NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

INTRODUCTION TO WARD HEALTH SYSTEM

BRIEFING PACKAGE FOR SENSITIZATION ON THE WARD HEALTH SYSTEM.

April 2006

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ACKNOWLEDGEMENT.

Against the background of continuing effort to reform the health sector in Nigeria, and the historical hindsight of two previous failed attempts at revitalizing primary health care in Nigeria, the Agency is poised to make success out of the current effort, which is the third attempt at revitalizing primary health care system through the Ward Health System, hence the development of this briefing manual.

I therefore wish to express my gratitude to Dr. A. O. O. Sorungbe Chairman Governing Board, NPHCDA, Dr Shehu Mahdi, Executive Director, Mr Patrick Ehimwenma, Director of Finance and Administration and Prof. C. O. Akpala, Director of Planning, Research and Statistics respectively for their support and encouragement. I am also grateful to all the technical officers for their contributions and publicity particularly Mr A. S. Lawal (Deputy Director, Health Systems Development), Dr M. J. Abdullahi (Assistant Director, Health Systems Development), Mr Tanimu Marafa (Technical Assistance to Executive Director), Mr A. O. Amusan (Chief Community Health Officer) and many others.

It is our belief that this document would serve as a tool for Advocacy and Sensitization on the Ward Health System and accelerate progress in the attainment of health Millennium Development Goals.

Thank You.

Mrs T. I. Koleoso – Adelekan
Director, Health Systems Development,
For: Executive Director

April 2006.

BACKGROUND

There have been several attempts in the past to provide effective and efficient health services with wide coverage in Nigeria. The **first attempt** was in 1976 when the Federal Government introduced the Basic Health Services Scheme (BHSS) as part of the 1975-1980 Development Plan. Many health facilities of different categories were constructed and equipped all over the country.

In addition, new cadres of community health workers were introduced. These were the Community Health Officer (CHO), Community Health Supervisor (CHS), Community Health Assistant (CHA) and the Community Health Aide (CHAide). The cadres were later on streamlined into 3 cadres, the CHO, Community Health extension Worker (CHEW) and Junior Community Health Extension worker (JCHEW).

The **second attempt** was in 1986 when 52 pilot LGAs were chosen to be developed as model PHC LGAs. Rigorous activities were carried out, starting with baseline data survey and situation analysis. Project Formulation and Plan Implementation workshops were conducted to plan activities using collected data. The LGAs were granted a "seed package" comprising a motorcycle, drugs from an "Essential Drugs List" and five hundred thousand Naira each to implement their activities.

In 1988, Bamako Initiative (BI) was introduced as a strategy to strengthen PHC in the same 52 LGAs and the LGAs were supported with resources and provided guidelines for the managerial infrastructure. Community Development Committees operated a 'Drug Revolving Fund" and this worked well in some LGAs. However, the desired objectives were generally not achieved because the people were passive recipients in most places and had limited power.

Nigeria, however made tremendous progress in the LGA focused PHC initiative of 1986 - 1992, which culminated in the attainment of Universal Child Immunization (UCI) target of 80%, high rating of the country by the WHO Review Team and the creation of the National Primary Health Care Development Agency in 1992.

Unfortunately, the period between 1993-1999 once again witnessed loss of the earlier gains as a result of instability in governance, poor funding, lack of political support, low capacity of the local governments to manage PHC and withdrawal of donor support etc

Recognizing the serious deterioration in the nation's health system and the central role of PHC, the present regime in 2000 repositioned the agency and mandated it to revitalize the nation's PHC system. The Ward Health System was adopted as a strategy for the purpose.

INTRODUCTION OF THE WARD HEALTH SYSTEM

The WHO Review team in 1992 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 30,000 people) which elects a councilor to the LGA*"

It was in the light of the foregoing that the Agency introduced the Ward Health System in 2001 by adopting the political wards as the operational units for the implementation of the PHC programmes. The "LGA-District/Village" structure, therefore gave way to the "LGA-Ward–Community/Village" structure. The idea is to provide a nationally acceptable targeted area of operation with clearly defined boundary, political representation and population.

