Establishing a Sustainable Ward Health System in Nigeria: Are Key Implementers Well Informed?

Abosede OA1, Campbell PC2, Olufunlayo T3 and Sholeye OO*1

1Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria
2College of Medicine, Lagos, Nigeria

Abstract

In response to World Health Organisation recommendation that “community mobilization would greatly be assisted if the boundaries of the health district are the same as the electoral ward which elects a councillor to the LGA”, the Federal Government of Nigeria re-vitalized the National Primary Health Care Development Agency (NPHCDA) and introduced the Ward Health Service (WHS) system in the Year 2000. This study identified one of the major reasons why the WHS was still not well established.

Objective: The objective was to determine and document gaps in the knowledge of the key implementors on WHS.

Methodology: A self-administered multiple choice questionnaire was administered to a total of 955 participants including 200 Primary Health Care Coordinators and 200 Zonal Technical Officers (ZTOs) of the NPHCDA in the 6 health zones of the country, 255 final year medical students of the College of Medicine, University of Lagos and 300 Community Development Committee/Association members. Five years after, the same instrument was administered to 139 Primary Health Care providers of Lagos State.

Result: The medical students were the most informed, 76.5% scoring above the cut-off mark of 50% but only 9.8% above 70%. Of the Medical/Community Health Officers, ZTOs (75.5%) were better informed than the PHC Coordinators (72.3%). Community leaders were the least informed; none of them having adequate knowledge about the WHS and therefore all scoring below the cut-off mark.

Conclusion: Inadequate stakeholder mobilization remains a major problem of Nigeria’s primary health care system. For effectiveness and sustainability, rigorous effort directed to this is urgently needed.

Keywords: Ward health system; Primary health care

Introduction

Reviews of Nigeria’s previous attempts at developing the National Primary Health Care system indicated that the main problems, among others, were inadequate community mobilization and participation, inadequate orientation of the health manpower, and inequitable distribution of resources [1,2]. The 1978 – 1983 Basic Health Service Scheme models never fulfilled their purpose. A very important reason why they were not sustained was the poor and ineffective participation of the community in the provision of the services. As a result, most of the equipment provided for static facilities was carted away by hoodlums, rendering the latter inefficient.

The current models are derived from the prototype under-fives clinic developed by David Morley in Imesi-ile, Osun State, in the fifties and sixties that became famous all over the world. That clinic prototype was further developed by the Institute of Child Health of the University of Lagos to provide maternal services, family planning and adult care. Mechanisms were instituted in the clinic for ensuring the quality of the care provided. For example, the patient’s waiting time was reduced to the barest minimum by using home-based records and pre-packed drugs, for ensuring that care procedures were carried out according to standard practice and that the child got all the preventive and curative measures due to him/her at that visit at the “Exit Table”.

The second attempt (1986 – 92) propagated the modified prototype and assisted communities to form Village or Community Development Committees (VDCs or CDCs) in rural and urban areas respectively. The main problem again was that the communities saw the projects as government owned properties and paid little or no attention to their sustenance [3].

Community participation

Community participation is the process by which individuals and families assume responsibility for their own health and for those of the community and develop the capacity to contribute to their and the community’s development [4].

The first experience of PHC development in Nigeria indicated tokenism with regards to community participation. The “do to” and “do for” approaches were used by the government. This must have contributed to a general euphoric state of expecting government to “do everything”, a situation the second attempt failed to overcome. Evaluating PHC throughout the community in 1992, Ransome-Kuti observed that this was gradually changing to a state of realism and communities were beginning to contribute resources. "In my journeys throughout Nigeria, I have seen the results of these efforts, especially at the community level, manifested in renewed enthusiasm for primary health care projects, buildings, equipment, other material and human resources are now donated by communities for primary health care work. This momentum must be expanded and sustained” [5].

*Corresponding author: Sholeye OO, Olabisi Onabanjo University Teaching Hospital, Sagamu, Nigeria, Tel: +23480886177954; E-mail: folasholeye@yahoo.com

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From the 1980s, countries, like Sri Lanka that are not as developed as the United Kingdom but who have adopted the Alma Ata declaration of 1978 show that health status and quality of life have improved markedly, one of the major reasons being committed participation of communities and more responsibility for their own health [6,7].

