Appraisal of Environmental and Personal Factors on the Ward Development Committees' Functionality on Primary Health Care Facilities in Akinyele Local Government Area.

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Abstract
Ward Development Committees, as outlined in the WHS operational guidelines, are citizen representatives and are expected to play a vital role in identifying & addressing health priorities at the community level. This study evaluated the functionality of WDCs within the PHC system in Akinyele LGA of Oyo State, Nigeria. The study employed descriptive survey research design with purposive sampling to select 240 WDC members and 12 heads of health facilities in Akinyele LGA. Structured questionnaires, alongside in-depth interviews were used for data collection. The analysis, conducted using descriptive statistics and linear regression at a significance level of P = 0.05. The result showed that there is significant influence of environmental factors (institutional support & political interference) on WDCs functionality with ($F = 160.342$, $R = .758$, $R^2 = .575$ and Adjusted $R^2 = .571$; $p < .05$. While the result on personal factors (education & health status and residence in the community also showed significant influence on functionality of WDCs members with ($F = 46.269$, $R = .609$, $R^2 = .370$ and Adjusted $R^2 = .362$; $p < .05$. The study concluded that addressing environmental & personal factors is essential to improving the functionality of WDCs. However, there is a need to minimize political interference, provide institutional support through trainings etc, and consider personal attributes such as residence in the community, when selecting WDC members will substantially impact positively on the WDCs' functionality within phc system.

Keywords: *Functionality, Ward Development Committees, Environmental, Personal Factors, Community Participation.*

Introduction

Background of the Study

Community participation in primary health care refers to involvement of community members in the organisation, governance and policy making of primary health care facilities (WHO *Declaration of Alma Ata*, 2024). People centered activity is the heart of primary health care and a sure way to programme sustainability (*World Health Report*, 2022).

However, communities in Nigeria rarely participate actively in health care planning and decision-making, leading to various challenges within the health sector (Sulaiman, et al., 2024). Many health facilities are located inconveniently, some are abandoned, and others, though completed, remain non-functional. Even in cases where facilities are in use, they are sometimes mismanaged, resulting in low levels of utilization (Sulaiman, et al., 2024).

Nigeria's health care system operates on three levels: tertiary, secondary, and primary. Primary Health Care (PHC) is the closest to the people, and it is constitutionally the responsibility of local governments to collaborate with community members to ensure the delivery of PHC services. This

collaboration is guided by the operational guidelines for PHC, as outlined in the Revised National Health Policy 2004 (NPHCDA, 2022). PHC remains a foundational philosophy and strategy for national health development (NPHCDA, 2022).

The Alma Ata Declaration of 1978, which introduced PHC, was based on the democratic ideals of equity, self-reliance, and community empowerment (WHO, 2022). PHC aims to address health care needs at the grassroots level, focusing on preventive, promotive, and curative services that communities can afford and accept (Miano, 2016). Despite the significant potential of PHC, evidence points to poor access and low community participation in health care management, particularly through the involvement of Ward Development Committees (Azuh, 2017).

Primary Health Care is a conceptual model encompassing primary care, disease prevention, health promotion, and community development within a holistic framework (WHO, 2024). The fundamental principles of PHC include access, equity, appropriate technology, multi-sectoral collaboration, and community participation (OECD, 2010). However, Nigeria's overall health system performance has been rated poorly. In 2000, the country was ranked 187th out of 191 member states by the World Health Organization, with one key factor being the lack of community participation in health care, particularly at the local government level (World Health Report, 2000). To address this, the Federal Government of Nigeria adopted the Ward Health System (WHS) as a strategy to revitalize PHC and ensure community participation(NPHCDA 2022). The WHS focuses on making wards the operational units for PHC implementation. Over 2,000 WDCs have been established or reactivated nationwide since 2001 (NPHCDA, 2022). The WDCs are designed to develop community capacity for owning and managing PHC services (Ojwang & Bwisa, 2014). However, the functionality of these committees remains a challenge due to various environmental and personal factors.