Suffice to note that the current effort (2000 to date) at revitalizing PHC is the **third attempt**. In the past five years, the Federal Government has provided funds each year to build model PHC

Centres, 200 centres in 2001, 120 centres in 2004 and 61 centres in 2005. **The new model PHC centre is to serve as apex health facility and referral centre within the ward**. It is to coordinate and supervise all the health services within the ward, both at the facility and community level. These health centres are managed by their respective communities and emphasize community-based services. The communities are actively involved right from the construction stage of the health centres, and the centres are handed over to their Ward Development Committees (WDC) to ensure ownership and co-management of services.

Goal

The goal of WHS is to improve and ensure sustainable health services with full and active participation of people at the grass root level.

Aims and the Objectives of the Ward Health System

1. To promote full and active community participation at the grass root level in order to sustain an effective and efficient delivery of PHC services in the ward.
2. To improve access to quality health care and ensure equity.
3. To promote local initiatives and encourage poverty alleviation activities in the ward.
4. To re-enforce political commitment to PHC at the grass root level i.e. the ward.
5. To reduce morbidity and mortality especially amongst women of child bearing age and children under five years.

PROGRAMME STRUCTURE

The Ward Health Services (WHS) provides primary health care services to a political ward, constituency from where a councilor is elected into a local government council. It has a referral Ward Health Center (WHC) which provides integrated services to cover all PHC

components as its apex health facility.

The Ward Health Centre staffs coordinate and supervise all the health services within the ward. Each ward is subdivided 6 health areas comprising of groups of villages. Each health area has **Static Health Facilities (SHF)** made up of health post/clinics/dispensaries/maternity and outreach clinics all linked to the **Ward Health Centre (WHC) or Primary Health Centre** and are supervised by a resident JCHEW.

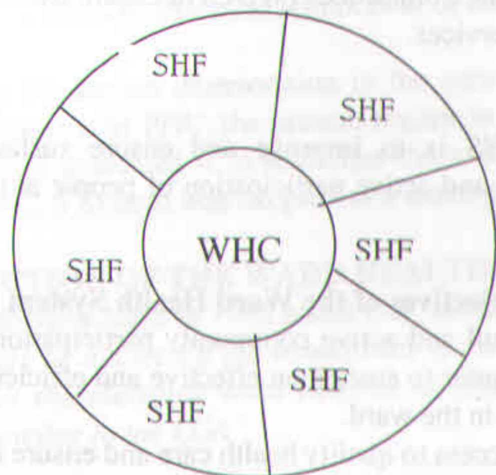

Figure 1: Sub division of the Ward.

SERVICE OUTREACH

The manpower requirement of the model ward health services is made up of the facility health team and community-based health care providers. The facility health team comprises 1 CHO (the in - in-charge, 2 Midwives, 4 CHEWs, Laboratory technician and Medical Officer (if the latter two are available) while the community-based providers comprises of 6 JCHEWs, the VHWs and the TBAs.

CHOs and CHEWs spend about 40% of their time paying regular and scheduled visits to their communities (field visit or supervisory visit). On such occasions, they may participate in community activities, attend VDC meetings, supervise the activities of JCHEWS or follow up on clients referred to community-based health care providers. A two-way referral system is thus sustained between them and the community-based care providers, and through such a linkage, information is shared both ways. The health situation of the community is easily assessed and feedback given to the communities for re-planning or modification of intervention activities.

The ward is divided into 6 health areas and each area is assigned to a JCHEW who is stationed at a static health facility and outreach for supervision. At the community level, services are provided by the community-based workers (TBAs and VHWs) under the direct supervision of JCHEWs. JCHEWs are in turn supervised by CHEWs, and the CHEWs by CHOs.

