SHORT COMMUNICATION

Assessment of Community Participation in Ward Development Committee as A Vehicle for Inclusion in Community Programmes in North-West Nigeria: A Cross-Sectional Study

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ABSTRACT

Background: Community participation is a process where community members come together to identify and plan how to solve their needs. 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 and patient satisfaction. This study sought to determine the level of community participation in Ward Development Committee from the perspectives of the committee members, Healthcare workers and community members. **Objective:** to evaluate the extent of Ward Development Committees' (WDCs) involvement in community-based initiatives and projects. **Methods:** The study was a descriptive cross-sectional study, conducted in Kudan Local Government Area of Kaduna State, Nigeria. All HCWs who had been in service for at least 6 months and WDC members who had served on the committee for at least 6 months were involved in the study. A multistage sampling technique was used to select the respondents from the community. Data was collected using a semi-structured interviewer-administered questionnaire developed by the researchers. The level of community participation was assessed by adapting Rifkin's model for assessing community participation which has 5 indicators; needs assessment, organization, resource mobilization, leadership, and management. **Results:** From the perspective of the healthcare workers, ward development committee and community members, the level of community participation was 5 in organization and 4 in Leadership, Resource mobilization and Management, respectively. This indicates wide participation. The level of community participation is 3 in Needs Assessment from the perspective of healthcare workers and Ward Development Committee members and 1 for community members indicating moderate and narrow community participation. **Conclusion**: While community participation in Kudan's WDC activities is commendable, there is potential for enhancement. We recommend that the government develops a policy on community engagement to ensure comprehensive community participation in all health-related projects.

Keywords:

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Introduction

Community participation was identified as a cornerstone for Primary Health Care (PHC) at the international conference of PHC.[1] The Basic Health Service Scheme was the first attempt by Nigeria to implement primary health care.[2–4] It focused on the provision of health facilities and training of health workers without giving much attention to community participation, intersectoral collaboration, use of appropriate technology, and financial sustainability which led to the failure of the scheme.[2–4] The second attempt saw the establishment of the District Health System (DHS).[3,4] During this period, the government implemented various programme components of primary health care without integrating the services or having mapped out plans

and objectives.[2] Village and District health committees were formed, although the guidelines for establishing them were not followed; there was a paucity of basic health statistics and inequitable distribution of manpower.[4] This attempt also suffered setbacks partly due to a lack of community participation,[4] and fragmentation of services with the states and federal government pursuing different objectives.[2] The third attempt was the replacement of DHS by the Ward Health System (WHS) in December, 2000.[3–5]

The objective of the WHS is to improve knowledge, attitude, and practice on health issues, encourage self-reliance, reduce maternal and infant mortality, improve immunization coverage and nutritional status of under-fives, make essential drugs available, affordable, and accessible, also to encourage collaboration between stakeholders and alleviate poverty.[3,4] The Nigerian National Health Policy adopted in 1988 and revised in 2004 still maintains PHC as the basic philosophy and strategy for national health development.[6] The goal of the policy is to establish a comprehensive healthcare system, based on primary health care that is promotive, protective, preventive, restorative, and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social wellbeing and enjoyment of living.[6] One of the key principles of PHC is community participation.[2,6,7]

Community participation has been part of man's existence since time immemorial but, it came into the limelight following the international conference on PHC.[8–10] There is always some level of community participation in every community; from the local people delivering medical services in Ding Xian China in the 1920s to the barefoot doctors in Maoist China to Community members serving as doctor's assistants in colonial Africa.[8–10] Community participation is a process where members of the community come together to identify their needs and plan on how to solve them.[1,11,12] Degree or level of community participation ranges from; the lowest level of "no participation" where the members of the community have no power in deciding which needs are to be taken care of nor on deciding the required activities to be carried out, to the highest level where the people are empowered in deciding what need to be done to improve their health and how it should be done, the professionals play the role of a facilitator who guide the people and give expert advice while the people have the final decision on addressing their needs.[13,14] 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 and patient satisfaction.[15]

In assessing the progress of community participation five indicators were identified; needs assessment, leadership, organization, resource mobilization and management Each of these indicators was placed on a continuum with wide participation at the outer end and narrow participation towards the middle of the spider gram. The points on the continuum do not meet at the center because it is agreed that there is always some degree of community participation in every community. These indicators can be used to compare differences in participation at different times in the same programme and by different participants in the same programme. It also allows us to assess community participation to account for progressive and retrogressive periods and analyzing relative changes rather than linear relationships.[12]

This study sought to evaluate the extent of Ward Development Committees' (WDCs) involvement in community-based initiatives and projects, to identify deficiencies and propose pertinent recommendations. There is a dearth of studies on assessment of levels of community participation in community development interventions.