The Ward Health System was premised on a functional Model Health Centre, which is to serve as the focal point for the new PHC. The Model Health Centre was to be provided with appropriate number of health personnel, equipment and drugs, and linkage with network of other health facilities/post in the ward and the village health system; Managerial support was to be provided by the Ward Development Committees/Village Development Committees (NPHCDA, 2022).

Some of the roles and responsibilities of the Ward Development Committee as stated in the WHS operational guideline 2001 include the following;

- Mobilizes and motivates active community participation in health, and other health related programmes
- Identification of health and social needs of the Ward and planning solutions.
- Mobilization of resources (Financial and Material)
- Supervision, monitoring and evaluation of health activities in the Ward
- Liaison with Government, NGO and other partners in the implementation of health programmes
- Supervision and support to TBA/VHW/CHEWs
- Support the establishment of health facilities and overseeing their functions at ward level *(NPHCDA, 2022).*

The major roles and responsibilities which are not effectively implemented by the WDCs include the areas of mobilizes and motivate active community participation in health and other health related programmes, identification of health and social needs of the ward and plan for solutions, mobilization of resources (financial and material), supervision, monitoring and evaluation of projects, stimulate active involvement of prominent and other local people in planning,

implementation and evaluation, oversee the functioning of the health facilities in the ward etc. (NPHCDA, 2022).

Objectives of the Study

The specific objectives are to:

1. Ascertain the extent to which environmental factors, namely, institutional support and political interference influence the functionality of ward development committee members' in primary health care facilities in Akinyele LGA of Oyo State Nigeria.
2. Examine the extent to which personal factors such as educational status, health status status, and residence in the community influence the functionality of ward development committee members' in primary health care facilities in Akinyele LGA of Oyo State Nigeria.

Research Hypotheses

The study is anchored on the following hypotheses:

1. There is no significant influence of environmental factors, such as institutional support and political interference on the functionality of ward development committee members' in primary health care facilities in Akinyele LGA, Oyo State Nigeria.
2. There is no significant influence of personal factors such as educational status, health status and residence in the community etc, on the functionality of ward development committee members' in primary health care facilities in Akinyele LGA, Oyo State Nigeria.

Literature Review

The term 'community participation' is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs (Azuh, 2017). This is not an isolated pronouncement. The origins of the concept of community participation in rural health lie in its application by international organizations, such as the World Health Organization (2010) in developing countries in an attempt to improve health, social and economic conditions. However, these purposes are undermined by environmental and personal factors.

Studies have proved evidences on how environmental and personal factors influence the functionality of WDCs in the PHC system. Distance, transportation costs, and service availability are identified as factors that significantly affect the functionality of WDCs and their ability to engage the community in health care decision-making and utilization.

For instance, in Vietnam, where the average distance from provider to client is 1.85 km with a travel time of 20 minutes, utilization of primary health care facilities has been encouraged. In this context, distance was not perceived as a barrier to accessing health services (Tesha et al., 2015). However, in Nepal, clients living more than 2 km away from primary health clinics were found to have lower utilization rates, with many opting for home deliveries instead of seeking maternal health services at clinics (Yadav, 2010). The urban-rural factor is significant as it determines the utilisation of PHC. Residents in urban area use primary health facilities more compare to rural residents (Adeyemo, 2005).

Azuh (2017) argued that if WDCs are to be effective in managing primary health care services, they must address these environmental challenges to ensure that health care is accessible to all members of the community. Education plays a key role in shaping individuals' health-seeking behaviors, particularly for maternal and child health services. Studies have shown that mothers

with higher levels of education are more likely to seek health care for their children and themselves. In Nigeria, mothers with higher education were more likely to bring their children for medical care compared to those with lower levels of education (Adeyemo, 2005).