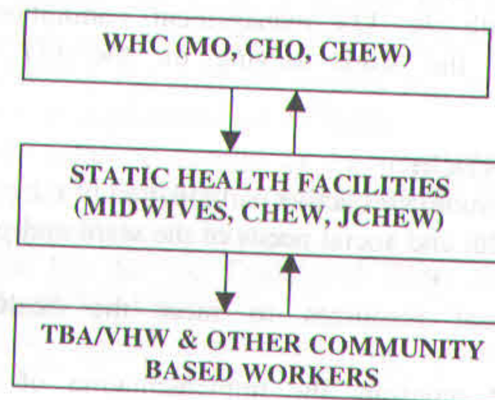

Figure 2: Flow of Service from Clinic to Community/Two-Way Referral

MANAGERIAL STRUCTURE FOR WARD HEALTH SYSTEM

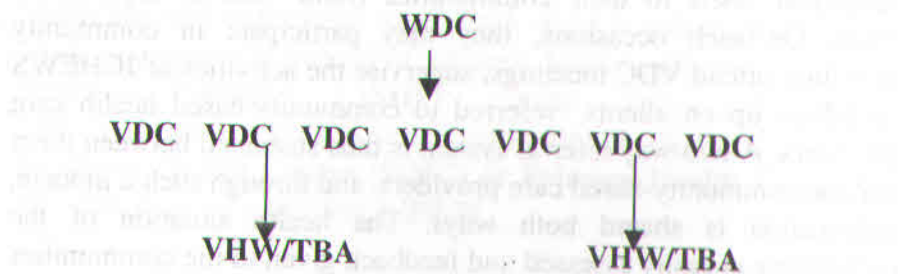

Figure 3: Flow of Administrative Supervision

The management structure of the ward health service is mainly community-based. It consists of the WDC at the ward level and the Village Development Committee (VDC) at the village levels respectively. The WDC consists of Chairmen of each VDC in the ward, and serves as the supreme body for the functions of the health centre and other development activities carried out in the ward. It has a direct link with the LG management committee through a representative of the ward serving on the LG management committee.

Function of the WDCs:

1. mobilises and motivates active participation of the people
2. identifies health and social needs of the ward and plans for their solutions
3. mobilises local resources to meet the health needs of communities
4. supports and monitors the implementation of Work Plans, including activities of the community-based workers and health facility staff
5. forwards all health development plans to the LGA
6. provides feedback regularly to communities
7. serves as the linkage between communities and government/other partners
8. Support the maintenance of the WHC

Operational Guidelines of the WDC, VDC

1. The committee meet regularly as decided by the members
2. The committee comply with the quorum set for meetings
3. Minutes of all meetings are recorded and signed by the Chairman and Secretary
4. The committee operate a bank account whose signatories are the Chairman and the Treasurer
5. The treasurer keep all records of funds received and expenditure
6. Money is spent only on the directives of the committee

The Village Development Committees (VDC)

The VDC has similar functions and operational guidelines to that of the WDC but they are limited to their respective communities/villages.

Roles of the Local Governments in the Ward Health System

1. To provide appropriate health manpower to the health centre.
2. To provide basic amenities in the health centre such as light, potable water, access road and staff quarters.
3. Provide funding and material support e.g. vaccines, drugs and equipment for implementation of WHS.
4. To provide technical support in the areas of capacity building: training of health workers, Voluntary Health Workers, members of the development committees.
5. To provide kits for the Traditional Birth Attendants and the Village Health Workers.
6. To supervise, monitor and evaluate health activities taking place in the ward
7. To collaborate with the WDCs/VDCs to establish static health facilities in the communities in the ward where there are none.
8. To coordinate the activities of other partners such as development agencies, NGOs and community based civil society organizations.
9. Replicate the Ward Health Services in other wards in the LGA.

Roles of the State Governments in the Ward Health System

1. Support the LGAs through the LGA Service Commission in the provision of appropriate health manpower in the health centres.
2. Provide technical assistance to the LGAs in the implementation of the Ward Health System.
3. Supervise the LGA's PHC programmes through the various State program managers
4. Collaborate with the LGAs to replicate the ward health system in other wards of LGAs in the State
5. Attract programs of local and international NGOs to develop Ward Health System.
6. Provide funding and material support e.g. vaccines, drugs and equipment to the LGAs for implementation of WHS.
7. Strengthen referral linkages between Primary and Secondary levels of health system
8. Supervise, Monitor and Evaluate the implementation of PHC in the LGAs.
9. Establish and Ensure effective State PHC Technical Committee
10. Provide all necessary support to School of Health Technology and other PHC Training institutions..

DEVELOPMENT OF THE WARD HEALTH PLANS

The WDC together with the health team in the ward, supported by the LGAs are trained by the National Primary Health Care Development Agency on how to identify health problems, prioritize them, formulate a plan of action, monitor and evaluate their wards' programmes.

