

Ward Health System in Nigeria: An Assessment of the Awareness and Role of Community Members

Ifeoma Anne Njelita^{1,*}, Patrick Anibbe Ikani², Chinyerem Cynthia Nwachukwu¹,
Ifeyanyi Gabriel Eyisi¹, Chijioke Amara Ezenyeaku³,
Chigozie Ozoemena Ifeadike³, Chukwudi Uchenna Njelita⁴

¹Department of Community Medicine and Primary Health Care, Chukwuemeka Odumegwu Ojukwu University, Awka, Nigeria

²Institute of Strategic Communication, Development and Innovation (ISCODI), Abuja, Nigeria

³Department of Community Medicine and Primary Health Care, Nnamdi Azikiwe University, Nnewi, Nigeria

⁴Anambra State Primary Health Care Development Agency (ASPHCDA), Awka, Nigeria

*Corresponding author: ifeomanjelita@yahoo.co.uk

Received January 05, 2023; Revised February 13, 2023; Accepted February 21, 2023

Abstract Ward Health System is an implementation strategy of Primary Health Care in Nigeria. It was introduced in 2001 and is aimed at promoting community mobilization and participation in health care, thereby enhancing an effective, efficient and sustainable health care system. This study assessed the awareness and role of community members in the Ward Health System. A semi-structured interviewer administered questionnaire was used to conduct an exit poll of 240 Primary Health Care facility clients. Approximately 12%, 13% and 29% of the respondents had ever heard of the terms Ward Health System, Village Development Committee and Ward Development committee respectively, while up to 73% have no idea of the role of any of the stakeholders. Inadequate knowledge and involvement of the community members in the Ward Health System constitutes a big challenge to the effective and efficient implementation of Primary Health Care in Nigeria. Efforts towards community education on Ward Health System should be intensified.

Keywords: ward health system, primary health care, community members, stakeholders

Cite This Article: Ifeoma Anne Njelita, Patrick Anibbe Ikani, Chinyerem Cynthia Nwachukwu, Ifeyanyi Gabriel Eyisi, Chijioke Amara Ezenyeaku, Chigozie Ozoemena Ifeadike, and Chukwudi Uchenna Njelita, "Ward Health System in Nigeria: An Assessment of the Awareness and Role of Community Members." *American Journal of Biomedical Research*, vol. 11, no. 1 (2023): 1-6. doi: 10.12691/ajbr-11-1-1.

1. Introduction

The report of the international conference on Primary Health Care (PHC) in Alma Ata, USSR in 1978, popularly referred to as 'Declaration of Alma Ata' set the background for a new vision of health development based on equity and social justice [1]. It strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right whose realization requires sustained Inter-sectoral collaboration [2,3]. It proposed that health systems should be designed based on the concept of PHC to enable the achievement of the goal of 'Health for All' [1,4]. PHC is a practical approach to making essential health care universally accessible to individuals and families in their community in an acceptable and affordable way, with their full participation [2,4,5,6,7].

Nigeria has made two failed attempts in 1976 and 1986 to implement and sustain PHC [3,4,5,8,9]. The failures were attributed to inadequate community participation, inter-sectoral collaboration, self-reliance and use of

appropriate technology [3,4,5,8,9]. The community members were mainly passive recipients and visualized the program as government's own with virtually no form of contribution or participation. The communities looked to the government to do everything for them with a very deep sense of 'entitlement'. Community participation was virtually non-existent in the two previous failed attempts. At the end of these failed attempts, the achievements made rapidly deteriorated or disappeared completely [8].

In view of the massive dilapidation of the nation's health system, the National Primary Health Care Development Agency (NPHCDA) was given a fresh mandate to revitalize the PHC system in Nigeria, bearing in mind that it is the cornerstone of the national health system [8]. The NPHCDA, in response to the World Health Organization (WHO) review in 1992 which stated that community mobilization would be greatly enhanced if the boundaries of the health district were the same as the electoral ward which elects a councillor to the Local Government Area (LGA), introduced the Ward Health System (WHS) in 2001 [8,9]. This represents the third national attempt at implementing PHC in Nigeria. The political wards were adopted as the units of operation for the implementation of PHC programs. The LGA-Ward-

Community/Village structure, therefore replaced the LGA-District-Community/Village structure [5,8].

