

How Ready are the Ward Development Committees to Facilitate Universal Health Coverage in Ebonyi State, Nigeria?

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Abstract

Background: The commitment to universal health coverage (UHC), requires a strong community-participation. In December 2000, Nigeria adopted the Ward Development Committees (WDC) as a framework to institutionalise community participation. WDC high performance is critical to making progress in UHC. This study aims to assess the efficiency of the WDC in fostering community participation and identify factors that hinder their performance in communities in Ebonyi State, Nigeria.

Methods: This study was a an analysis based on questionnaire, focus group discussions/key informant interviews, performed as controlled intervention study conducted in six rural communities in Ebonyi State, Nigeria. Assessment was done by gathering information from record books in the health facility, minute books of the WDC, and from the focus group discussions and key informant interviews using standard guides. Study participants included WDC members, health workers and the council of elders from the communities.

Results: WDCs existed in 7 (39%), 6 (25%) and 4 (29%) of the wards in Izzi, Ikwo and Ivo local government areas respectively. The WDCs' functionality was poor (score below 9 out of 36) in all the wards at the baseline assessment, and became fair (10 to 18 out of 36) after intervention in the intervention wards. However, the performance remained poor both before and after intervention in the control wards. Members of the WDC expressed dissatisfaction with the weak human and infrastructural resources at the health facility, and this demotivated them from efficiently performing their role despite the community- driven incentives introduced.

Conclusion: A major weakness has been identified in availability and efficiency of the WDC in all the communities studied. This is likely to compromise effective delivery of essential health care services. Therefore, urgent attention should be given to close the existing gaps in the national health systems to make the desired progress in the UHC possible in Nigeria.

Keywords: Community participation, Ward Development Committee, Universal Health Coverage

Background

In 1992, the Report of WHO Review Committee noted that “community mobilization would greatly be assisted if the boundaries of the health district are the same as the electoral ward (20,000 to 30000 people) which elects a councillor to the Local Government Areas (LGA) [1]. Sequel to this, the National Primary Health Care Development Agency (NPHCDA), established to strengthen the Primary Health Care (PHC) system in Nigeria, adopted the Ward Health System in December 2000 because it also has other advantages which include; increasing physical access to the communities; having an elected Ward Councillor that will expectedly be the political advocate of the people; in urban LGAs where social integration diminishes the importance of their village settlements, the ward health system provides an acceptable alternative for subdividing the LGA [1]. Because of the critical role of community participation in PHC management and sustainability, the NPHCDA instituted the Ward Development Committees (WDC), as a framework to institutionalise community participation [1,2]. They should usually be constituted by the NPHCDA as an independent body without political considerations and trained to function as representatives of the people in management and development of the PHCs.

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The WDC membership includes community representatives and their functions bridge the gap between the health facility and the community served as well as monitor the quality of services received by members of the community [1]. Through their activities, local resources in the community are harnessed making more human, financial and material resources available to the health centres [3]. The community is most likely to get more committed and take ownership of the health facility, and the overall effect will be improvement in quality and service coverage³. However, absence of functional WDCs in most Nigerian communities has made community participation difficult and contributed to ineffective PHC system and poor health care coverage in Nigeria [4-6].

The WDC composition, functions and operational modalities are well defined including that the members should not be on salary. It is expected that altruism will sustain them. But attrition of volunteers has been a major problem for services rendered by volunteers. This is because even though intrinsic factors such as altruism play a major role as motivators in volunteerism, studies show that there is always a need for extrinsic factors in order to ensure sustainability of the volunteers for a long time [7,8]. However, extrinsic factors such as regular wages is seen as financially unfeasible and a potential threat to the volunteers' social respect and thereby to their motivation [7]. The payment of sitting and transport allowances has been suggested [6,9] but, its effectiveness and importance is not clear. There is a need to identify appropriate and sustainable incentives to motivate the WDC members. Therefore, the aim of this study is to assess the effectiveness of the WDCs in enhancing community participation and facilitating quality service delivery and coverage, as well as to identify the factors that influence their efficiency.

Materials and Methods

Study area

The study was conducted in Ebonyi State in the South-East of Nigeria. It is bounded to the north by Benue State, to the west by Enugu State, to the east by Cross River State and to the south by Abia State. It has a total of 13 local government areas (LGA) and 171 wards in the three senatorial zones of the State. The population is 2,387,765 (projected from 2006 census).