MANPOWER FOR THE WARD HEALTH SYSTEM

The manpower requirement for the ward health service is designed to be affordable to the LGAs and the communities. At the community level, the community-based workers (TBAs, VHWs and JCHEWs) constitute the workforce while at the facility level, the CHOs, Midwives, CHEWs and the JCHEWs are the care providers.

Traditional Birth Attendants (TBAs)

These community-based workers live in the community, taking deliveries and gaining experience over a long period of time. Although they have been doing a good job, there are inadequacies in their practice. These include unhygienic procedures, non-recognition of their limitations and ignorance of certain factors which put some women "at risk" of having difficulty during the pregnancy or delivery.

To address their inadequacies, all practicing TBAs are expected to go through basic training on normal and abnormal pregnancies, aseptic procedures, how to identify women at risk and how and where to refer them as well as counseling skills.

They are also trained on how to counsel women appropriately on family planning, immunization, nutrition and infant feeding since they provide ANC services where no health facility is within easy reach.

Village Health Workers (VHWs)

These community-based health care providers are nominated by their communities. They are preferably resident in their communities and may or may not have ability to read and write. They are trained on how to identify simple health problems and deal with them.

TBAs are paid for their services by their clients either in kind or cash

while communities are responsible for remunerating VHWs. Financial remuneration from any authority is strongly discouraged as doing so will convert the volunteer workers into government employees. The purpose of their selection and remuneration by their communities is to encourage community participation and ownership of their own health programmes.

Junior Community Health Extension Worker (JCHEW)
JCHEWs are trained to provide basic and essential community services with guidance from their Standing Orders. They spend about 90% of their working period in the community where they supervise the VHWs/TBAs closely, among other duties. They are supervised by the CHEWs from the Ward Health Centre.

Administrative functions

1. maintains the Static Health Facilities with the assistance of the VDC.
2. oversees the upkeep of the clinic surroundings
3. supervises the functions of VHWs and TBAs (Monitoring & Evaluation, Drug prescriptions, storage and Drug Revolving Fund)
4. develops Action Plan and schedule of activities with VDC
5. collates data on community-based NHMIS forms from VHWs and TBAs
6. updates record keeping at the static health facility and outreach and presents to appropriate persons (CHEW, VDC)
7. organizes regular meetings with TBAs and VHWs for feedbacks on on-going activities
8. attends VDC meetings
9. organizes continuing education for community
10. maintains link with the health centre

Community health functions

1. obtains/produces a map of village/community served
2. finds out what the community's health problems are

3. plans interventions with VDC
4. ensures that communities participate in health and other health related programmes.
5. goes on home/community visits regularly to assess community-based services, environmental and water situations and for follow-up of clients.

MCH functions

1. ensures that all pregnant women are identified and have access to antenatal services
2. promotes preventive maternal and child health care including screening for anaemia and mothers prone to pregnancy risks (e.g. short stature, first pregnancy, more than two previous pregnancies, previous history of oedema or excessive bleeding or caesarian section, pre-eclampsia etc), giving routine malaria prophylactic, identifying immunization needs, and growth monitoring and nutrition interventions.
3. plays own part in maintaining two-way referral for clients
4. maintains link between clinic and VHW/TBA services

Clinical Functions

1. manages clients according to standing Orders
2. takes care of referrals from VHW/TBA and refer appropriately.

Community Health Extension Worker (CHEW)
The CHEW supervises the JCHEWs and spends at least 40% of their working period in the field.

Administrative functions:
supervises JCHEWs

1. collates, analyses and interprets NHMIS forms
2. keeps records and presents to appropriate persons (CHO/CHEW-in-charge)
3. attends VDC/WDC meetings

4. organizes continuing education for community-based providers

Community health functions

1. finds out what the community's health problems are
2. ensures that JCHEW prepares communities for participation in health and other health related programmes.
3. visits communities regularly to assess community-based services, environmental and water situations and for follow-up of clients.

