Journal of Health Science 4 (2016) 155-159
doi: 10.17265/2328-7136/2016.03.007

Effect of Professional Designation on the Level of Task Performance by Community Health Workers in Enugu State

Ndie Elkenah Chubike[1], Ezenduka Pauline Ojinika[2], Ehiemere Ijeoma[3] and Mba Chioma Judith[4]

1. Department of Nursing Science, Ebonyi State University, Abakaliki, Nigeria

2. Department of Nursing Science, Nnamdi Azikiwe University, Nnewi Campus, Nigeria

3. Department of Nursing, University of Nigeria, Enugu Campus, Nigeria

4. Department of Nursing Science, Bayero University, Kano, Nigeria

Abstract: The study aimed at assessment of level of task performance of Primary Health Care Worker (PHCWs) according to their professional designations in selected Local Government Areas (LGA) in Enugu State. Descriptive survey research was used. 291 PHCWs were randomly selected from 9 LGA using a multistage method. Questionnaire was used to collect data and the instrument was validated using test-retest method with correlation coefficient of 0.79. The findings show that Community Health Extension Workers (CHEWs) performed higher than Environmental Health Officer (EVO) and Community Health Officers (CHOs) in the area of health education concerning prevailing health problems and method of control. They scored 66.09% as against 52.8% and 60.61% for EVO and CHEW respectively. The result showed that the professional designation has no significant effect ($P < 0.05$) on the level of task performed by PHCW and their levels of task performance were low. It was recommended that public Health physicians and Nurses should be involved in the PHC in Enugu State to provide the right supervision to the PHCW.

Key words: Professional designation, task performance, primary health care workers.

1. Introduction

The success of Primary Health Care (PHC) implementation in Nigeria requires effective task performance by Primary Health Care (PHCWs). PHC is an essential health care designed to meet the specific health needs of individual, their families and the entire community by means acceptable to them with their full participation [1]. The Alma Ata Conference (1978) endorsed PHC as the key strategy for implementation by all countries of the world in order to improve the health status of the people and lead to achievement of Health for All by the year 2000. This attainment is still elusive 16 years after the target in Africa [2].

The challenges in implementing PHC in Nigeria are rooted in the policy formulation and planning as well as recruitment of appropriate workforce [3]. In early 1990s Nigeria abandoned public health system to adopt a new system that excluded the public health (community) physicians and nurses from PHC [4].

The PHC tasks enumerated at the Alma-Ata include education concerning providing health problems and methods of preventing and controlling them, promotion of food supply and adequate nutrition, safe water supply, basic sanitation and many others. The PHCWs found in Health Centers in Nigeria include Environment Health Officers, Community Health Officers and Community Health Extension Workers. This work is relevant now that WHO is talking about task-shifting. Task shifting is interpreted in Nigeria as nurses given up most of their tasks to these groups of workers in PHC.

Even Ransome-Kuti [5] (who championed the elimination of the of public health system in Nigeria)

Corresponding author: Ndie Elkenah Chubike, associate professor, research fields: public health, nursing and nutrition.

observed that certain constraints were responsible for the poor performance of tasks involving PHCWs. He went on to state that during training schools did not equip the CHEWS with skills to setup PHC system. They were only trained to provide services. They never venture into community to perform their assigned expected task. Akpala [6] reported that most health centers were not performing their functions. He went on to state that junior CHEWS were expected to spend 90% of their time in community and 10% in the health centers while senior CHEWS were expected to spend 60% of their time in the health centers and 40% in the community performing their tasks. Moreover, most of the PHCWs neither had idea of their catchment population for health centre nor the other health-related resources available within the community. He further stated that health centers existed as mini hospitals and PHCWs serve as "Doctors" and "Nurses". There is an urgent need to identify how satisfactory these tasks are performed by PHCWS in Enugu State of Nigeria. Hence this study that aimed at assessing task performed by PHCWs in Enugu State in relation to their profession designations. This study is important to identify the level of task performed by those PHCWs.

2. Methodology

Descriptive survey research design was adopted to examine the task performed by various groups of PHCWs in health centers in Enugu State of Nigeria. Enugu State is made of 17 Local Government Areas (LGA) and 423 health centers. Multi stage random sampling method was used to select health centers. In the first stage three LGA were randomly selected from each of the three senatorial district of the State given a total of 9 LGA. In the second stage, three health centers were randomly selected from each of the 9 LGA given a total of 27 health centers. The total number of PHCWs was 315 but 291 were finally used. Only those who were willing to participate were included in the study.