Methods

The study was a descriptive cross-sectional study, conducted in Kudan Local Government Area of Kaduna State, Nigeria. It has 10 wards, all of which were involved in the study. All HCWs who had been in service for at least 6 months and WDC members in the wards who had served on the committee for at least 6 months were involved in the study. Heads of households and spouses in the selected communities who had resided in those communities for at least 6 months were included in the study. The sample size for the community members was determined using Fisher's formula, a minimum sample size including the non-response rate was 418 which was rounded up to 420 for equal distribution amongst the ten wards. A multistage sampling technique was used to select the respondents. Data was collected using a semi-structured interviewer-administered questionnaire which was developed by the researchers. It had a section for socio-demographic

characteristics of the respondents and another section for assessing community participation. The data was collected using Open Data Kit on Android devices by 4 trained research assistants within 5 days. Descriptive summary statistics such as mean and standard deviation were computed for continuous variables such as the age of respondents, while proportions and frequencies were computed for categorical variables such as sex, tribe, and marital status. The level of community participation was assessed by adapting Rifkin's model for assessing community participation which has 5 indicators; needs assessment, organization, resource mobilization, leadership, and management.[9,10] The indicators were arranged in a spider-gram. Along each indicator is a continuum from 1 being the narrowest level of community participation to 5 being the highest level of community participation. Needs assessment and Resource mobilization were each measured using two variables, while organization, management and leadership were measured using one variable each. The level of community participation was measured separately from the perspective of community members, healthcare workers and WDC members. The spider-gram for level of community participation was constructed using Microsoft Office 2010.

Ethical clearance was sought and obtained from the Ethics and Scientific Committee of Ahmadu Bello University Teaching Hospital, Shika-Zaria, before the commencement of the study. Permission to carry out the study was also sought and obtained from Kudan LGA chairman. Before commencing the interviews, the objectives of the study were explained to the respondents, and they were assured of confidentiality and the right to withdraw at any stage of the study. It was made clear to them that participation was voluntary and those who gave written consent were involved in the study.

Results

A total of 107 questionnaires were distributed to members of the WDC, all of whom completed them, resulting in a response rate of 100%. Similarly, community members received 420 questionnaires and all responded with a response rate of 100%. In addition, healthcare workers were given 35 questionnaires, and all were filled out with a response rate of 100%.

The mean age for HCWs was m 41.5 years ±6.8 years. The majority were male (65.7%), Hausa (77.1%), Muslim (94.1%), and married (94.3%). Over half were SCHEW (54.3%) and less than two-thirds had been in service for less than two years.

Community members had an average age of 35.6 years ±12.6 years; more than half of the respondents were female (54.8%), Hausa (94%), Muslim (100%), and married (97.1 %). Only a small percentage worked as civil servants (6 .7%) while only one-tenth held tertiary education degrees (8.3%).

Lastly, the mean age among WDC members surveyed was 45.9 years ± 9.4 years. The majority worked as farmers (47.7 %) male (73.8%), Hausa (92.5%), Muslims (99%), and married (93.5%). Approximately one-third worked as civil servants (29 9%) while over two-thirds have served on the council for more than two years.

Figure 2: Assessment of community participation in WDC from the perspective of healthcare workers in Kudan LGA, Kaduna State, 2017.

There was wide community participation in the organization and moderate community participation in needs assessment

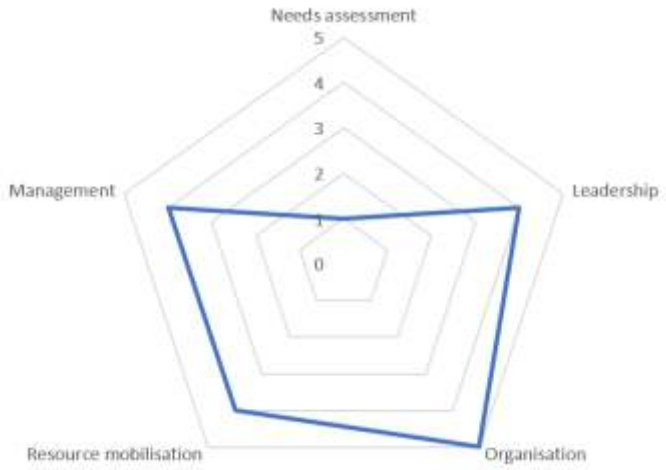

Figure 3: Assessment of community participation in WDC from the perspective of the community members in Kudan LGA, Kaduna State, 2017