MCH functions

1. ensures that all pregnant women are identified and have access to antenatal services
2. promotes preventive maternal and child health care (screening for anaemia and pre-eclamptic toxaemia, giving routine malaria prophylactic and tetanus toxoid, immunization, growth monitoring)
3. establishes two-way referral for clients, ensuring appropriate link between clinic staff and community-based service providers

Clinical Functions

1. manages clients according to Standing Orders
2. maintains high quality of care (checks at Exit table)
3. practices rational use of drugs

Community Health Officers (CHOs)

The CHO has many functions in the community and in the health facility, including being head of the WHCs and the ward health team.

Administrative functions

1. assigns responsibilities to other staff
2. maintains discipline
3. oversees the upkeep of the clinic and surroundings
4. supervises the functions assigned to other staff (Monitoring & Evaluation, Drug procurement, storage and Drug Revolving Fund)
5. develops Ward Action Plan and draws up schedule of activities with WDC
6. supervises analysis and interpretation of NHMIS forms
7. oversees record keeping and presentation to appropriate persons/groups
8. organizes regular staff meetings for feedbacks on on-going activities
9. attends VDC/WDC meetings
10. organizes continuing education for health team and community
11. maintains link with the LGA

Community health functions

1. obtains/produces a map of the target area
2. conducts community diagnosis exercises (finds out what the problems are)
3. plans interventions with other workers and WDC
4. ensures that communities participate in health and other health related programmes.
5. visits communities regularly to assess community-based services, environmental and water situations and for follow-up of clients.

MCH functions

1. ensures that all pregnant women are identified and have access to antenatal services
2. promotes preventive maternal and child health care (screening for anaemia and pre-eclamptic toxaemia, giving routine malaria prophylactic and tetanus toxoid, immunization, growth monitoring)
3. establishes two-way referral for clients
4. ensures appropriate link between clinic staff and community-based service providers

Clinical Functions

1. ensures management of clients according to standing Orders (at all levels of care)
2. maintains high quality of care (checks at Exit table)
3. encourages rational use of drugs
4. provides services beyond the level of expertise of other staff according to Standing Orders).

DELIVERY OF INTEGRATED WARD HEALTH SERVICES (WHS)

The WHS is designed to provide comprehensive health and development services in the ward. The main services provided are:

- Maternal and Child Health/Family Planning
- Nutrition and Growth Monitoring
- Immunization
- Environmental Sanitation and water supply
- Health Education and
- Treatment of health problems

The services may include oral health and mental health. Prevention and control of communicable diseases activities are also carried out in the community.

Maternal and Child Health Services

The objectives of these services are to:

- locate all pregnant women in the ward and provide ANC services to them
- prepare women for exclusive breast-feeding
- identify women at risk and refer them appropriately
- provide labour, delivery and post-natal services in the community
- immunise pregnant women and children under 5.
- provide appropriate case management for common childhood diseases using standing orders
- identify danger signs of ill-health and advise on timely referral
- motivate men and women for family planning services

At the Community/ Village Level the TBA mobilizes the community, counsel on ANC and its benefits, identifies pregnant women and provides ANC services (educate on nutrition, exercise, rest, clothing, hygiene, schedule of work, immunization and regular attendance for ANC) and prepares mothers for lactation.

She gives routine drugs to pregnant women and manages common complaints, identifies conditions that require immediate referral, identifies "at-risk" women during the first visit, recognizes women in labour through the common signs and simple examination, determines the stage of labour, and manages the various stages of labour.

She takes delivery and carries out all procedures related to delivery according to Standing Orders (deliver the placenta safely, recognize conditions requiring immediate referral and make referral promptly and observe blood loss after delivery for quantity and smell).

She also takes care of the new-born (cleaning of the air way, eyes and body). She discusses breast-feeding, complementary feeding, immunization and general care of the baby with the mother and visits her for post-natal care.

The TBA also counsels mothers on the benefits, methods and where to obtain family planning services and on HIV/AIDS.

At the Health Centre, the health workers perform all the functions of the community-based workers at a higher level of competence. They from time to time review reproductive issues with the women, WDC members and the community-based workers.

They also provide ANC services, immunization, and laboratory investigations. "Women at-risk" are identified and managed

appropriately.