Structured task performance questionnaire developed Ezenduka et al [7] was modified and used for data collection on the effect of professional designation on task performance. A pilot study was done in one of the LGA that was not selected for the study. A test retest method was used to test the reliability and the correlation coefficient was 0.79. Permissions were obtained from Coordinates of PHC in the selected LGAs and all the respondents gave their consents and were assured that the information they provided is for statistical analysis only. The questionnaire were distributed to the respondents in their places of work and collected by the end of the day's work by the researchers. The work was done from June-December 2014. The data were analyzed using SPSS version 20.

3. Result

Table 1 shows that Environmental Officer (EVO) scored 58% on maternal health as against 62.61 percent and 65.71 percent for CHOs and CHEWs respectively; treatment of common diseases and minor injuries EVO scored 20% as against 42.6% and 31.84% for CHOs and CHEWs respectively. Referral of patients with serious health problems, EVO scored 30% as against 47.83% and 52.24% for CHOs and CHEWs respectively. Child health services (immunization and growth monitoring) EVO scored 90.91% as against 82.61% and 74.69% for CHOs and CHEWs respectively; health education concerning methods of isolation of infectious cases EVO scored 40% as against 40.87% and 15.51% for CHOs and CHEWs respectively; EVO scored 52.82 as against 66.09% and 60.6% for CHOs and CHEWs respectively; health education concerning poor housing and its health implications EVO scored 26.86% as against 34.78 percent and 32.24 percent for CHORs and CHEWs respectively; disinfect and dress minor wounds 49.82 percent as against 56.52 percent and 49.59%; perform simple laboratory tests EVO scored 31.82% as against 31.74 percent and 26.12 percent for CHOs and CHEWs respectively, mobilize and encourage community participation in EVO score

Table 1 Types of task performed by PHCWs according to professional designations (n = 291).

Task performed	EVO (n = 111)		CHOs (n = 46)		CHEWs (n = 134)		Row Total N = 291	
	n	**%**	**n**	**%**	**n**	**%**	**N**	**%**
1. Maternal health services Ante-natal Natal, post-natal Care	111	38.00	46	62.61	134	65.71	291	69.21
2. Child health services(growth monitoring,immunization	111	70.91	46	82.61	134	74.69	291	76.49
3. Provide health education concerning:								
-Prevailing health problems and Methods of control	111	52.82	46	66.09	134	60.61	291	88.08
-Methods of isolation of infections cases	111	40.0	46	30.87	134	15.51	291	25.17
-Dangers of self medication and fake drugs	111	22.73	46	43.47	134	35.10	291	38.08
-Resources available in								
-Health centres and in communities	111	33.64	46	43.48	134	24.49	291	28.81
-Poor housing and its implications	111	26.82	46	34.78	134	32.24	291	34.44
4. Prevention and control of locally endemic diseases	111	71.82	46	62.61	134	52.65	291	74.50
5. Treatment of minor diseases and minor injuries	111	39.00	46	42.61	134	45.84	291	90.73
6. Referral of patients with serious health problems	111	30.00	46	47.84	134	52.24	291	85.76
7. Provide essential drugs such as panadol	111	40.91	46	50.00	134	51.84	291	52.98
8. Disinfect and dress minor wounds	111	49.82	46	56.52	134	69.59	291	76.16
9. Keep basic records of vital events (births, death) diagnosis, and treatment	111	22.73	46	39.13	134	32.45	291	75.50
10 Perform simple laboratory tests (urine and blood tests)	111	31.82	46	31.74	134	26.12	291	35.10
11 Mobilize and encourage community								
12 Participation in health programmes	111	43.64	46	50.52	134	38.49	291	58.28

EVO = Environmental Officers, CHO = Community Health Officers, CHEWS = Community Health Extension Workers.

43.64% as against 50.52% and 38.49% for CHOs and CHEWs respectively and home visits and contact tracing of treatment defaulters EVO scored 48.73% as against 54.34 percent and 58.37 for CHOs and CHEWs respectively.

The table further reveals that the following tasks were performed higher by CHEWs than EVO and CHOs; health education concerning prevailing health problems and methods of control 66.09% as against 52.8% and 60.61% for EVO and CHEWs respectively; keeping basic records of vital events (births, deaths), diagnosis and treatment CHOs scored 39.13% as against 22.73% and 32.45% for EVO and CHEWs respectively.

However, data in Table 1 further revealed that CHEWs performed higher than CHOs in the following tasks: treatment of common diseases and minor injuries 48.84% as against 42.61% for CHOs; referral of patients with serious health problems 52.24 percent as against 47.83 percent for CHOs, provide essential drugs 51.84 percent as against 50.00 percent for CHOs; disinfect and dress minor wounds 69.59 percent as against 56.52 percent for CHOs; keep basic records of vital events (births, deaths), diagnosis and treatment 48.84 percent as against 42.61% for CHOs and home visits and contact tracing of treatment defaulters 58.37 percent as against 53.34 percent for CHOs.

