

Stakeholders Knowledge on basic Primary Health Care structures in North-Western Nigeria; Implication for effective Primary Health Care implementation

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ABSTRACT

Background

Primary Health Care (PHC) is the bedrock of Nigeria's health system, however, more than 30 years after Alma-Ata the health indices in Nigeria are still poor. Village Development Committee (VDC) and Ward Development Committee (WDC) are managerial processes adopted to ensure community participation in PHC in Nigeria. When WDC members are knowledgeable about their roles, they can get the people involved in solving their own health problems.

Objective

To assess the knowledge of concept, functions, and forming WDC among community members, WDC members, and HCW.

Methods

A descriptive cross-sectional study design was used. A total of 420 community members were selected from Kudan LGA, using multistage sampling. Total populations were used for HCW and WDC members. Data collection was done using semi-structured interviewer-administered questionnaires and analysed using SPSS version 23. We determined the level of knowledge using a knowledge score.

Results

Majority (85% and 94.1%) of WDC members and HCWs had good knowledge of WDC. Less than half (47.9%) of the community members were aware of WDC, however, 57.7% of these had good knowledge of WDC.

Conclusion

This study has demonstrated a knowledge gap on WDC among various stakeholders. It is recommended that governments at various levels collaborate to provide training and raise awareness of WDC to achieve the aim of its establishment.

Keywords: Ward Development Committee, Knowledge, Stakeholders, Nigeria.

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INTRODUCTION

The concept of community participation was formally articulated during the international conference on Primary Health Care (PHC) at Alma-Ata in 1978 where it was identified as the cornerstone of PHC.¹ The failure of the Basic Health Service Scheme and the District Health System in Nigeria gave rise to the Ward Health System (WHS), in line with the World Health Organization's recommendation that the boundaries of health districts should be the same as the electoral ward for ease of community mobilization.²

In Nigeria the Village Development Committee (VDC) and Ward Development Committee (WDC) are managerial processes adopted to ensure community participation in PHC.^{1,3} The committees are established using participatory learning action (PLA). During these meetings, members who will serve on the committee are identified in keeping with the guidelines. They will then be trained by the facilitator about their roles and responsibilities.⁷

The committee members are selected by members of the community and at least 20% of members should be women, who should be given effective responsibility.^{2,8} The group is made up of people from diverse backgrounds to ensure equitable representation.⁹ The WDC is empowered to participate in activities of the ward health center and have control over the maintenance of the health facility, equipment, materials, and human resources.^{3,4}

PROBLEM STATEMENT

Though PHC is the bedrock of Nigeria's health system; more than 30 years after Alma-Ata, her health indices are still poor; maternal mortality ratio is 576 per 100,000 live births,⁵ in Kaduna state it is 1025 per 100,00 live births.⁶ It is thought that community participation in primary health care will result in more accessible, relevant, and acceptable services which will, in turn, result in better health outcomes.⁷ It has been shown that areas with health center committees have improved health outcomes and performed better on PHC indicators and health indicators.⁸

However, there are only 3109 (33%) functional WDCs in the country being formed/activated through collaborative efforts of the government for special intervention programs such as Midwives Service Scheme (MSS), Subsidy Re-investment Programme (SURE-P), and partners such as Global Alliance for Vaccines and Immunizations Health System Strengthening (GAVI HSS).⁹ Although the functional WDCs in the country are few, a study showed that in some wards in Lagos and Ogun states where the WDC are available, the community members and members of the WDC are not well informed about the roles and responsibilities of the committee.¹⁰ Another study in Benin, Edo State Nigeria reported that the WDC and VDC had deviated from their intended aim, they are either non-functional or marred by politics.¹¹

JUSTIFICATION

The majority of the health facilities in Nigeria (85.8%) are primary health facilities and 60% of public primary health care facilities are located in Northern Nigeria.¹² The Nigerian government in a bid to reform its health care system made the ward a unit of PHC implementation.¹³ Following the replacement of the district health system by the ward health system in the year 2000, the strategy for community participation changed from the district development committee to WDC.¹⁴ Community participation in PHC is thought to result in better services, patient satisfaction, and indeed better health outcomes.^{7, 15} It is important to find out if the WDCs are carrying out the duties they were established for or if they have deviated from their intended aim. There is a dearth of studies about knowledge of various stakeholders on WDC.¹⁵ This study aims to assess the knowledge of WDC members, Health Care Workers (HCW), and community members on WDC since it has been shown that when WDCs members are clear about their roles there is a positive change in the community, in the sense that the committee can get the people involved in solving their problems.¹⁶ The objective of the study is to determine the level of knowledge on the concepts, formation and functions of WDC amongst Health Care Workers, WDC and Community members in Kudan LGA Northwestern Nigeria.