The Alma Ata Declaration (iv) says “The people have a right and duty to participate individually and collectively in the planning and implementation of their health care”.

When there is community ownership, communities identify their needs and seek technical assistance from the experts. Adopting a “do by” themselves approach, they monitor the resources and services of their health care providers and facilities [8,9].

Self reliance

Self reliance means using what you have to get what you want and this is fully embraced by primary health care.

"Primary Health Care requires and promotes maximum community planning, organization, operation and control of PHC, making fullest use of local, national and other available resources and to this end, develops through appropriate education, the ability of communities to participate ---“ [10].

It is encouraged by various declarations and the Nigeria National Health Policy [11] but measures have to be taken to ensure enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of the people, individuals, families and communities assume greater responsibility for their own health and welfare.

The ward health system

In the past, Nigeria like many other developing countries, especially in sub-Saharan Africa also operated the District Health System but in the later, there was no clear demarcation of the “district”, as all LGAs carved themselves into what they perceived as districts. The entire LGA was considered then as the functional unit and there was no uniformity [12].

Therefore, in response to WHO recommendation of 1992 [13] that “community mobilization would greatly be assisted if the boundaries of the health district are the same as the electoral ward (10,000 to 30,000 people) which elects a councilor to the LGA”, the Federal Government of Nigeria re-vitalized the National Primary Health Care Development Agency (NPHCDA) and introduced the Ward Health System (WHS). So, instead of the “LGA-District/Village” structure, the “LGA-Ward-Community/Village” structure was adopted in December, 2000.

That year, the Federal Ministry of Health (FMOH) provided the resources to build 200 model Ward Health Centers to be sited in wards that had no health facility in the 6 health zones of the country. This was an opportunity to develop a health system in the ward around the health centers. This was also the next attempt by the nation to build standard national health centers throughout the country as part of the development of its PHC services. The Government identified PHC as the only panacea for health problems in Nigeria [14]. Based on this, the President of the then democratic era, in the 2001 Appropriation Bill, mandated the NPHCDA to facilitate the construction of 200 health centers across the country which will be the fulcrum for the implementation of PHC.

By the end of the Year 2003, a model health centre had been handed over to their Ward Development Committees (WDC) for supervision. This was a major departure from previous practice and a giant step towards community ownership.

Five years after the commencement of activities for the third attempt, apart from the commissioning of model facilities, service utilization, communities’ response and participation were still below expectation [15]. Some facilities were locked up after commissioning and non-staffing of community Health Posts by Junior Community Health Extension Workers (JCHEWs) remained a major constraint. Several JCHEWs had been trained but they were not employed by their LGAs. Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs) who were trained during the first two attempts had either died or abandoned their community-based activities [16]. Abandoning of community functions has been attributed to long periods of no supervision resulting from real financial constraints or the culture of “inadequate funds” of those that had been accustomed to previous years of abundant funding [17].

Two of the 375 wards in Lagos State were among the first set of the national 200 models.

Seven years after WHS operation in Lagos State, it was expected that all the primary health care providers would have been well informed about the WHS.

Justification of the study

Three years after the inauguration of the Ward Health System (2000 to 2003), reports from model wards to the NPHCDA indicated that implementors were still not clear about the process and some communities had not formed their Ward Development Committees. Gaps in knowledge needed to be identified and addressed before scaling up to cover more wards nationally. Four years later (2007), the same problem was suspected, necessitating an investigation on the knowledge of key players in the implementation of the WHS in Lagos State.

Methodology

A pre-designed, self-administered 100 item questionnaire was pre-tested on 5 zonal Technical Officers based in Abuja NPHCDA Head Office. The instrument tested:

1. the concept of the Ward Health Services and its attributes;
2. the functions of stakeholders and how they are to be carried out;
3. the steps for developing the WHS and
4. Relation of services to the Ward’s Programme Implementation Plan.

Participants were drawn from attendees of a fact finding workshop on WHS organized by the NPHDA in the Year 2003, final year medical students of the College of Medicine of the University of Lagos, who would be implementors in the next two years (National Youth Service Corps).

Participants comprised two sets, the first of which was assessed three years after onset of implementation and the second set seven years after.
The first set in the Year 2003 comprised four groups:

1. The NPHCDA Zonal Technical Officers (ZTOs)
2. PHC Directors of LGAs.

The above were from all the 200 model wards located in LGAs from the six health zones. They were key implementers from the onset of the re-organization for WHS (2000 – 2003), who had all attended, in addition to previous trainings, re-orientation workshops on WHS organized by the NPHDA in the Year 2002.