Sampling method

A multistage sampling technique was used to select a total of six wards, including two each from three LGA. Thus from Izzi LGA in Ebonyi north senatorial zone, Ndieta ward was chosen as the intervention ward, while Iboko ward was chosen as control ward. From Ikwo LGA in Ebonyi central senatorial zone, Enyibichiri and Ndufu Echara were chosen as intervention and control wards respectively. From Ivo LGA in Ebonyi south senatorial zone, Amagu/Ihie and Obinagu wards were chosen as intervention and control wards respectively.

Study population

The study population included members of the WDCs, community leaders (i.e. the traditional rulers of the communities, their council of chiefs, chairmen of the village/community development unions) and the health care providers. The community/town union in this part of the country has a president and his cabinet members are usually elected by the village

parliament. They are the representatives of the people and play important role in community governance.

This study was a an analysis based on questionnaire, focus group discussions/key informant interviews, performed as controlled intervention study, conducted in three phases: pre-intervention, intervention and, post-intervention

Study instruments

Questionnaires: The WDC functionality was assessed using a standardised questionnaire. The number, frequency and time of the activities carried out by the WDC over a six month period before and after the study were assessed. The investigators and assistants were trained in the monitoring of these activities. The functions of the WDC as outlined by the NPHCDA were used as a check list to determine the activities carried out.⁵ These functions include: Identify health and social needs and plan for them; Supervise the implementation of developed work plans; Identify local human and material resources to meet these needs; Forward all health/community development plans to the LGA; Mobilize and stimulate active involvement of prominent and other local people in the planning, implementation and evaluation of projects; Play active role in the supervision and monitoring of ward's drug revolving fund; Raise funds for community programmes when necessary at village, facility and ward levels; Provide feedback to the rest of the community on how funds raised are disbursed; Liaise with government and other voluntary agencies in finding solutions to health, social and other related problems in the ward; Monitor activities at both the health facility and village level; Oversee the functioning of the health facility; Ensure that a bank account is opened with a reliable bank; Provide necessary support to village health workers (VHW)/community Resource Person and the community health extension workers (CHEWs); Monitoring equipment and inventory at monthly intervals; Ensure the proper functioning of the health facility. The committee is expected to meet monthly.

The efficacy of the WDC was determined by extracting information from the minute books and hospital registers, and performance of each function was scored by assigning between one to two points to each performed function in the pre and post intervention periods in line with a scoring scale developed for the purpose. For inventory of equipment, carrying out 2 inventories in the 6 months was accepted as the standard, giving a total of 2 points for the 2 inventory takings in the 6 months period. For the remaining 13 functions, carrying out any of them twice in the 6 months period was accepted as the standard for the period giving a total of 26 points in the 6 months for those 13 activities. All together this gave a maximum score of 36 points in the 6 months which was used as measure of functionality (Table 1).

The level of functionality was assessed based on the following grading according to the following scores: 1- 9 poor, 10-18 fair, 19-27 active, and 28-36 very active.

Focus group discussion and key informant interview guides: Focus group discussion (FGD) and key informant interview guides were developed specifically for this study was used to obtain information on knowledge of the function of the WDCs and their limitations from the WDC members themselves, the PHC workers and the community leaders. The first set of FGDs was conducted with eight members of WDC (the six

s/n	Activity/Item	Score per activity	Maximum core obtainable in six months
1	Availability of minute book	1	1
2	Monthly meeting	1	6
3	Account opening	1	1
4	Inventory of equipment	1	2
5	The other 13 activities	2	26
Total	Score for the 17 activities assessed		36

Account opening and availability of minute book was a one-time activity, scored 1 each for the six months period. All other activities were scored 1 per each activity performed for a maximum of 2 of such activities in the six months period.

Table 1: Scoring of WDC functionality.

executive committee members, and two others selected based on regularity to meetings) in each of the six wards. The second set of FGDs were conducted with eight members of the executive committees of the community/village development unions in the six communities studied and the third set with staff of the various ward PHCs in the six wards. Key informant interviews (KII) were conducted with each of the chairmen of the WDCs, the chairmen of the community/village development unions and the health facility heads. These were facilitated by the principal investigator using the appropriate instruments aided by a team of trained research assistants

The package of incentives which were agreed upon, and offered to the members of the WDCs by the communities, included entertainment during meetings, transport for meetings, money to open accounts and to purchase drugs for their campaigns, provision of T shirts.