Nutrition and Growth Monitoring

The objectives of these services are to:

- identify the problems of food security and nutrition in the community
- take appropriate actions to manage the identified problems
- mobilize village and ward committees for food and nutrition activities
- explain the importance of adequate food security and nutrition to the community
- monitor food and nutrition programmes at the various levels

At the Community/Village Level, the TBAs/VHWs discuss with the VDC members to identify food and nutrition problems, assess the community's knowledge, attitude and practices regarding food and nutrition. They assess the nutrition situation in the community by identification of malnourished children, food production and storage problems and nutritional problems (e.g. goitre) in the general population.

During home visits they are able to assess food availability, preservation, preparation methods and distribution among family members. They can identify factors militating against infant and young children feeding, identify common infections (e.g. worm infestation, chronic diarrhoea) contributing to malnutrition, assess availability of equipment and materials for nutrition activities (growth charts, scales and reporting forms) and organize periodic weighing of children.

They also assess pregnant and lactating mothers for anaemias or malnutrition, collate information and give regular feedback to the VDC, WHC and WDC.

Promotion of Household Food Security and good nutrition at the Community/ Village Level

The JCHEWs, TBAs and VHWs are adequately trained to promote household food security through encouragement of home gardening, communal farming, and establishment of communal fish-ponds, rabbitory, snailry etc. It is part of their duty to encourage community ownership or hiring of equipment (mills, tractors etc), production of complementary foods using the locally available resources and appropriate processing and storage of food.

The health facility staff organise refresher trainings for health workers as well as WDC members on adequate diet (using local foods), nutritional problems and interventions, food hygiene, growth monitoring and nutritional assessment. They also organise the training of local food vendors and monitoring and evaluation of nutrition activities.

Growth Monitoring

Members of the health team counsels on growth monitoring and promotion and also carry out GMP both at community and facility levels.

VHWs and TBAs mobilize the community for growth monitoring and promotion sessions, identify children needing special care, prepare and assist Growth Monitoring and Promotion activities, weigh children and plot weights on the growth chart or use mid-arm circumference strips for quick community assessment. They interpret growth curves and make appropriate entries, provide prompt interventions when required such as breast-feeding and complementary feeding counseling, as well as conduct of food demonstration.

Periodically, e.g. once a quarter, quick community surveys should be done by the health team and scatter diagrams of the children's weights plotted to present the community's nutritional status at a glance.

Immunization
VHWs and TBAs identify and mobilize target groups, with the assistance VDC for immunization. They give health talks on the importance of immunization and assist JCHEWS during immunization activities. They are trained to report suspected cases of preventable diseases e.g. measles, poliomyelitis to the health staff promptly.

The staffs at the WHC, in addition to giving immunization at the WHC are responsible for calculation of required quantities of vaccines and other consumables, submission of requisition and collection of same from the LGA. They distribute vaccines and other consumables to the health centres and other static units in the ward.

Water Supply and Basic Sanitation
The VDCs/WDCs/TBAs/VHWs identify possible sources of water for the community e.g. rain, ponds, streams etc and encourage proper citing, construction and maintenance of wells. They educate community members on the prevention of contamination of water sources with water borne diseases and how to treat water to make it potable (boiling, sedimentation, filtration and chemical disinfection)

Health workers provide technical assistance to the village level workers and assist them in organizing relevant community intervention activities to ensure access to water in the clinics and homes.

Promotion of Personal Hygiene and Environmental Sanitation
VHWs/TBAs and JCHEWs educate the community on the relationship between unhygienic practices and ill health. They organize seminars on personal hygiene and maintenance of a clean surrounding for school children and the community. They also supervise the construction, utilization and maintenance of VIP

latrines. ***Health workers supervise these community activities and provide assistance when necessary.***

TWO WAY REFERRAL SYSTEMS

A "Two-way" referral system is an integral part of Primary Health Care practice. Referral is to both the higher and lower levels of health care delivery. If a condition cannot be effectively managed at a level, the patient is referred higher-up. The patient having been treated successfully at the higher level is referred back to the lower level for continuity of care and follow up. Also some clients whose first point of contact is a higher level may be referred to the appropriate level of care as necessary.

In the Ward Health System, a suitable facility is identified in the LGA for referral of serious cases from the Ward Health Centre.