METHODS

The study was conducted in Kudan LGA of Kaduna State, Northwestern Nigeria. Kudan LGA with headquarter at Hunkuyi located 136 km north from the state capital. The LGA was created in 1996 from the former Makarfi LGA. There are ten political wards in this LGA; Doka, Hunkuyi, Sabon Gari, Garu, Zabi, Kudan, Taba, KauranWali north, KauranWali south and Likoro. The projected population of the LGA for 2017 was 181,353. There are 36 health facilities in the LGA with 10 comprehensive PHC centres (one in each ward) and one general hospital, the others being health centres and health posts. There are 10 WDC, one in each ward. There are 42 HCW comprising of nurses/ midwives, CHEW, and Community Health Officers (CHO). The LGA has other associations and CBOs. The majority of the people are farmers.¹⁷

The study was a descriptive cross-sectional study with quantitative method of data collection. The population studied were: Ward Development Committee members, Community members, and Healthcare workers. Those included in the study were: Nurses, midwives, CHO, and CHEWs in the LGA who had been in service for at least 6 months; Members of WDC who had served in the committee for at least 6 months; Heads of households and spouses in the selected communities who had resided in those communities for at least 6 months. Total population was used for HCW and WDC members who met the inclusion criteria, while sample size for community members was calculated using fisher's formula¹⁸

$$n = \frac{Z^2 pq}{d^2}$$

Where;

n = minimum sample size.

Z = standard normal deviate at 5% type I error = 1.96.

p = 0.45 (Proportion of community members who were aware of Health Facility Committee from a study in Kenya)¹⁹

q = complementary probability = 1 - p, q = 0.55

d = desired degree of precision = 0.05

$$n = \frac{(1.96)^2 \times 0.45 \times 0.55}{(0.05)^2} = 380$$

Given a maximum anticipated non-response rate of 10% i.e. 10% of 380 = 38

The minimum sample size was $38 + 380 = 418$ which was increased to 420 to enable equal distribution in all 10 wards in the LGA. The community members were selected using multi-stage sampling. The first stage was the selection of a community from each of the 10 wards in Kudan LGA; using simple random sampling by balloting; the second stage was selection of 3 neighborhoods from each community; using balloting. Lastly the households were selected using systematic random sampling; a sampling interval of 5 was used to select the 5th household in each neighbourhood, the head of household and their spouse were interviewed. For households with more than one spouse, balloting was used to select a spouse.

Structured interviewer-administered questionnaire was designed from the national guidelines for development of PHC systems in Nigeria.¹ All the questionnaires were translated into the local dialect (Hausa) then back-translated into English. Six trained data collectors administered the questionnaire one community at a time. The data was collected using Open Data Kit on Android devices, which was transferred to Statistical Package for Social Sciences (SPSS) version 23 for analysis. The questionnaire was pre-tested at Giwa LGA which is like the study population. Knowledge was assessed using a knowledge score; which was calculated using the response to 28 questions. Each question had a "Yes/No/Do not know" response, each "Yes" response was scored 1 while "No" and "Do not know" were scored zero. The minimum score obtainable was zero and the maximum was 28. The scores were converted to percent. A score of <50% was poor, 50-60% was fair, 61-70% was moderate and >70% was good. This scoring was adapted from a study conducted on Assessing knowledge of implementers on WHS in Lagos State Nigeria.¹⁵ These questions were divided into the three aspects of knowledge; the concept of WDC had 4 questions, functions of WDC had 16 questions and forming WDC had 8 questions. Ethical clearance was sought and obtained from the Ethics and Scientific Committee of Ahmadu Bello university Teaching Hospital Shika- Zaria (ABUTH/HREC/CL/05), Nigeria before commencement of the study.