Training of WDC members and health facility staff in the study communities: The information gathered during FGDs was also used to design refresher training for the WDC members and the health facility staff in the intervention communities. Only the WDC members were trained in the control wards. The training of the WDCs was on community participation in PHC management, the functions of the WDC and its benefits to the community. The health care providers in the intervention wards were trained on the functions of the WDC and their roles in community participation, as well as the role of health care providers in community participation in Primary Health Care Management. There were two days training in each intervention site, one for the health care providers and the other for the WDC members.

Intervention activities: Implementation of community-directed incentive package was through the following designed packages for the different study wards in the various LGAs, which were implemented during the intervention phase of the study:

Izzi LGA: The community leadership provided the sum of fourteen thousand Naira (N14, 000.00) to open an account with Izzi Microfinance Bank to help in running the committee; Entertainment during meetings with soft drinks and water, at N150.00 per person per meeting and any village hosting the WDC was required to provide food to them.

Ikwo LGA: Entertainment during meetings with light refreshment (at N100.00 per person per meeting); Purchase of drugs and other materials for their campaign activities with N20,000.00; Provision of transport money for their activities as the need arose. A total of N3000.00 was spent on transport within the period.

Ivo LGA: Entertainment during meetings with light refreshment at N200.00 per person per meeting. These incentives were implemented for six months. In the control wards there were no incentives implemented but the WDC members were given refresher training on their functions.

Follow-up: Monitoring the functionality of the WDC for the impact of the intervention was done by the same investigator using the same study instruments through a monthly examination of the minute books of the WDC in both control and intervention sites to ascertain meetings held, and to identify activities carried out using the previously described NPHCDA list of roles of the WDCs as a checklist.

Statistical analysis

The outcome measure in this study was the level of functionality of the ward development committees graded as poor, fair, active and very active. Data were presented in simple frequency tables and simple percentages and proportions calculated. The level of functionality of the WDCs in the intervention and control wards before and after intervention was scored and converted to percentages (where a score of 36 would be equal to 100%) and this was compared with each other in each LGA and any difference in the proportions was tested for statistical significance using the Chi Square Statistic. Significance was set at 95% Confidence Interval at $P < 0.05$. Ethical clearance for this study was obtained from the author's institution. Furthermore, written permission was obtained from the State ministry of health, while oral consent was obtained from all participants in the FGDs.

Results

Status and functionality of the ward development committees

In the three LGAs selected for the study, there were a total of 18 wards in Izzi, 24 wards in Ikwo and 14 wards in Ivo LGAs but only a smaller proportion of these had existing WDCs (Table 2). The functionality scores of the various WDCs as extracted from their minute books and graded according to the developed code showed that their functionality score was poor (score 1 to 9) at baseline in all the wards (Table 3). However, following the intervention, the score improved marginally, from poor to fair, but this was only in the intervention wards and was not statistically significant. Consequently there was no significant relationship between incentives and functionality of the WDCs in all the wards in the three LGAs (Table 4).

Factors affecting the functionality of the ward development committees

Poor understanding of the role of the WDCs by members, transportation difficulties experienced by WDC members in carrying out their duty, lack of entertainment during their

Local Government	With WDC No. (%)	Without WDC No. (%)	Total (%)
Izzi	7 (39)	11(61)	18 (100)
Ikwo	6 (25)	18(75)	24 (100)
Ivo	4 (29)	10(71)	14 (100)

Most of the Local governments no longer had the WDCs as earlier inaugurated by the NPHCDA years back.

Table 2. Availability of WDCs in the LGAs.