The ward is the lowest political unit in Nigeria [8,10]. It is a geographical area with a population range of 10,000 to 30,000 people [10]. There are 8,812 political wards in Nigeria [3]. The wards are represented by democratically elected councillors at LGA level [8,10]. The goal of the WHS is to improve and ensure sustainable health services with full participation of people at the grass root level [8]. The objectives of the WHS [8] include to promote active community participation at the grass root level for sustained effective and efficient delivery of PHC services; to improve access to quality health care and concurrently ensure equity; to promote indigenous initiatives and encourage poverty alleviation activities at the ward level; to mobilize and reinforce political commitment to PHC at the ward level; and to reduce morbidity and mortality with emphasis on women of reproductive age and under-fives. The Alma Ata declaration emphasizes that full community involvement is a pre-requisite for a successful delivery of effective and efficient PHC services. A most vital aspect of the multi-sectoral approach of PHC is the involvement and participation of every community in the decision-making process for any health action in the community, their commitment to the decisions so taken and their active contribution to the management, supervision and monitoring of the services provided by the health workers of their LGAs. The Alma Ata declaration says "The people have a right and duty to participate individually and collectively in the planning and implementation of their health care" [2,9]. When there is community ownership, community members identify their felt needs and seek technical assistance from the experts, this approach, aids them to monitor the resources and services of their health care providers and PHC facilities within their communities [9].

In recognition of the foregoing, the management structure of the WHS is mostly community-based [5,8,10,11]. It consists of the Ward Development Committee (WDC) at the ward level and the Village/Community Development Committee (VDC/CDC) at the village level [8]. The WDC has a direct link with the LGA PHC management committee [8]. The VDC is composed of an elected Chairman, a secretary, representatives of religious groups, women's groups, occupational groups, non-governmental organisations (NGOs) among others [5]. The WDC is made up of an elected Chairman, Chairmen of each VDC in the ward, a secretary, community development officer and head of health facilities in the ward [5,8,10]. In some instances, the committee may consist of additional people like school Principals and Headmasters, agricultural extension workers, representatives of non-governmental organisations (NGOs) and some occupational groups among others [5,10].

The roles and responsibilities of the VDC include [5]; identification of health and health related needs in the village; planning for the health and welfare of the village; identification of locally available human and material resources and appropriately allocating them to PHC programmes; supervision of the implementation of PHC work plan; monitoring and evaluation of the progress and impact of the implementation of health activities; selection of appropriate persons within the community to be trained

as Village Health Workers (VHWs) or Traditional Birth Attendants (TBAs); supervision of the activities of the VHWs/TBAs, including review of monthly work record; remuneration, in cash or in kind, of the VHWs; agreeing with the VHW the number of hours he/she should work per day; establishment of a village health post where none exists and forwarding of local community health plan to the ward level.

The roles and responsibilities of the WDC include [5,8,10,12]; identification of health and social needs of the ward and planning solutions to them; supervision of the implementation of developed work plans; identification of locally available human and material resources required to meet the needs of the ward; forwarding all health development plans of the entire ward to the LGA; mobilization and stimulation of active participation of the people in the planning, implementation and evaluation of projects; supervision and monitoring of the activities of the VHWs, TBAs and CHEWS; provision of regular feedback to the communities on all matters; liaison with government, NGOs and other partners in the implementation of health programmes and supporting the establishment of health facilities and overseeing their functions.

The LGA PHC management committee comprises the [5]; the Chairman of the LGA (Chairman); Supervisory Councillor for health; the LGA secretary; LGA PHC Coordinator (Secretary); the Medical Officer in-charge of the secondary health facility in the LGA; the most senior CHO in the LGA; Chairmen of the various WDC in the LGA; the community development officer for the LGA; Heads of other health-related departments in the LGA (Education, Agriculture, etc.); representatives of International Organizations having PHC programmes in the LGA; representatives of health-related occupational groups and representatives of NGOs, women/youth groups and religious groups.

The WHS is a people oriented program, where the health care of a community should be the collective responsibility of the community members not only the health care provider and the government. Over two decades after the institution of the WHS, in addition to the paucity of research on this subject, it is very crucial to ascertain the knowledge of the community members and their role in the WHS. This study therefore determined the knowledge and role of PHC facility clients in the WHS.

2. Materials and Methods

2.1. Description of Study Area

This study was carried out in Anambra State which is one of the five States in the South-east geopolitical zone of Nigeria. It has a total land area of 4,416 square kilometres and is situated on a generally low elevation on the eastern side of the River Niger [13]. It has a population of 4,177,828 with 62% of the population resident in the urban areas of the State, making the State one of the most urbanized state in Nigeria [14]. Anambra State is made up 3 Senatorial zones, 21 local government areas (LGAs), 330 wards and 177 communities, with the capital at Awka [13]. Various categories of health facilities abound in the

State belonging to government, religious organisations and private individuals. These include teaching hospitals, general hospitals, primary health care centres and maternity homes.