Zuluwa (2012) argued that Nigeria operates a three-tiered health care delivery system, with a large percentage of services provided at the primary care level. She seeks to examine the factors responsible for the poor functionality and utilization of Ward Development Committees (WDC) in PHC delivery in Nasarawa State. The study adopted a qualitative research methodology, collecting data through focus group discussions and individual interviews. Sixty participants were sampled, including ten staff members, twenty non-users, and thirty facility users from PHC centers. Facility users were randomly selected as they attended clinics, while non-users were chosen using snowball sampling. Data were analyzed using thematic analysis.

Despite these challenges, there is a lack of comprehensive study focusing on the environmental and personal factors affecting WDC functionality, particularly in the rural regions of Nigeria. Most studies on health service utilization have employed either quantitative method or qualitative method, leaving a gap in understanding the aspects of the joint influence of environmental and personal factors in WDC functionality and adoption of mixed methods.

Methodology

The study adopted the descriptive survey research design. This type of design is usually adopted where the researcher does not aim at manipulating the variables of the study. It enabled the researcher to make proper investigation for description, drawing inferences and making generalization while determining how the independent variables influence the dependent variables. The population of this study comprised of two hundred and forty (240) ward development committees (WDC) members, twelve (12) officers in Charges (OICs) of health facilities and sixty (60) community members from all the 12 wards in Akinyele LGA. Multi-stage sampling procedure was adopted in the study. The stage started with purposive selection of Akinyele LGA in Oyo State base notable factors that undermine the functionality of WDCs in the area. Thereafter, purposive sampling was used to select all 12 wards in the study area, lastly, sample random sampling technique was used to select twenty (20) WDCs members per ward resulting to a sub-total of two-hundred and forty (240) WDCs and twelve (12) heads of apex health facilities from the twelve wards, and 252 respondents were used for this study.

Data were collected quantitatively and qualitatively. While in-depth interviews were conducted for five (5) community members from each of the ward, totaling sixty (60) community members. Three instrument was used to gather data for the study, this comprised Environmental Factors Scale (EFS), Personal Factors Scale (PFS), and Knowledge of Community Members on Community Participation Scale (KCMCPS). It was constructed using the four-point liker-rating scale with responses varying from Strongly Agree (SA)=4, Agree (A)=3, Disagree (D)=2, and Strongly Disagree (SD)=1. The validity of the instrument was ascertained by experts' critique. The reliability was determined through a pilot that lasted 3 days. The result of the reliability revealed that (EFS, r = 0.76), (PFS, r = 0.71), and (KCMCPS, = 0.84). This implies that variables are consistent in measuring the construct they intend to measure. Data were analysed with SPSS. Questionnaire and In-depth interview were method for data collection. Data were analysed using descriptive statistics, Pearson Product Moment Correlation and Multiple Regression analysis.

Results and Discussion

This chapter presents the results of the study based on the research questions, hypotheses and the demographic variables of the respondents.

Table 1: Demographical Variables of the respondents

S/N	Distribution	Labels	Frequency	Percentage
1	Gender	Male	146	57.9
		Female	106	42.1
2	Age	18 – 27	15	6.0
		28 – 37	61	24.2
		38 – 47	80	31.7
		48 -57	54	21.4
		58 -67	33	13.1
		68 & Above	9	3.6
3	Religion	Christianity	103	40.9
		Islam	145	57.5
		Traditional Worship	4	1.6
4	Educational Background	Non-Formal	11	4.4
		Primary	94	37.3
		Secondary	100	39.7
		Diploma / OND	19	7.5
		HND / University Degree	22	8.7
		Others	6	2.4
5	Residence	Fully Residence	127	50.4
		Partial Residence	123	48.8
		Non-Residence	2	0.8
6	Marital Status	Single	11	4.4
		Married	234	92.9
		Widow / Widower	5	2.0
		Divorced	2	0.8
7	Economic Level	Lowest	2	0.8
		Low	21	8.3
		Middle	213	84.5
		High	14	5.6
		Highest	2	0.8
8	Health Status	Good	248	98.4
		Fair	4	1.6
9	Employment Status	Fully Employed	112	44.4
		Partially Employed	131	52.0
		Non Employed	4	1.6
		Retired	5	2.0

