional ambulance for emergency	1.70	Low
Effective routine immunisation exercise	1.69	Low

Source: Field Survey, 2016

Table 5 showed the indicators of health services performance. In the opinion of the respondents, all the variable were rated low with mean values less than minimum acceptable value of 2.50. Generally, the respondents were of the opinion that the health care services provided by the European Union Micro-health project performed below expectations in all aspects of evaluation and assessment. The findings corroborated those of Adesiji et al (2012) and Akesode (2009) who found that one critical factor diminishing the performance of rural health care services was the attitude of health officials. Their attitude to work and poor human relations among other factors were serious constraints to the effective performance of rural health centres.

VII. CONCLUSION

Based on the findings the following conclusions were made;

That personal characteristics of the beneficiaries of the health project did not influence their utilization of the health care services provided, however, there was the indication that more aged people sought health care services than the young. There were paucity of physical infrastructure in majority of the health centres which invariably affected their patronage negatively. The rate of performance of the health centres and the services rendered therein were rated low by the beneficiaries who attributed the low performance of certain factors, principally among them was the attitude to work and poor human relations of health personnel posted to the health centres.

VIII. RECOMMENDATIONS

Based on the findings the following were recommended;

1. Development projects should be planned, executed and monitored along with the

beneficiaries. Their participation at all stage of the project cycle would make them perceive the project as their own, patronize and cherish it, while making other contributions to keep it functional and effective.

2. Community development projects/programmes should be adequately funded and the necessary facilities provided. This is the same way of motivating the people (beneficiaries) to participate and patronize the facilities. Adequate funding may reduce cost and cause change in attitude of both personnel and clients.
3. Development agencies in collaboration with governments at all levels (Local, State and Federal) should ensure that adequate staff are posted to man the health centres. Qualified health personnel who are punctual to duties are booster to the utilization of the health care facilities.
4. Development projects/programmes should be monitored and evaluated periodically to ascertain the realization of its objectives or otherwise find solutions to the problems bedeviling it, thereby making the achievement of programme objective impossible.

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