2.1.1. Study Design

This was a descriptive cross-sectional study that utilized a semi-structured interviewer administered questionnaire, developed from the NPHCDA hand book on the WHS, to obtain information from the facility clients in selected PHC facilities.

2.1.2. Study Population

The study population consisted of clients that assess health care services at the PHC facilities in the LGAs in Anambra State.

2.1.3. Sampling Technique

A multistage sampling technique was used to select six LGAs from the study State (three urban and three rural LGAs). Five wards were also selected from each of the six LGAs. Ten health facilities were selected from each of the six LGAs. Anambra State administratively, comprises twenty-one LGAs across three senatorial zones.

Firstly, the component LGAs of each senatorial zone was categorized into urban and rural LGAs. Simple random sampling technique applying the balloting system was used to select the six LGAs. Thus, one rural and one urban LGA were selected from each of the three senatorial zones in Anambra State.

The next step in the sampling process involved the listing of the component wards that make up each selected LGA. With the aid of balloting, five wards were selected from each of the selected LGA. A total of thirty wards were selected.

Finally, the PHC facilities in each selected ward were listed, and with the aid of balloting two PHC facilities were selected per ward. A total of sixty (60) PHC facilities were selected for this research.

Exit interview was conducted with four (4) facility clients in each of the sixty (60) selected PHC facilities. The facility clients were selected by convenience sampling. A total of 240 respondents were interviewed.

2.1.4. Data Entry and Analysis

Data collected were entered into and analysed with the aid of the computer software: SPSS version 20 after verification and consistency checks by the investigator. Frequency distribution of all relevant variables was represented in tables for easy appreciation. Relevant means and standard deviations were calculated.

2.1.5. Ethical Considerations

Ethical clearance and approval for this study was sought and obtained from the Chukwuemeka Odumegwu Ojukwu University Teaching Hospital (COOUTH) Health Research Ethical Committee. Permission to conduct the study was also obtained from the Anambra State Primary Health Care Development Agency (ASPHCDA). Informed consent was obtained from the respondents and participation was voluntary.

3. Results

Table 1. Socio-demographic characteristics of PHC facility clients, 2022

Variable	Frequency (n = 240)	Percent
Age (years)		
25 – 34	43	17.9
35 – 44	86	35.8
45 – 54	63	26.3
55 – 64	32	13.3
>64	16	6.7
mean±SD	45.14±11.254	
Gender		
Male	34	14.2
Female	206	85.8
Marital status		
Never married	10	4.2
Currently married	120	50.0
Separated	31	12.9
Divorced	15	6.3
Widowed	58	24.2
Cohabiting	6	2.5

A total of 240 health facility clients took part in the study. The ages of the respondents ranged from 25 – 80 years while the highest proportion of respondents (35.8%) was aged 35 – 44 years. Over 85% of the respondents were females with majority (50.0%), currently married.

Table 2. Knowledge of WHS by PHC facility clients I, 2022

Variable	Frequency (n = 240)	Percent
Ever heard of WHS?		
Yes	29	12.1
No	211	87.9
Ever heard of VDC?		
Yes	32	13.3
No	208	86.7
Functions of VDC		
Don't know	210	87.5
They are in charge of the PHCs	5	2.1
Ensure proper development & management of PHCs	19	7.9
Ensure active community participation in development process	6	2.5
Ever heard of WDC?		
Yes	70	29.2
No	170	70.8
Functions of WDC		
Don't know	175	72.9
Provision of basic amenities in the PHCs	18	7.5
In charge of the affairs of the PHCs	26	10.8
Serve as a link between the community & the PHCs	2	0.8
Assist in the development & maintenance of the PHCs	15	6.3
Ensure community involvement in health issues	4	1.7

A small proportion of respondents have ever heard of WHS (12.1%) and WDC (29.2%). Most of the respondents do not know the functions of the WDC.

Table 3. Knowledge of WHS by PHC facility clients II, 2022

Variable	Frequency (n = 240)	Percent
Ever heard of LGA PHC management committee?		
Yes	4	1.7
No	236	98.3
Functions of LGA PHC management committee in the WHS		
Don't know	236	98.3
Supervision of PHCs within their LGA	4	1.7
Role of the Federal government in the WHS		
Don't know	239	99.6
Provision of vaccines for immunization	1	0.4
Role of the State government in the WHS		
Don't know	239	99.6
They employ mid-wives	1	0.4
Role of the Local government in the WHS		
Don't know	238	99.2
Provision of financial support to the PHCs	1	0.4
Post nurses to various PHCs	1	0.4
Ever attended a VDC meeting?		
Yes	16	6.7
No	224	93.3
Ever attended a WDC meeting?		
Yes	27	11.3
No	213	88.8

Almost all the respondents do not know the roles of the federal, State and local governments, as well as the LGA PHC management committee in the WHS. Very few of the respondents (11.3%) have ever attended a WDC meeting.