RESULTS

The mean age for community members was 35.6 years, ± 12.6 years. 54.8% were female, 94.8% Hausa, 97.1% married, 6.7% civil servants and 8.3% had tertiary education. The mean age of WDC members was 45.9 years, ± 9.4 years, 47.7% farmers, 73.8% male, 92.5% Hausa, 93.5% married, 66.4% had been in the WDC for over two years.

The mean age of HCW was 41.5 years ± 6.8 years, Hausa 77.1%, married 94.3%. Senior Community Health Extension Workers (SCHEW) 54.3% and 60% had < 2 yrs work experience. Most healthcare workers (97.1%) and community members (80.1%) knew the WDC was set up to enable people solve their health issues. Table 1 shows most of the WDC members knew the idea behind WDC (96.3%), all of these knew it was set up to enable people solve their health issues.

Table 1: Knowledge on the concept of WDC among community members and HCW in Kudan LGA, Kaduna State, 2017

Knowledge item	Frequency (%)	
	Community members (n=201)*	Healthcare workers (n=34)*
Aware of WDC	201 (47.9)	34 (97.1)
Enable people to solve their health issues	161 (80.1)	33 (97.1)
Have representatives from VDC	126 (62.7)	31 (91.2)
Have representatives from other interest groups	113 (56.2)	30 (88.2)

* *Community members and HCW who were aware of WDC*

Most of the community members (80.1%) knew identifying health needs of the people, (82.1%) knew that mobilizing community for health programmes, are all functions of WDC. Very few (19.9%) knew the WDC members have to ensure whether NHMIS forms are correctly filled and submitted. All the healthcare workers knew that mobilizing the community for health programmes, supervising activities of VHW, TBA, and CHEWs, and supervising implementation of work plans are functions of WDC. There was a statistically significant difference in the knowledge of HCW compared with the WDC members and community members in eight functions of WDC ($p < 0.001$).

Below Table 2 shows that the majority (98.1%) of the WDC members knew the secretary of the committee should be elected by members. Majority (79.6%) of the community members knew the facility in charge should be a member of WDC.

Most (97.4%) of the health care workers knew the membership of WDC should be voluntary. There was a statistically significant difference in the knowledge of the HCW on forming WDC compared with WDC and community members ($p < 0.001$), The HCW had better knowledge than the WDC and community members



Table 2 : Knowledge on functions of WDC among WDC members, community members, and HCWs in Kudan LGA, Kaduna State, 2017

Knowledge item	Frequency(%)			Test statistics	p value
	WDC members (n=107)	Community members (n=201)*	Healthcare workers (n=34)*		
Identify health needs of the people	107 (100.0)	161 (80.1)	33 (97.1)	$\chi^2 = 37.7$	<0.001
Identify resources to take care of needs	64 (59.8)	121 (60.2)	28 (82.4)	$\chi^2 = 165.0$	<0.001
Mobilize community for health activities	106 (99.1)	165 (82.1)	34 (100)	$\chi^2 = 30.2$	<0.001
Involve people in managing community projects	99 (92.5)	127 (63.2)	32 (94.1)	$\chi^2 = 85.6$	<0.001
Liaise with government and NGO	84 (78.5)	127 (63.2)	32 (94.1)	$\chi^2 = 109.9$	<0.001
Supervise activities of VHW, TBA and CHEWs	107 (100.0)	162 (80.6)	34 (100.0)	$\chi^2 = 30.9$	<0.001
Provide support to VHW, TBA and CHEWs	95 (88.8)	153 (76.1)	29 (85.3)	$\chi^2 = 89.8$	<0.001
Supervise implementation of work plan	94 (87.9)	122 (60.7)	34 (100)	$\chi^2 = 97.8$	<0.001
Supervise health facilities	106 (99.1)	154 (76.6)	33 (97.1)	$\chi^2 = 48.9$	<0.001
Supervise the wards drugs and DRF	102 (95.3)	116 (57.7)	33 (97.1)	$\chi^2 = 85.7$	<0.001
Raise money for community programmes	62 (57.9)	96 (47.8)	21 (61.8)	$\chi^2 = 1662.2$	<0.001
Provide feed-back to the community	104 (97.2)	142 (70.6)	33 (97.1)	$\chi^2 = 52.6$	<0.001
Ensure NHMIS forms are filled and submitted	62 (57.9)	40 (19.9)	20 (58.8)	$\chi^2 = 266$	<0.001
Give feed-back to LGA PHC management committee	56 (52.3)	113 (56.2)	25 (73.5)	$\chi^2 = 191$	<0.001
Forward developed plans to LGA	69 (64.5)	124 (61.7)	30 (88.2)	$\chi^2 = 135$	<0.001
Ensure the committee bank account is opened	82 (76.6)	84 (41.8)	20 (58.8)	$\chi^2 = 202$	<0.001