3. Final year medical students of the College of Medicine, University of Lagos (CMUL), 2002 / 2003 session, who would be implementors in another two years.

4. CDA members of Ogun and Lagos State LGAs community leaders of the University practice communities.

The second set, comprised 139 Primary Health Care providers from the 20 original LGAs of Lagos State.

First set, Year 2003: Groups 1 & 2 - Before presentations at each one-day training workshop in the 6 geopolitical zones, a 100 item multiple choice questionnaire was used to test the knowledge of 200 Primary Health Care Coordinators of model LGAs and 200 Zonal Technical Officers (ZTOs) of the NPHCDA.

Group 3 - 255 final year medical students, after an eight weeks course on the Principles and Practice of Primary Health Care were tested with the same instrument.

Group 4 – A total of 300 Community Development Committee/Association members of the University practice communities in Ogun and Lagos states were tested with the same instrument in their various communities during the students’ community Diagnosis Exercise.

Second set, Year 2007: One hundred and thirty-nine (139) Primary Health Care providers of Lagos state were asked questions on the same 100 item questionnaire before training at a one-day workshop organized by the State Ministry of Health. For each group (13 Medical Officers of Health/Medical Officers, 55 Community Health Officers/Community Health Workers, 9 Chief/Senior Nursing Officers, 31 Community Health Extension Workers and 27 other cadres in Primary Health Care) scores were calculated and gaps in knowledge were identified.

They were assessed on their knowledge of the Ward Health System and in response to a needs assessment questionnaire; they identified areas on which they wished to be trained.

Informal interview

Information about sources from which participants had obtained information on the WHS was ascertained through interviews.

Results

Knowledge of the concept of the ward health services and its attributes, 2003

The medical students were the most informed of all groups, with 76.5% of them scoring above the cut-off mark of 50% correct information on the WHS. The ZTO (75.5%) ranked second, having performed better than the PHC Coordinators (72.3%). No community leader (CDA/CDC member), whether of the old LGAs or the newly created LCDAs in Lagos state and the VDC/WDC members of the University practice communities in 2 LGAs of Ogun state, scored higher than the cut-off mark (Table 1).

Only 9.8% of the medical students and none of the other participants had over 70% of the required knowledge on the concept of the WHS and its attributes. Up to approximately 25% of each group of primary health care providers scored less than 50%.

Knowledge of the functions of stakeholders in WHS and how they are to be performed, 2007

None of the participants had more than 60% of expected knowledge of the functions of the stakeholders in WHS. All medical students had 50% to 60% while all the MOs, CHOs, CHEWs and CDA/CDC members had less than 50% of the expected knowledge (Table 2).

Knowledge of the steps for developing the WHS

All participants acknowledged the need for community mobilization and constitution of community committees. However, none of them was aware of the crucial step of formation of VDCs or CDAs/CDCs before WDCs.

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<th>Performance Level</th>
<th>Proportion (%)</th>
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<tr>
<td></td>
<td>ZTO</td>
</tr>
<tr>
<td>A</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>34 (30.9)</td>
</tr>
<tr>
<td>C</td>
<td>49 (44.5)</td>
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<tr>
<td>&lt; Cut-off (50%)</td>
<td>27 (24.5)</td>
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<tr>
<td>TOTAL</td>
<td>110 (100)</td>
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</table>

A = >70%, B = 60-70%, C= 50-60%

Table 1: Performance of Stakeholders on Knowledge of the Ward Health System, 2003.

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<thead>
<tr>
<th>Performance Level</th>
<th>Proportion (%)</th>
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<tbody>
<tr>
<td></td>
<td>Medical Officers</td>
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<tr>
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<td>0</td>
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<tr>
<td>B</td>
<td>0</td>
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<tr>
<td>C</td>
<td>13(100.00)</td>
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<tr>
<td>&lt; Cut-off (50%)</td>
<td>0</td>
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<tr>
<td>TOTAL</td>
<td>13(100.00)</td>
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</tbody>
</table>

A = >70%, B = 60-70%, C= 50-60%

Table 2: Performance of Stakeholders on Knowledge of the Ward Health System, 2007.
Relation of services to the ward’s programme implementation plan

Only the medical students and participants who had been trained by the NPHCDA could relate services rendered at the WHS to Action Plans developed by WDCs.