Ho1: Environmental factors as institutional support and political interference do not significantly influence functionality of WDC members in PHC system in Akinyele LGA

A. The Result obtained from Ward Development Committees in PHC

Table 2a: The composite effect of environmental factors (institutional support and political interference) on functionality of WDCs

R = .758[a]
R^2 = .575
Adjusted R^2 = .571
Std. Error of the Estimate = 0.816

ANOVA

Sources of Variation	Sum of Squares	Df	Mean Square	F	Sig.
Regression	213.620	2	106.810	160.342	.000[a]
Residual	157.875	237	.666		
Total	371.496	239			

Significant at 0.05 level

Table 2b: The relative influence of environmental factors (institutional support and political interference) on functionality of WDCs

Variables	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	14.244	.459		31.012	.000
Political interference	.821	.062	.660	13.251	.000
Institutional support	-.821	.048	-.858	-17.222	.000

a. Dependent Variable: WDC Functionality

Table 2a shows that the effect of WDC's environmental factors (institutional support and political interference) on functionality of its members is significant (F = 160.342, R = .758, R^2 = .575 and Adjusted R^2 = .571; $p < .05$. This means that 58% of the variance in functionality of WDCs was predicted by the predictor variables (institutional support and political interference). As a result, the WDC members' environmental factors to a larger extent, determines the level of functionality of WDCs. Table 2b reveals the relative influence of the WDC members' environmental factors on functionality of WDCs. It was revealed that political interference (β = .660, $p < .05$) and institutional support (β = -.858, $p < .05$) were statistically significant. Table 2b further reveals that dependent variable (functionality of WDC) is positively influenced by political interference $t(13.251) = 14.244 + .821$, $p < .05$, and negatively influenced by the institutional support $t(-17.22) = 14.244 - .821$, $p < .05$. This means that, as political interference increases, the extent of functionality of WDCs also increases; while increase in institutional support decreases the extent of functionality of WDCs.

B. The Result obtained from Officers in Charge (OIC) of Ward Health Facility

Table 2c: The composite effect of environmental factors (institutional support and political interference) on functionality of WDCs

R = .762[a]
R^2 = .580
Adjusted R^2 = .487
Std. Error of the Estimate = 1.537

ANOVA

Sources of Variation	Sum of Squares	Df	Mean Square	F	Sig.
Regression	29.408	2	14.704	6.225	.020[a]
Residual	21.258	9	2.362		
Total	50.667	11			

Significant at 0.05 level

Table 2d: The relative influence of environmental factors (institutional support and political interference) on functionality of WDCs

Variables	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	15.482	5.484		2.823	.020
Political interference	.751	.809	.228	.928	.378
Institutional support	-.841	.245	-.843	-3.436	.007

a. Dependent Variable: WDC Functionality

Table 2c shows that the effect of WDC's environmental factors (institutional support and political interference) on functionality of its members is significant (F = 6.225, R = .762, R^2 = .580 and Adjusted R^2 = .487; $p < .05$. This means that 58% of the variance in functionality of WDCs was predicted by the predictor variables (institutional support and political interference). As a result, the WDC members' environmental factors to a larger extent, determines the level of functionality of WDCs. Table 2d reveals the relative influence of the WDC members' environmental factors on functionality of WDCs. It was revealed by the OIC that political interference ($\beta = .228$, $p > .05$) was not statistically significant while institutional support ($\beta = -.843$, $p < .05$) was statistically significant. The table further reveals that dependent variable (functionality of WDC) is positively influenced by political interference $t(.928) = 15.482 + .751$, $p > .05$, and negatively influenced by the institutional support $t(-3.436) = 15.482 - .841$, $p < .05$. This means that although to OIC, political interference is insignificant in predicting the extent of functionality of WDCs, increase in institutional support decreases the extent.