* **Community members and healthcare workers who were aware of WDC**

Table 3 shows the members of WDC are mainly selected by traditional rulers and community leaders. They nominate people who are trustworthy, hardworking, and willing to sacrifice their time. Women and youth are also included. There was a statistically significant difference in the knowledge score of HCW compared with the WDC members and community members in eight functions of WDC ($p < 0.001$). The HCW had better knowledge than the WDC and community members on functions of WDCs in Table 4.

DISCUSSION

The HCW in this study had better knowledge of the concept, functions, and forming WDC than the WDC members and community members. This was unexpected because only the facility in-charges are members of WDC. However, this difference in knowledge was statistically significant (P value < 0.001). When the HCWs have good knowledge of the functions of WDC. They know the WDC members are only carrying out their duties when they come to monitor activities in the facilities such as supervising



the drug revolving fund. With this, there will be harmony in the working relationship between the WDC members and HCW, when this occurs service delivery for the benefit of the patient will be improved. This study found that all the health care workers had good knowledge of the concept of WDC, Majority had

good knowledge of the functions of WDC and how it is formed. They had better knowledge compared to a cross-sectional pre-training assessment conducted in the year 2007 among PHC workers in Lagos Nigeria, where none of the HCW had good knowledge on the concept, formation, and functions of the WDC.

Table 3: Knowledge on forming a WDC among WDC members, community members, and HCWs in Kudan LGA, Kaduna State, 2017

Knowledge item	Frequency(%)			Test statistics	p-value
	WDC members (n=107)	Community members (n=201)*	Healthcare workers (n=34)*		
Membership of WDC should be voluntary	75 (70.1)	102 (50.7)	27 (97.4)	$\chi^2 = 134.5$	< 0.001
Members of WDC should be selected by community	74 (69.2)	121 (60.2)	29 (85.3)	$\chi^2 = 122.3$	< 0.001
At least 20% of members should be female	6 (5.6)	10 (5.0)	2 (5.9)	$\chi^2 = 111.0$	< 0.001
Females should hold executive positions	61 (57.0)	141 (70.1)	30 (88.2)	$\chi^2 = 142.9$	< 0.001
The secretary should be elected by the members	105 (98.1)	130 (64.7)	33 (97.1)	$\chi^2 = 63.3$	< 0.001
Facility in-charge should be a member of WDC	101 (94.4)	160 (79.6)	33 (97.1)	$\chi^2 = 42.9$	< 0.001
Members of the WDC should include other workers	74 (69.2)	154 (76.6)	33 (97.1)	$\chi^2 = 109$	< 0.001
The ward head should serve as the patron	104 (97.2)	153 (76.1)	32 (94.1)	$\chi^2 = 45.7$	< 0.001

These differences could be due to several reasons. There is a 10-year gap between the 2 studies and,

there have been efforts to reactivate the WDC where the National Primary Health Care Development

Agency (NPHCDA) collaborated with NGOs to do so.⁹ There were also increased efforts to revitalize PHC and with this came revitalization of WDC, guidelines for the roles, responsibilities, and functions of WDC, and other development committees were published¹. In the Lagos study, the questionnaire was administered as part of a needs assessment for training and it was self-administered. Perhaps the

respondents downplayed their knowledge so they could have the training. Even though this study and the Lagos study had the same aspects in the knowledge, the tools used were not the same and the mode of questionnaire administration differed. This study employed an interviewer-administered questionnaire and the Lagos study employed a self-administered questionnaire.