	Study ward			Control ward			X ² and p value
	Score(N=36)			Score(N=36)			
	Before intervention No. (%)	After intervention No. (%)	% increase in functionality	Before study No. (%)	After study No. (%)	% increase in Functionality	
LGA							
Izzi	7 (19.4) Poor	16(44.4) Fair	25	7 (19.4) Poor	4 (11.1) Poor	-8 (decrease)	X ² =3.38 P=0.06
Ikwo	4 (11.1) Poor	11(30.5) Fair	19.4	1(2.7) Poor	4 (11.1) Poor	8.4	X ² =0.09 P=0.07
Ivo	7(19.4) Poor	11(30.5) Fair	11.1	1 (2.7) Poor	4(11.1) Poor	8.4	X ² =0.61 P= 0.43

Functionality improved marginally from poor to fair after the intervention in the study wards while it remained poor before and after the study in the control wards

Table 3. Functionality of the ward development committees in the LGAs.

LGA	Ward	% increase in functionality	X ² and p value
Izzi	Study ward (incentivized)	25	X ² =3.38; P= 0.06
	Control ward (not incentivized)	8(reduction)	
Ikwo	Study ward (incentivized)	19.4	X ² =0.09; P=0.77
	Control ward (not incentivized)	8.4	
Ivo	Study ward (incentivized)	11.1	X ² =0.61; P= 0.43
	Control ward (not incentivized)	8.4	

There was no significant relationship between incentives and WDC functionality in all the wards studied.

Table 4: Relationship between incentives and WDC functionality in the various LGAs.

meetings, community members' poor understanding of their role in enhancing the functions of the WDCs, lopsided composition of the WDC membership, WDC members' perception that they are to discharge their functions from their homes at their convenience, WDC members' unwillingness to mobilize the community due to lack of doctors in the health facilities, lack of respect for members of the WDC by the community members, lack of work plan by the WDC, failure of the WDC to let the community leadership know their problems, lack of sitting allowance for the WDC members, perception of the community members that it is the government that should fund the WDC, lack of drugs in the health facilities, PHC workers' poor understanding of the role of WDCs in strengthening Primary Health Care service delivery, PHC workers' perception that WDCs would interfere with the work of health workers in an uninformed and unprofessional way. These factors were uniformly identified in all the wards and by all the people interviewed. For instance, concerning the role of WDC in promoting the work of PHC services delivery, one participant of the FGD in the intervention ward in Izzi LGA had this to say: "Our work is to tell the villagers to come and receive medicine in the clinic". Another participant in response to the question 'how can the WDC ensure proper functioning of the health centre said: "How can we go to teach them their job since we are not doctors.

We don't have that type of power and they will not even listen to us." All the members present concurred to this statement.

In the study ward in Ikwo LGA, participants in the FGD with WDC members also displayed the same level of poor understanding of their role. For instance, one participant said: "We cannot go to involve ourselves with the work of the health workers. It is not our duty; they are trained to do it". One of the community leaders had this to say concerning the functions of the WDC: "They are supposed to let people know what to do when they are not well and also to inform them when government is going to do immunization for children".

In the key informant interview with the traditional ruler of Amagu/Ihie ward in Ivo LGA, he had this to say concerning the functions of the WDC: "I do not see how the people can take over or get involved in the work of the government in providing health care which is solely the responsibility of government"

Most of the participants in the FGDs and respondents in the interviews in all the wards in the study area agreed that the WDCs had problems of lack of transportation for their work as well as lack of entertainment in their meetings. One participant in the FGD said: "Our work takes us to many places and we do not use water to move our motor cycles around, so we want government to provide transport or give us fuel money" In another group, a participant said: "Nobody gives us even water or kola during our meetings". In another ward, another participant said: "the Coordinator of the Local Development Centre promised to provide mobilization for us to go round like motor car or motor cycle, but where are they? We go for meeting and we will be hungry from morning till the end of the meeting. There is no water, or drinks, nothing". When asked if the community can do anything to help, there was a general laughter and the answer came thus: "The people are poor, nobody has money. It is the government's responsibility". These themes echoed in all the other FGDs with the other WDC members.