Discussion of the findings

The result shown in table 2a, 2b, 2c and 2d reveals that, as a result, the WDC members' environmental factors to a larger extent, determines the level of functionality of WDCs and Table

4b reveals the relative influence of the WDC members' environmental factors on functionality of WDCs, as political interference increases, the extent of functionality of WDCs also increases; while increase in institutional support decreases the extent of functionality of WDCs. The finding is in-line with Vukic & Keddy, (2002) which says PHC embodies a spirit of self-reliance and self-determination; it is driven by and implies community empowerment and building community capacity and resilience: the negative influenced of political interference was further collaborated by Adnan et al. (1992), a key notion advocated in this context was that the communities need to "feel a sense of ownership," or "gain a sense of commitment" to the project rather than being alienated and kept at a distance. Farazi (1997) reported that one of the main reasons for the failure of the World Bank- sponsored embankment project in Bangladesh was that almost none of the parties (local people, contractors, engineers etc) involved in the project, or affected by the project, took any responsibility for its effective implementation.

H2: There is no significant influence of WDCs members' personal factors such as gender, educational status, marital status, employment status, health status and residence in the community, on functionality of WDC in PHC system in Akinyele LGA

A. <u>The Result obtained from Ward Development Committees in PHC</u>

Table 3a: The composite effect of personal factors (gender, health status and residence in the community) on functionality of WDCs

R = .609[a]
R^2 = .370
Adjusted R^2 = .362
Std. Error of the Estimate = 2.779

ANOVA

Sources of Variation	**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**
Regression	1071.999	3	357.333	46.269	.000[a]
Residual	1822.601	236	7.723		
Total	2894.600	239			

Significant at 0.05 level

Table 3b: The relative influence of personal factors (gender, health status and residence in the community) on functionality of WDCs

Variables	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	38.304	2.136		17.934	.000
Gender factor	-.909	.168	-.297	-5.418	.000
Health status factor	-.862	.156	-.306	-5.524	.000
Community residence factor	-1.027	.242	-.237	-4.241	.000

a. Dependent Variable: WDC Functionality

Table 3a shows that the effect of WDCs' personal factors (gender, health status and residence in the community) on functionality of its members is significant (F = 46.269, R = .609, R^2 = .370 and Adjusted R^2 = .362; p < .05. This means that 37% of the variance in non-functionality of WDCs was accounted for by the predictor variable. As a result, the WDC members' personal factors to a larger extent, determines the level of functionality of WDCs. Table 3b reveals the relative influence of the WDCs' personal factors (gender, health status and residence in the community) on functionality of WDCs. It was revealed that the WDC members' gender (β = -.297, p < .05), health status (β = -.306, p < .05) and residence in the community (β = -.242, p < .05) were statistically significant. The table further reveals that dependent variable (non-functionality of WDC) is negatively influenced by WDCs' gender, health status and residence in the community: *t*(-5.418) = 38.304 - .909, p < .05; *t*(-5.524) = 38.304 - .862, p < .05 and *t*(-4.241) = 38.304 - 1.027, p < .05. This means that increase in the WDCs' personal factors (gender, health status and residence in the community) tend to decrease the extent of functionality of WDCs, although residence in the community had greatest influence (increase).

B. <u>The Result obtained from Officers in Charge (OIC) of Ward Health Facility</u>

Table 3c: The composite effect of personal factors (gender, health status and residence in the community) on functionality of WDCs

R = .858[a]
R^2 = .737
Adjusted R^2 = .638
Std. Error of the Estimate = 1.865

ANOVA

Sources of Variation	Sum of Squares	Df	Mean Square	F	Sig.
Regression	77.853	3	25.951	7.464	.010[a]
Residual	27.813	8	3.477		
Total	105.667	11			

Significant at 0.05 level

Table 3d: The relative influence of personal factors (gender, health status and residence in the community) on functionality of WDCs