The data in Table 2 revealed that the difference was significant at .05 level and 2 degree of freedom only on the method of isolation of infected cases. This means that the type of professional designation of PHCWs had no influence on the types of task performed except on method of isolation of infectious cases.

This result is surprising because their training had different focus one expected this to reflect in their job performance. This finding then agree with Ransome-Kuti [5] who observed that during training, the Schools of Health Technology did not equip CHEWs with skills to function well in the PHC system. They never ventured into the community to perform their assigned/expected tasks. Contributing further to this Akpala [6] reported that most health centers were

Table 2 Summary of chi-square values verifying the difference in types of task performed by PHCWs in Enugu State according to professional designation (n = 291).

Types of Task performed	Cal. X^2 Values	Table X^2 Values
1. Maternal health services Ante-natal Natal, post-natal Care	27.62217	.00001
2. Child health services (growth monitoring, Immunization)	115.40126	.00000
3. Provide health education concerning:		
-Prevailing health problems and Methods of control	59.93776	.00000
-Dangers of self medication and fake drugs	267.12350	.00002
-Resources available in health centres and in communities	27.62217	.00001
-Methods of isolation of infections cases	2.22229*	.69495
-Poor housing and its implications	44.77002	.00000
4. Prevention and control of locally endemic diseases	27.31931	.00002
5. Treatment of minor diseases and minor injuries	81.62227	.00000
6. Referral of patients with serious health problems	75.19843	.00000
7. Provide essential drugs such as panadol	35.07703	.00000
8. Disinfect and dress minor wounds	35.00948	.00000
9. Keep basic records of vital events (like births, death) diagnosis, and treatment	18.25557	.00110
10 Perform simple laboratory tests (urine and blood tests)	18.18518	.00114
11 Mobilize and encourage community participation in PHC programmes	28.18925	.00001
12 Home visits and contact tracing of treatment defaulters	18.14968	.00115

*significance difference.

not performing their functions. For instance, junior CHEWs were expected to spend 90 percent of their time in the community and 10 percent in the health centers while senior CHEWs were expected to spend 60 percent of their time in the health centers and 40 percent in the community performing the tasks. He further stated that the way health centers existed as mini hospitals without managerial impact on the health of the communities where they exist.

It is very surprising to note that majority of CHEWs perform better than CHOs in the following tasks even though some CHOS had midwifery training: provision of health education concerning prevailing health problems and methods of controlling them (X^2 = 59.938 > 000); health education concerning resources available in health centers and communities (X^2 = 27.622 > 000); treatment of common diseases and minor injuries (X^2 = 81.622 > 000); and mobilization and encouragement of community participation in PHC programmes (X^2 = 28.187 > 000).

4. Conclusions and Recommendation

It was concluded from the study that type of professional training do not have significant effect ($P < 0.05$) on the task performance by PHCWs in Health Centers in Enugu State and that they performed poorly in all the tasks. This poor performance can account for the poor health indices Nigeria has been recording. It is then recommended that PHC should be restructured in Nigeria since it the same system that is obtainable throughout the country. This is to allow the community physicians and public (community) health nurses play active role in health care provision in the community. These groups of workers will provide the necessary supervision needed by the current PHCWs.

References

[1] WHO/UNICEF 1978, Alma-Ata 1978 Primary Health Care, Genena: WHO, 79.

[2] WHO 2008. International Conference on Primary Health Care and Health System in Africa. 28-30 April 2008 Onogadougou, Burkina Faso Discussion paper AFR/PHC/08/1.

[3] The Library of Congress Country studies and CIA World Factbook 1991 Nigeria Primary Health Care policy—flog, map, economy, history http://www.photius.com/countries/Nigeria/Society/Nigeria_Society.

[4] Ndie, E. C. 2014. "The Place of Public Health Nurses in National Health Policy in Nigeria." *A Review International Research Journal and Medical Sciences* 2 (1).

[5] Ransome-Kuti, O. 1990. "Stranghaumy Primary Health Care at Local Government Level." *The Nigerian Experience* 11 (1): 303-89.

[6] Akpala, C. O. 2001. "Are Primary Health Care Centres fulfilling Their Role in Primary Health Care?" *The Road* 4 (4): 23.

[7] Ezenduka, P. O., Ndie, E. C., and Ehiemere, I. 2015. "Assessment of Effect of Years of Experience on Level of Task Performance by Primary Health Care Workers in Enugu State." *British Journal of Applied Science and Technology* 13 (6): 1-6.