Lack of qualified health personnel such as doctors and nurses was mentioned as one of the limitations the WDCs face. In one FGD in the intervention ward in Ikwo LGA, one participant said: "Our people want to see a doctor. Nurses are not doctors but do what they were told to do. It is the doctor that gives the orders. How can we go to be mobilizing the community to come to the clinic when they are not going to see a doctor" Most participants agreed to this statement. In the control ward in Ivo LGA, one participant in the FGD said: "the health centre has no equipment and there is no

doctor, it makes it difficult to keep on mobilizing the community to make use of the facility, and some health centres are locked up and closed in the night” To this, all the other participants chorused: “it is true; it is the doctor that attracts the people to the hospital and people do not like to go to a hospital where there is no doctor and the place closed in the night”

Discussion

This study found that only a few of the Ward Development Committees inaugurated by the NPHCDA were still in existence in the study area. The incentives examined in this study did not significantly affect the performance of the WDC within the study period

The lack of WDCs in majority of the wards in our study area implies that community participation as envisioned by the NPHCDA will be difficult to implement in the study area leading to the loss of the associated benefits to the community. Various committees set up at different times to assess the state of PHC in Nigeria also found that most of the committees in various parts of the country were no longer in existence due to the lack of motivation and poor community support.^{4, 6} Also studies in other countries have demonstrated that attrition of volunteers is a major problem associated with sustenance of their work done [8-11].

The composition of the WDC membership in the wards did not conform with the guidelines by NPHCDA as none of the WDCs had any of the key local government health-related ministries staff (such as PHCN, agricultural extension and water board staff) and representatives of NGOs as members¹ Political considerations and patronage has also become a factor in the choice of WDC members.

The factors that affected functionality of the WDCs include poor understanding of their functions by both the WDC and the community members, lack of incentives, lopsided composition of the WDCs, absence of quality service in the health facilities (lack of skilled manpower, equipment and drugs), lack of 24 hours service in most facilities, poor understanding by the health facility staff of the roles of the WDC in PHC programmes and their hostile attitude towards the WDC members. It was also noted that the PHC facilities were closed to patients/clients anytime there was any programme involving the PHC workers in the local government headquarters. These findings are similar to the findings in Tanzania which found poor recognition and knowledge of functions of the PHC committees, dissatisfaction with the lopsided composition of the membership and shortage of health manpower as factors that affect the functions of the PHC committees [12].

The incentives that communities were able to give to WDC members in this study included: appreciating them during ‘Eze (chief)-in-council’ meetings, provision of transport allowance, and entertainment during meetings, provision of money to open account, and to buy drugs for campaigns. Surprisingly, the incentives offered in this study did not sufficiently motivate the WDCs in the study wards as functionality marginally improved in the study wards from poor to fair after the intervention while it remained poor in the control wards both before and after the intervention. This is likely to be related to the fact that the members of the WDC thought that their mobilizing the community will be

met by disappointment given the existing weakness in the human and infrastructural resources of the health facility. Therefore until such core components in a health facility such as doctors, 24 hours service rendering, medicines and equipment are provided, the members of the WDC saw no need to mobilize the community. Studies in other countries showed quite a number of other packages that motivate the volunteers such as celebration of volunteer days, uniforms, free health care for members, education and training, for members [7,8,12]. Perhaps the type of incentives provided in this study was not adequate. It could also be related to high level of poverty among the rural people in the communities where this work was carried out and their belief that health care provision is government’s responsibility. Similar work in more communities and for a longer period may be needed to further evaluate the impact of the incentives offered in this study.

The result of this study should be interpreted with caution realising that it is from only a few wards in one of the 36 states of Nigeria. Similar assessment in more wards and in more states of Nigeria are needed to have a national overview of the status of the WDC. Nevertheless, the fact that there was no WDC in majority of the wards and functioned poorly everywhere they existed are pointers that significant weakness exists in a major component of the drivers of good quality primary health care delivery services at community level, and this needs to be addressed urgently.

Conclusion

Majority of the previously established WDCs were no longer in existence in the communities, and where they exist, their functionality was poor. This is mainly related to the dissatisfaction of the WDC members with the persistent lack of human and infrastructural resources in the health facility in the community. Thus, a major defect in the management of the primary health care exists and compromises effective community participation for the effective delivery of essential health care services. Therefore, urgent attention required to close the existing gaps in the national health systems to make the desired progress in the UHC and SDGs agenda in Nigeria.

Recommendations

The researchers believe that the following recommendations, based on our findings, will be of great value in facilitating community participation and universal health coverage: man power needs assessment and consequent development, advocacy and mobilisation of the community members and the traditional institutions for ownership and investment in PHC and to specifically contribute in funding/motivating the WDCs, health care provider education on the concept of community involvement in PHC development, making more funds available to PHC through community based health insurance and the DRF managed by the community members through the WDCs.

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