Variables	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	41.099	5.999		6.851	.000
Gender factor	.736	.571	.294	1.288	.234
Health status factor	-.940	.383	-.450	-2.453	.040
Community residence factor	-2.867	.798	-.821	-3.593	.007

a. Dependent Variable: WDC Functionality

Table 3c shows that the effect of WDCs' personal factors (gender, health status and residence in the community) on functionality of its members is significant ($F = 7.464$, $R = .858$, $R^2 = .737$ and Adjusted $R^2 = .638$; $p < .05$. This means that 74% of the variance in non-functionality of WDCs was accounted for by the predictor variable. As a result, the WDC members' personal factors to a larger extent, determines the level of non-functionality of WDCs. Table 3d reveals the relative influence of the WDCs' personal factors (gender, health status and residence in the community) on functionality of WDCs. It was revealed that the WDC members' gender ($\beta = .294$, $p > .05$) was not statistically significant, while health status ($\beta = -.450$, $p < .05$) and residence in the community ($\beta = -.821$, $p < .05$) were statistically significant. The table reveals also that dependent variable (functionality of WDC) is positively influenced by the WDCs' gender $t(1.288) = 41.099 + .736$, $p > .05$; and negatively influenced by health status and residence in the community $t(-2.453) = 41.099 - .940$, $p < .05$ and $t(-3.593) = 41.099 - 2.867$, $p < .05$. This means that although to OIC, gender factor is insignificant in predicting the extent of non-functionality of WDCs, health status and residence in the community tend to decrease the extent, as residence in the community had greatest influence on the WDC functionality.

Discussion of the findings

The result from table 3a, 3b, 3c and 3d shows that increase in the WDCs' personal factors (gender, health status and residence in the community) tend to increase the extent of functionality of WDCs, although residence in the community had greatest influence (decrease in non functionality of WDCs). The findings on the residence in the community agreed with *NPHCDA: Introduction to Ward Health System (2006)* That Ward Development Committees (WDCs) is Community-Based support groups that are formed by the community with the help of the health workers to identify leaders in the communities who are concerned about their community. Significantly on gender issue the national guidelines for development of Primary health care system in Nigeria, fourth revised edition (2012) recommended at least 30% of membership shall be women and they should be given effective post to take care of the gender in-balanced.

Conclusion

The study concludes that both environmental (political interference, institutional support) and personal factors (such as gender, residence in the community, health status) play a significant role

in determining the extent of WDC's functionality and addressing both environmental and personal factors is essential to improving the effectiveness of WDCs in managing primary health care facilities in Southwest Nigeria. Environmental factors, particularly political interference, were found to negatively affect the functionality of WDCs by undermining the community's ownership and commitment to the committees.

On the other hand, institutional support, especially regular training and capacity building, emerged as a key factor in enhancing WDC functionality. Personal factors such as residence in the community and the ability of members to read and write, particularly in the roles of chairman and secretary, were shown to be crucial in promoting committee functionality.

Recommendations

Minimizing Political Interference: Government authorities should establish clear guidelines that prohibit political interference in the selection and functioning of WDCs. This will ensure that community members are fully involved in the process and that WDCs operate independently to serve the needs of the community effectively.

Enhancing Institutional Support: WDC members should receive regular capacity-building opportunities, including training programs focused on leadership, community mobilization, and health system management. Additionally, providing transport allowances or modest stipends could improve the functionality and commitment of members.

Residence Requirement for Members: WDC members should be required to reside within the community they serve to ensure they are accessible and familiar with local health needs. This will enhance the WDC's ability to respond effectively to community health challenges.

Ensuring Gender Balance: Efforts should be made to meet the national guideline recommending that at least 30% of WDC members be women, and these women should be empowered to take up leadership roles within the committees. Gender-balanced representation will ensure that diverse perspectives are considered in decision-making processes.

Promoting Educational Qualifications: To enhance the functionality of WDCs, especially in leadership roles, it is essential that the chairman and secretary possess basic literacy skills. This will enable them to carry out their duties effectively and ensure proper documentation and communication within the committee.

Empowering Community Ownership: The government and health workers should facilitate community ownership of WDCs by promoting self-reliance and reducing dependence on external influences. This will build community capacity and resilience, ensuring that WDCs function effectively in the long term.

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