

Online Publication Date: 9 December, 2011

Publisher: Asian Economic and Social Society

International Journal of
Asian Social Sciences



The Role Of Health Education In Participatory Rural Health Development; The Case Of The Rural Fulani In Kogi West, Nigeria

Steve Metiboba (Department Of Sociology Kogi State University Anyigba, Nigeria)

Citation: Steve Metiboba (2011): “The Role Of Health Education In Participatory Rural Health Development; The Case Of The Rural Fulani In Kogi West, Nigeria ” International Journal of Asian Social Science, Vol.1, No.5,pp.181-187.



The Role Of Health Education In Participatory Rural Health Development; The Case Of The Rural Fulani In Kogi West, Nigeria

Abstract

Author (s)

Steve Metiboba

Department Of Sociology Kogi State
University Anyigba, Nigeria

Key words: Participation, Health
Development, Health education, Health
programs

This study is a social survey of 235 Fulani rural dwellers living at the outskirts of 3 communities in Kogi west senatorial district of Kogi State, Nigeria. The main objective of the study was an investigation of the role of health education principles in health programs among the study population. Through the stratified sampling technique, a structured interview schedule was administered on the respondents. Findings of the study revealed that relevant health education principles served as a potent reinforcing factor in effecting expected behaviour change (e.g. acceptance and adoption of health programs) among the nomadic rural Fulanis. It is recommended in this paper that any plan for beneficiary participation in health matters by the local populace must take into cognizance several circumstances and factors, especially the unique socio-cultural context in which health education principles or actions are being taken into consideration.

Introduction

Since the 1970s, several studies have established high correlation between project performance and levels of community participation in many Third World Countries. Citizen participation has been used for agricultural extension services in Kenya, the rural water supply in irrigation projects in Asia region as well as the control of infectious diseases in Israel (Moench 1993, Norton and Stephens 1994).

In the area of health in particular, the World Health Organization (WHO) has played an important role in the promotion of community participation. Since the 1970s, WHO has actively supported real opportunities which had begun to examine community participation efforts in different fields of health practice so as to define a clear strategy for health development (WHO/UNICEF 1990, World Bank 1996).

Apologists of participatory development have argued that participation of the local people in a project which directly or indirectly affects them is inevitable since it is hardly possible for such a project to succeed by not involving the target group for which it is supposedly designed. In most parts of Africa, south of the Sahara, when the ordinary people are involved in community-based programs, it is usually not beyond the mere provision of money, labour and materials. At the critical stages of project planning, evaluation and implementation, the ordinary man who is the “drawer” of water and “hewer” of wood” is often marginalized or out rightly neglected.

The non-involvement or ‘official’ marginalization of prospective project beneficiaries in a project which concerns them has resulted in colossal amount of financial and material wastage in many developing countries. Even when citizen participation is enlisted in some of these countries, failure to adopt appropriate health education principles has led to abysmal failure of programs initiated by service and facilities’ providers. This paper therefore, is a theoretical exploration of the pertinent health education principles and their role in participatory health development in Nigeria.

What is Participation?

Participation as a concept, within the larger frame work of development generally, is often used to connote the involvement of the local people in the development process of a particular program initiated for the general good of the people. Participation has been used in some relevant literature to mean any of the following:

- i. To mobilize people and thus increasing their willingness to respond to development programs, as well as to encourage local initiatives.
- ii. People’s involvement in decision-making process, in implementing programs, sharing in the benefits of development programs, and their involvement in efforts to evaluate such programs.
- iii. Organized efforts to increase control over resources and regulative institutions in given social institutions on the part of groups or movements of those hitherto excluded from such

control (Pearce and Stiefel 1979, Oakley 1989).

Whatever definition one adopts, there seems to be some consensus among scholars on this subject that participation is based on two basic principles: first is the readiness or otherwise of the target group to change, and second is the method or approach that the target group or local populace believe that such participation will enable them to change (Young and Klinge, 1996).

For the purpose of this study, participatory health development is used to connote the following;

- i. decision making during project planning
- ii. monitoring of health services
- iii. evaluation or assessment of health projects
- iv. utilization of health projects
- v. Donation of labour, money or materials to health projects.

Some cross-cultural studies on participation have revealed that sometimes when people participate in programs designed for their socio-economic transformations, the desired result is not often realized by service providers. This has been attributed in certain cases to the non-application of appropriate health education principles for community participation as a veritable process of behaviour change (Adebayo 1992, Johnson 1987, Tomwine 1989, Metiboba 2005).