Table 4: knowledge score on the concept, functions, and forming of WDC among WDC members, community members, and HCWs in Kudan LGA, Kaduna State, 2017

Frequency(%)					
	WDC members	Community members	Healthcare workers	Test statistics	p-value
Level of knowledge on the concept of WDC					
Poor	0	38 (18.9)	0	Fisher's exact=56.7	<0.001
Fair	2 (1.9)	27 (13.4)	0		
Good	101 (98.1)	136 (67.7)	34 (100.0)		
Total	103 (100.0)	201(100.0)	34(100.0)		
Level of knowledge on functions of WDC					
Poor	3 (2.8)	59 (29.4)	0	$\chi^2=44.8$	<0.001
Fair	6 (5.6)	9 (4.5)	1 (2.9)		
Moderate	11 (10.3)	23 (11.4)	3 (8.8)		
Good	87 (81.3)	110 (54.7)	30 (88.3)		
Total	107 (100.0)	201(100.0)	34(100.0)		
Level of knowledge on forming WDC					
Poor	4 (3.7)	42 (20.9)	0	Fisher's exact=50.3	<0.001
Fair	8 (7.5)	18 (9.0)	1 (2.9)		
Moderate	35 (32.7)	37 (18.4)	0		
Good	60 (56.1)	104 (51.7)	33 (97.1)		
Total	107 (100.0)	201(100.0)	34 (100.0)		

Most of the HCW in this study correctly identified the functions, roles, and responsibilities of the WDC, though about two-thirds of HCWs knew that raising funds for community projects is a function of WDC members. This was lower than what was reported from a cross-sectional study carried out in Kenya between 2007 among 35 health facility in-charges, in which 70% of them knew that the Health Facility Management Committee (HFMC) is supposed to raise funds for the facility.²⁰ These differences could be because different cadres of HCWs were interviewed;

nurses in the Kenyan study while CHEWs and CHOs in study. In this particular study, 97.1% of the HCW knew the WDC are supposed to supervise the activities of the health facilities, which is higher than what was reported in the Kenyan study where only 34.5% of health facility in-charges knew the functions of HFMC included supervising the health facility. This difference could be because the HCW in this study had instances of their colleagues being reassigned at the request of WDC members.



There was low awareness of WDC among community members in this study, however among those who were aware, about two-third had good knowledge of the concept, half had good knowledge of the functions of WDC and how they are formed. This could pose a problem because the WDC is supposed to serve as a link between the community and the health facility and to engage in other developmental activities through the full participation of the community. Hence when people in the communities are not aware of WDC and not knowledgeable about the functions of WDC, the aim of establishing the WDC to engender community participation in primary health care will not be met which could affect the health outcome of the people.⁷

Almost all the WDC members had good knowledge of the concept of WDC, hence they know the importance of the committee in bridging the gap between the people and the health facility. About half of the WDC members did not know they are responsible for identifying needed resources to solve the health problems of the community and to mobilize these resources from within and outside the community. This will affect the ability of the WDC to carry out development projects for their communities. Most of the WDCs do not plan for projects because of lack of funds, perhaps if they knew they have to mobilize funds rather than wait on allocation from the government which never comes, they will be more proactive in raising such funds which they can use for community projects.

Less than half of the community members interviewed in this study were aware of WDC. Even the WDC members were aware of low awareness about WDC among the community members as was highlighted during the FGD. This low awareness of WDC among the community members will affect the ability of the WDC members to get the people involved in their activities. The awareness about WDC in this study is similar to that reported following a cross-sectional study in Kenya in 2010, 44.5% of respondents at a health facility exit interview were aware of HFMC,²⁰ and another cross-sectional study in Kenya in 2007, also reported 44.8% of them were aware of Health Facility Committee (HFC).¹⁹ The awareness in this study is however higher than that from a study in Zambia in 2004, among community

members where only 20% of respondents were aware of Health Centre Committee (HCC).²¹ The similarity in the level of awareness between this study and both Kenyan studies could be because of the low educational status of respondents in all the studies.