Table 4. Knowledge of manpower requirement for the WHS by PHC facility clients, 2022

Variable	Frequency (n = 240)	Percent
Cadre of staff that should work in PHCs		
Medical officers	1	0.4
Community health officers	47	19.6
Community health extension workers	115	47.9
Junior community extension workers	96	40.0
Nurse/Mid-wives	208	86.7
Laboratory technicians	0	0.0
Community based Health workers		
Village health workers	110	45.8
Traditional birth attendants	133	55.4
Functions of village health workers		
Identify simple health problems in the community	3	1.3
Provide basic health care services in the community	10	4.2
Assist in the development of the PHCs	2	0.8
Assist in provision of basic health care services in the PHCs	102	42.5
Mobilizing the villagers for health care services	22	9.2
Managing the affairs of the PHCs	3	1.3
Don't know	98	40.8
Functions of traditional birth attendants		
Conducts labor & delivery services in the community	103	42.9
Don't know	86	35.8
Health education of pregnant women	48	20.0
Provide herbal treatment to pregnant women	3	1.3

Only 0.4% of respondents were of the opinion that medical officers should be part of the staff that work in PHCs. Almost half of the respondents said that village

health workers work in the PHCs (42.5%) and the TBAs conduct labor & delivery services in the community (42.9%).

4. Discussion

Up to approximately 12% of the surveyed PHC facility clients had ever heard of the WHS. In addition to this, only 13.3% and 29.2% had ever heard of VDC and WDC respectively. Given that a minute proportion of the respondents had ever heard of the VDC and the WDC, one begins to wonder how the members of these committees were selected or appointed and if the community members were even aware of the selection process. As much as 87.5% and 72.9% of facility clients do not know any function of VDC and WDC respectively. This finding is a cause for worry as the facility clients, being a part of the community, are potential members of the VDC and WDC. If and when they become members of these committees, they will not be able to function optimally thereby impacting negatively on the output of the committees.

The current National health policy recognized and allocated roles to the three tiers of government namely; the local government to be the key implementer of PHC policies and programs, the state government to provide logistic support to the local government and the federal government to formulate overall policy [15,16]. Almost all (over 99%) of the PHC facility clients do not know the roles of the local, state and federal governments in the WHS. This is similar to the finding in a study conducted seven years after the onset of the WHS in Nigeria that a high percentage of the key actors in the WHS were poorly informed [9].

A very low proportion of the PHC facility clients had ever attended a WDC and VDC meeting (11.3% and 6.7% respectively). It appears the VDCs are almost non-existent or not fully operational as the WDCs. This is despite the fact that formation of VDCs is a mandatory step before the formation of WDCs [9]. The chairmen of each VDC in a ward are statutory members of the WDC, making the formation of VDCs a very important prerequisite for the establishment of the WDCs. Observations in the course of this study showed that mostly the WDCs were functional. The low proportion of PHC facility clients' involvement in VDC/WDC meetings could be attributed to the fact that over 85% of them were females giving that males were more likely to be involved in WDC meetings [12]. This could be attributed to the prevalent socio-cultural practice whereby the females require permission from their husbands or head of households to be involved in such committees besides, they are also fully involved in the care of the children, coupled with other responsibilities at home.

Less than 1% of the respondents were of the opinion that medical officers should be part of the PHC staff. In contrast to this finding, approximately up to 20% and as much as 87% of the PHC facility clients were of the opinion that CHOs, CHEWs, JCHEWs, and nurse/midwives should be part of the staff at the PHC facilities. This discovery is quite anticipated and could be attributed to the fact that majority of the PHC staff are either community health extension workers or nurse/mid-wives who they now perceive to be the usual staff in PHC facilities. VHWs and TBAs are community-based health care providers that live and work within their communities. The ideal functions of VHWs include mobilizing their communities for development actions, providing treatment

for simple ailments, keeping of simple records and identification of persons with serious health issues for referral purposes amongst other roles in the community [4]. In contrast to these functions of the VHWs, majority (42.5%) of facility clients affirm VHWs work in the PHCs assisting the facility-based health workers to provide basic health services to the community, even as 40.8% of them do not know any function of VHWs. The TBAs, ideally, handle most of the labour and deliveries in their community, identify pregnant women who are at risk for complications and refer, keep simple records, counsel/educate pregnant women on family planning, immunization and nutrition among other duties [4,8]. Approximately 43% and 20% of the PHC facility clients correctly identified taking deliveries in the community and education of the pregnant women respectively as the duties of the TBAs, while over 35% were not aware of the duties of the TBAs.