For the system to be sustained:

- Two-way referral forms are printed and readily available/accessible.
- All health workers are adequately oriented on the system.
- Officers in charge of facilities are also adequately oriented on the system and what role is expected of them.

ESTABLISHMENT OF THE M&E SYSTEM

The community health workers and members of the various committees are trained on how to monitor their wards' programmes. There are specific forms for collecting data on health and health related activities at the community and health facility levels.

The CHO-in-charge or CHEW are responsible for creating awareness about the M&E system and mobilizing the JCHEWs, TBAs/VHWs and the VDC members to establish the system at the Community/Village level. They are also responsible for:

- training literate community-based workers, VDC and WDC

members on placement of home-based records

- organizing placement of home-based records
- identification of an area to be used as the static health facility and outreach
- ensuring that JCHEWs complete the Clinic Master Card for every household and place it in the static health facility and outreach.
- providing community-based workers with pictorial records of works and wall chart
- seeing that JCHEWs are able to explain what the zero (0) in the tally sheet means in the VHW/TBA Record of Work and can teach the VHW/TBA how to slash the zeros
- assisting JCHEWs to develop an effective system of returns where forms from the field reach other static health facilities promptly

At the Static Health Facilities, the CHEW:

- assist the JCHEW to identify a suitable area within the satellite health facilities as M&E section
- equip the section with all the necessary logistics such as file jackets, M&E forms etc
- show JCHEWs how to fill the M&E forms, update community bio-data, collate and tabulate the calculated totals, add all column totals and cumulate the total number of cases by age group and sex on monthly basis and transfer monthly totals into annual forms.
- demonstrate how to draw simple graphs based on selected indicators and interpret the graphs.

At the Ward Health Centre, the CHO:

- Orientates all health workers and WDC members to the M&E system
- designates a trained health worker to be responsible for coordinating the M&E system

- identifies a suitable area within the health facility as the M&E section
- equips the M&E section (file jackets, M&E forms, calculators, and cardboard sheets etc)
- ensures accurate filling of the M&E forms

At the LGA Level:
The PHC Coordinator/ M&E Officer/ZTO:

- orientates all health workers and members of LGMC to the M&E system
- equips the M&E Office (file jackets, M&E forms, calculators, and cardboard sheets etc)
- Incorporates all data from the wards into LGA returns
- Sends LGA monthly returns to the State within the second week of the following month
- Analyzes LGA data within the LGA and gives feedback to all concerned (WHC, WDCs, state M&E department)

Generally, data analysis includes comparison of monthly returns on health / health related problems, and progress of intervention activities. Observation of changes in the trend of events is illustrated in simple graphs.

At the Community/Village Level, the VHW/TBA gives verbal report to the VDC and JCHEW while the JCHEW gives a written report to the VDC and WHC.

At the Static Health Facilities, the JCHEW prepares monthly/annual report, duplicates all reports and forward copy to the CHEW at the WHC. The JCHEW (at the Static Health Facilities) and CHO at the WHC display information on indicators such as:

- Immunization coverage
- ANC attendance by trimester

- Number of deliveries (by TBAs,or Midwife)
- Number/% of malnourished children
- Birth weights and
- Deaths

At the Health Centre Level, the CHO/CHEW prepares monthly/annual reports, duplicates all reports, files WHC copies and sends a copy to the LGA

At the LGA Level, the M&E Officer prepares the LGA monthly/annual reports, duplicates all reports, files LGA copies and sends a copy to the State/NPHCDA

SUPERVISION AND MONITORING

The officer heading the WHC identifies major activities to be supervised at each level, prioritizes the activities for each level and determines the indicators for supervising each activity (home visits, report submission, quality of patient care etc). Appropriate checklists must be used for each level.

Supervision at the Community/ Village Level

The JCHEW attends VDC meetings to see that they are properly constituted and important issues are addressed, checks VHW/TBA record of work, drugs stock and cash at hand regularly and randomly visits selected homes with VHW/TBA. She observes the VHWs/TBAs at work and visits the source(s) of water supply and drainage system with them.

It is important for the JCHEW to discuss observed problem areas and other findings with the VDC and VHW/TBA.