The knowledge of community members on the functions of WDC varied among different functions. This study found that about 60.7% of community members knew that supervising the implementation of developed work plan is a function of WDC which is lower than what was reported in the study in Kenya, (2010) 77.7% of respondents knew that contributing to the development of work plan is a function of HFMC.²⁰ In this study 76.6% of community members knew supervising health facilities was a function of WDC which is higher than the study in Kenya (2010), 58.0% of the respondents knew the HFMC were supposed to supervise the health facility.²⁰ This is also higher than the study in Zambia, where 8.7% of community members from high functioning HCC and 34.7% of those from medium functioning HCC said the HCC does not monitor services at the health facility. The study in Zambia however noted as a limitation their method of determining the functionality may have been faulty because people from the high functioning HCC did not have better knowledge on HCC than those in medium functioning HCC.²¹ This study also found that only 47.7% of the community members knew raising funds for community activities was a function of WDC which is lower than the Kenyan study which found that 65% of respondents knew raising funds for the health facility was a function of HFMC members.¹⁹ This low level of awareness of fundraising as a function of WDC could be responsible for the community members not contributing towards the activities of WDC. About half of the community members who were aware of WDC knew that membership is voluntary, and more than half knew the members should be selected by the community. This is higher than a study in Kenya where 80% of respondents did not know how members of HFC were selected.¹⁹

In this study majority of the WDC members identified supervising health facility as a role of WDC, they can have poor performing HCW redeployed. This is higher compared to a study in Kenya where 61.9% of HFMC



members identified supervising health facilities as a role of HFMC.²⁰

Less than a quarter of community members who were aware of WDC had poor knowledge of the concept of WDC, while none of the WDC members had poor knowledge of the concept of WDC. This is higher than what was found in a study in Lagos Nigeria (2003) where all of the community leaders and WDC members had poor knowledge of the concept of WDC.¹⁰ This study found that 29.4% of community members and 2.8% of WDC members had poor knowledge of the functions of WDC, this is lower than the study in Lagos Nigeria (2003) where all 300 WDC members had poor knowledge of the functions of WDC.¹⁰ This study also found that 20.9% of community members and 3.7% of WDC members had poor knowledge on forming WDC, this is also lower than a study in Lagos where all the WDC members and community members had poor knowledge about steps involved in forming WDC.¹⁰ These differences could be attributed to training received by WDC members and publication of national guidelines for the establishment of PHC system in Nigeria where the roles and responsibilities of WDC are clearly outlined. Also, the NPHCDA reactivated WDC by using participatory learning activities where members of communities were involved in identifying weaknesses in their communities and identifying people who will help in overcoming these weaknesses.²² The study being in one LGA is a limitation though total population of that LGA was used. The study having used probability sampling is a strength of the study.

CONCLUSION

This study has demonstrated that a knowledge gap exists on the entire concept of WDC among the various stakeholders. It is recommended therefore that government at every level should collaborate and provide training for the various stakeholders on the roles, responsibilities, and the general concept of WDC as enshrined in the national health policy to optimise the functionality of PHC in northern Nigeria. Further studies are also needed on the levels of functionality of the existing WDCs in the north.

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List of abbreviations

ABUTH	Ahmadu Bello University Teaching Hospital
ANC	Ante Natal Care
CHEW	Community Health Extension Worker
CHO	Community Health Officer
FGD	Focus Group Discussion
GAVI	Global Alliance for Vaccines and Immunization
HCC	Health Centre Committee
HCW	Health Care Workers
HFC	Health Facility Committee
HFMC	Health Facility Management Committee
JCHEW	Junior Community Health Extension Workers
LGA	Local Government Area
MSS	Mid-wives Service Scheme
NGO	Non- Governmental Organization
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PLA	Participatory Learning Activity
SCHEW	Senior Community Health Extension Worker
SPSS	Statistical Package for Social Sciences
SURE-P	Subsidy Re-investment Programme
TBA	Traditional Birth Attendant
VDC	Village Development Committee
VHW	Village Health Worker
WDC	Ward Development Committee
WHS	Ward Health System



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