The level of knowledge and awareness displayed by the PHC facility clients, who are community members and as such are one of the primary actors in the implementation of the WHS, was very poor. The WHS has been in operation for over twenty decades in Nigeria and majority of the facility clients were neither aware of its existence nor that of the VDCs and WDCs. This is unacceptable as well as worrisome, throwing up far more questions than answers. The community members are key stakeholders in the implementation of WHS and when they are knowledgeable and fully mobilized they become active participants, taking ownership of the program, instead of passive recipients. This will ensure that the community actively participates in the planning and implementation of their health care services, leading to them demanding accountability from their health care providers and sustainability of implementation in accordance to their level of development.

5. Conclusion

The awareness level and role in WHS of the PHC facility clients, who are members of the community, were far below the expected for a program that has been in existence for over two decades. Community education with the provision of adequate information on WHS should be embarked on promptly to ensure wholesome community participation and ownership in health care delivery at the grass root.

Declaration of Conflicting Interests

The authors declare there is no conflicts of interest with regards to the research, authorship and publication of this article.

Funding

The authors did not receive any funding from any source for the research, authorship and publication of this article.

List of Abbreviations

CDC – Community Development Committee
 CHEW – Community Health Extension Worker
 CHO – Community Health Officer
 JCHEW – Junior Community Health Extension Worker
 LGA – Local Government Area
 NPHCDA – National Primary Health Care Development

Agency

TBA – Traditional birth Attendant
 VDC – Village Development Committee
 VHW – Village Health Worker
 WDC – Ward Development Committee
 WHS – Ward Health System

References

- [1] Health Reform Foundation of Nigeria, *Nigerian Health Review, 2007; Primary Health Care in Nigeria: 30 years after Alma Ata*, National Library of Nigeria Cataloguing-in-Publication Data, 2008.
- [2] Lucas, A. O. & Gilles, H. M., *Short Textbook of Public Health Medicine for the Tropics (4th edition)*, Arnold Publishers London, 2003, ch. 10 pp. 300-306.
- [3] Abosede, O.A, and Sholeye, O.F, Strengthening the Foundation for Sustainable Primary Health Care Services in Nigeria, *Primary Health Care*, 4(3): 167. 2014.
- [4] Obionu, C.N, *Primary Health Care for Developing Countries (2nd edition)*, Delta Publications Nigeria Limited, 2007.
- [5] NPHCDA, *Operational Training Manual and Guidelines for the Development of Primary Health Care System in Nigeria*, Abuja, 2004.
- [6] Park, K, *Textbook of Preventive and Social Medicine (23rd edition)*, M/s Banarsidas Bhanot Publishers India, 2015, ch. 21 pp. 890-895.
- [7] Rahim, A, *Principles and Practice of Community Medicine (1st edition)*, Jaypee Brothers Medical Publishers(P) Limited India, 2008, ch. 4 pp. 23-24.
- [8] NPHCDA, *Introduction to the Ward Health System*, Abuja, 2006.
- [9] Abosede, O.A, Campbell, P.C, Olufunlayo, T, and Sholeye, O.O, Establishing a Sustainable Ward Health System in Nigeria: Are Key Implementers Well Informed? *J Community Med Health Educ*, 2: 164. 2012.
- [10] NPHCDA, *Ward Minimum Health Care Package 2007-2012*, Abuja, 2007.
- [11] Banigo, I.G, Roles of LGA, State, FMOH, NPHCDA in Implementation of PHC. *The Road, Quarterly News Magazine of PHC in Nigeria*, 13-15, Sept.2001.
- [12] Ezinwa, A. D, The Role and Challenges of Ward Development Committees in Promoting Grassroots Health Awareness in Ogun State Nigeria. *IOSR Journal of Business and Management*, 19(7): 41-48. 2017.
- [13] Ministry of Health, *Anambra State Strategic Health Development Plan 2010-2015*, 2010.
- [14] National Bureau of Statistics, Legal Notice On Publication of 2006 Census Final Results. *Federal Republic of Nigeria Official Gazette*, 96(2), 2009.
- [15] Uzochukwu, B.S.C, *Primary health care systems (PRIMASYS): case study from Nigeria*. Geneva: World Health Organization, 2017.
- [16] Federal Ministry of Health, *Revised national health policy*. Abuja, 2004.



© The Author(s) 2023. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<http://creativecommons.org/licenses/by/4.0/>).