Sources of information on the WHS

None of the community leaders had heard about the new system; medical students during formal lectures on Primary Health Care; and PHC Coordinators / ZTOs during NPHCDA orientation trainings and on-the-job. No group mentioned hearing about the WHS on radio or television or reading about it in mass circulated printed materials.

Limitations

Being a retrospective study with participants who were not exposed at the same time or to the same information sources (formal or informal) or details, mean scores and significant differences could not be meaningfully compared.

Discussion

The fact that CDC/CDA members who take the lead in implementing health and developmental interventions had inadequate knowledge of the WHS, was a reflection of the past, when community involvement in PHC implementation had been a kind of tokenism [1,2]. Lessons from the past had not been effectively utilized and the direct and/or indirect impacts of this neglect are probably responsible even for the country’s current poor health development and unacceptable vital statistics (Infant, Under-five and Maternal Mortality Rates) [18]. When communities have adequate knowledge and are fully mobilized, they participate actively in the running of their PHC services. Service utilization and coverage improve and the indices for measuring the quality of health are better. In countries, like Sri Lanka health status and quality of life have improved markedly, one of the major reasons being committed participation of communities and more responsibility for their own health [19,20].

Nigeria’s primary health care system has potentials for effectiveness judged by the health worker/population ratio at this level. As at the Year 2006, one cadre alone (Community Health Extension Workers) had 117,568 (91/100,000 population) [20] functioning in the country. If health care providers, in addition to mass media efforts had educated community members, the community leaders’ knowledge in this study would probably have been much better. Mass education and mobilization is more necessary now than ever if the WHS is to be well used. Health information transfer should improve as fast as the proportion of Nigerians having access to communication media.

The PHC Coordinators and Zonal Technical officers who were to supervise and provide technical assistance for the establishment and implementation of PHC activities in their LGAs did not perform best among all groups. On the concept of the WHS and its attributes, only 9.8% of the medical students were the best informed group, and none of the other participants had over 70% of the required knowledge (Table 1). Reasons for not knowing the concept and attributes of the WHS may be the delay of the publication of national guidelines and accessibility to relevant information. For effective sustainability, stakeholders, especially community members must be fully involved and given adequate training on the modalities for operating the WHS.

Up to approximately 25% of each group of primary health care providers scored less than 50% yet these primary actors, PHC Coordinators of each LGA and their ZTOs are crucial to the success of the third national attempt. There is also the need for continuous education on the WHS for all cadres of PHC health team. A section of the 1992 Decree mandates the NPHCDA to accelerate and facilitate the implementation of PHC at the state and LGA levels [20]. The Agency provides this technical support through the ZTOs and it is the responsibility of the LGA PHC Coordinators to supervise the implementation of the WHS. They must know the concept of the WHS and the steps that should be adopted in its development and implementation. They need to fulfill their roles as providers of quality service and encouragers of community self-reliance in order to prevent some of the problems that had previously hindered the success of PHC in the country.

For a do-with approach, community members are crucial actors in the implementation of the WHS. They should be seen to work hand in hand and support the development committees in their environs to improve the quality of health, as in the case of Sri Lanka and some other developing countries, where community participation is reported to be effective [6,7,21-23].

Inclusion of training on the WHS in the medical and dental curricula is also an important strategy. The most likely reason why medical students performed best of all groups in this study is that they had been trained on the WHS as part of their PHC curriculum. As doctors and dentists who may be posted to work in the rural areas two years after qualification i.e. during their National Youth Service programme, they are a unique resource for community education and mobilization. Re-orientation on the WHS ought to be part of their orientation programmed in camps.

Conclusions

Even 7 years after its adoption, stakeholders (primary health care providers and community members) are not as knowledgeable as expected on the WHS.

Inclusion of training on WHS in the medical and dental curricula will prepare them appropriately for primary health care service in the country.

Recommendation

All stakeholders must receive adequate and continuous information on the WHS and the mass media should be optimally utilized to accomplish wide coverage.

References


10. Health For All By the Year 2000 (1978) WHO Report, paragraph 44.