At the Ward Level, CHEW or CHO visits each village at least monthly, checks and examines the JCHEW's record of work,

discusses the observed problem areas, attends meeting at least quarterly and visits randomly selected houses with the JCHEW and VHW/TBA. She must attend WDC meetings regularly and discuss findings of supervisory visits with the WDC, VDC, VHW & TBA.

At the LGA level, PHC department of the LGA visits each ward at least monthly, checks and examines Ward Health Centre (WHC) record of work, evaluates progress according to indicators and discusses observed problem areas with the WDC and WHC staff. The PHC Director should attend WDC meetings at least quarterly and the LGA PHC management committee meeting regularly. He/She must discuss observations on the meetings with WDC, WHC staff and LGA PHC management committee

At the State Level, the Ministry of Health in collaboration with the State department of Local Government and Zonal Technical Officers are expected to visit each LGA at least monthly, check and examine LGA records, evaluate the progress of activities according to identified indicators and discuss observed problem areas with appropriate persons.

At the Zonal Level the Zonal Coordinator visits each state at least monthly, each target LGA at least quarterly and each target ward at least quarterly. He/she must use the developed checklist to evaluate various activities and discuss observed problem areas and other findings with appropriate state/LGA staff.

MAINTENANCE OF INFRASTRUCTURE

Generally, maintenance is not adequately emphasized in programmes in Nigeria. This is why infrastructure, equipment etc degenerate, becomes unusable, or unserviceable within a short period. This leads to wastage of huge resources. Maintenance must be built into ward PHC programmes or activities to optimize the utilization of often meagre resources.

At Community/Village Level VHW/TBA/JCHEW

1. encourage communities, through discussions and meetings to create awareness on what should be maintained, at what stage and by whom
2. motivate communities to see that maintenance of their facilities is part of their development
3. facilitate community to replace any worn out furniture and equipment or part of their building.

At facility level Health Workers must discuss the following with the WDC

1. how to maintain the building, equipment, furniture and the road leading to the centre.
2. who should be responsible for ensuring that things are in their proper places.
3. who should report any damage, keep records of furniture, equipment, drugs and monitor their safety.

IMPLEMENTATION STEPS FOR THE WARD HEALTH SYSTEM

In order to establish the Ward Health System, the following steps/activities must be followed:

1. Awareness creation and Community mobilization/ sensitization for active participation, involvement and sustainability in the Ward Health System.
2. Identification of a suitable health facility and up grading of infrastructure and equipment where necessary as the Ward Health Centre (where **a model PHC facility does not exist**).
3. Formation/Reactivation of Development Committees using Participatory, Learning and Action (PLA) tools. Committees are formed at the following levels: Village Level -Village Development Committee (VDC), Ward Level - Ward Development Committee (WDC), LGA level - LGA Primary

Health Care Management Committee and LGA PHC Technical Committee. Members of the committees are selected based on the national guideline.
4. Formulation of the Ward Health Project and development of the Ward Health Plan (WHP).
5. Mapping and Division of the ward into 6 health areas,
6. Deployment of Health Workers to Ward Health Facility and other static health facilities. The minimum staff compliment per ward is: 1 CHO, 2 Midwife, 4 CHEWs, 5 JCHEWs and 1 Laboratory Technician.
7. Orientation of Health Workers on the Ward Health System and Training on Integrated Ward Health Service.
8. Training/Orientation of WDCs on their roles, responsibilities and operational guidelines in the ward health system.
9. Establishment of PHC Management Information System: House numbering and placement of Home-based and Facility records and Training on PHCMIS
10. Opening and Operationalization of Ward Health and Drug Revolving Fund (DRF) Account.
11. Establishment of a Two-Referral system by identifying a suitable referral facility in the LGA.
12. Establishment of an effective supervisory and feedback mechanism.

Opportunities offered by the Ward Health System

1. ***Local capacity*** for community driven socio-economic development and poverty alleviation.
2. ***Investment in health*** Investing in health is good economics: increased productivity and socio-economic progress.
3. ***Health Sector Reform***. Community ownership and increased private sector involvement in health: international agencies, NGOs and civil society organization; decentralization of management; efficient resource mobilization, utilization and accountability; equity and quality care.

4. ***Effective collaboration*** with stakeholders in PHC.