There was narrow community participation in needs assessment and wide community participation in organization

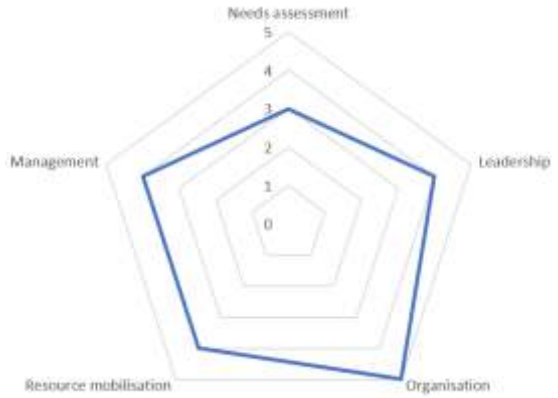

Figure 4: Assessment of community participation in WDC from the perspective of the WDC members in Kudan LGA, Kaduna State, 2017

There was moderate community participation in needs assessment and wide community participation in organization.

Discussion

The study found that community members, HCWs and WDC members agree there was wide community participation in the domains of leadership, organization, resource mobilization, and management, while the HWC and WDC members agreed there was moderate community participation in Needs Assessment while the Community members felt there was narrow community participation in Needs Assessment.

The ward development committees are development structures within a community that aim to get the people involved in their development. It serves as an interface between the community and outsiders.[16] In this study, the healthcare workers and WDC members agree that the NGO decided to form the WDC and the decision of activities to be carried out is influenced by the HCWs, while the community members are not aware of who made the decision on forming the WDC and on the activities to be carried out. The implication of this is there is no sense of ownership of the WDC by the community since they are not aware of how it is formed, and the activities it carries out. Since the HCWs influence the activities to be done, they are likely to suggest activities that will promote health. The NGOs will help communities develop WDC because they serve as gatekeepers to the communities

and are the community's voice. All the respondents agree that the community members are the interest groups who benefit from the leadership of the WDC. This means that the WDC in Kudan carries the community along in its activities, and the community experiences the effect of the WDC. All the respondents agree that already existing groups in the communities are involved in the activities of the WDC. With this, there will not be multiple WDCs hence no fragmentation of efforts, and discord among the members.

Survey participants were questioned about the areas in which WDCs engage within their communities. According to healthcare workers, WDC members exhibit greater involvement in organizational activities and less engagement in needs assessment. Additionally, they participate in management, leadership, and resource mobilization. Community members echo these findings with organization and need assessments ranking highest and lowest respectively among WDC activities. Similarly, WDC members report high levels of participation in organizing efforts as well as managing and leading initiatives while also contributing to resource mobilization; however, their involvement is limited when it comes to needs assessment.

It is apparent that most community development programmes/projects within the study area involve the engagement of WDCs but at what stage? Nearly all respondents agree that need assessments are typically conducted without input from WDCs. It should be noted that identifying a community's or group's needs and problems through a comprehensive assessment requires active participation from both professionals/experts and the community itself. Involving the community during this process ensures comprehensiveness, accuracy, and relevance to local concerns/needs thereby improving overall participation by fostering ownership of results; allowing for open expression of opinions/concerns; increasing trust/collaboration between stakeholders/professionals/experts/community members; ultimately resulting in tailored solutions for specific issues/problems. [16]

Conclusion

Community participation in the WDC of Kudan LGA of Kaduna State, Nigeria is commendable, though there is room for improvement. Further studies are required in this area as there is a dearth of literature on the topic. Studies to determine the functionality of WDC and the factors affecting them are apt.

Recommendation

The government should develop a policy on community engagement that would ensure all community-based programmes/projects should involve the full participation of the community through the WDCs from the needs assessment to the evaluation of the programme.

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No Conflict of interest

Funded by the corresponding author and study has not been presented at any conference.

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