Health Development and Community Participation

Up to this decade, in several developing countries of the world, the involvement by the people in health care development is believed to be still quite limited. By health development, within the scope of this analysis, is meant the aggregate for all purposeful activities designed to improve personal and public health through a combination of strategies. It is an inter-sectoral phenomenon that involves the socio-cultural, economic and legal aspects of the social structure.

The implication of the preceding paragraph is that health development cannot be divorced from societal general transformation, and it is generally influenced by ecological or environmental factors. It is also implied in that definition that health development is a function of a combination of several strategies including educational, political and regulatory approaches (Oakley, 1989).

Community participation in health development in most Third World countries generally and Nigeria

in particular, is believed to be mainly at the grassroots level of the village health worker/traditional birth attendants and village district health development committees where some participation in health care exists. Administratively, at the grassroots level, the community is represented at higher levels of primary health care and secondary health care planning and management by its representatives in Local Government Area's (LGA) administration (KHMIS, 2002). It is known that, for example, in many rural places in Nigeria. There are lay-members appointed to the state's health Management Board. Several of these communities are known to have expressed their concern in respect of the health facilities provided through their sweat or labour. Their expectation had always been that such facilities provided through their own sweat be immediately equipped with relevant material or drugs.

Where participation in health programs is not predicated on the norms, values, and aspirations of the people (prospective beneficiaries), sharing the benefits, such as facilities' utilization, of such programs have been reportedly turned down by the target group in many communities in Nigeria. And where the people's participation is marginally or fairly enlisted quite often, their participation does not go beyond the level of donating money, drugs, labour and materials. Their involvement in community-based health projects, especially at the critical stages of project planning, decision making and evaluation is usually relatively low (Metiboba, 2005).

The Need for Health Education;

Health education has been defined as a form of education which relates to all aspects of health behaviour including the use of health services and self-treatment. According to Lucas and Gilles (2009), health education is designed to help people improve their personal habits and to make the best use of health. Some experts today argue that health education should feature as an integral part of the health services.

This analysis believes that if some appropriate health education principles are put in place for the vast majority of the citizenry, some of the lapses in health care as aforementioned above, would be alleviated in these developing societies. The succeeding paragraphs in this paper, therefore, highlights some of the workable health education and behaviour change principles that are deemed quite relevant for community participation in health development in Nigeria, taking into cognizance her unique socio-cultural and political experience.

These principles are as follows (Huff and Kline, 1999):

- i. **Principle of educational diagnosis:** This involves identification of the causes of health behaviour in specific cultural groups. In some instances, when people have negative attitude towards a given promotion program, it is not quite easy to enlist their participation in development programs unless the main reason why they hold a certain opinion or attitude about a particular health program is identified and clearly defined. This principle is particularly relevant for behaviour change because it is also in consonance with the definition of education by one of the world's most renowned educationists – John Dewey. Dewey (1916) defined education as a constant reorganisation or reconstruction of experiences or the influence of an environment upon the individual to produce permanent attitudes.
- ii. **Principle of Hierarchy:** There is a natural order in the sequence of factors which tend to influence health behaviour. This natural order in a sequence of factors influencing non-participation of the people in health development should be identified with a view to taking appropriate action to redress an unfavourable attitude. Poverty, cultural barrier or religion, and low level of awareness, etc, are known to have impeded community participation in health programs thereby giving negative attitudes to the people concerning participation in development programs.
- iii. **Principle of participation:** Service providers need to realize that changes in behaviour will be greater if people have identified their own need for change and have actively selected a method or an approach that they believe will enable them to change.
- iv. **Principle of educational specificity:** under this approach, the effectiveness and efficiency of a particular participation strategy will depend on the circumstances and characteristics of the person and/or change agent. This means the socio-economic, demographic and personality characteristics of the target individual and the change agent are very crucial to a hitch-free behaviour change. In some parts of Nigeria, for example, some people develop nausea as soon as they take morning tea. This may have to do with their biological constitution or socio-economic background. Asking such people to participate in a program that

intends to change people's attitude in favour of taking tea in the morning may be an up-hill task.

- v. **Principle of relevance:** The more relevant the contents and methods used for behaviour change to the target individual, the more likely the learning and behaviour change process will be successful. Change agents should make community participation strategies relevant and meaningful to the beneficiaries in view.
- vi. **Principle of reinforcement:** Change agents should try to reward positively-inclined healthy behaviour as this has the tendency of being repeated. Such rewards will invariably enhance the rewardee's participation in community-based health project.
- vii. **Principle of facilitation:** Change agents should ensure that a health intervention program provides the means for people to take action or reduce the barriers to health behaviours. Application of this principle includes the development of skills to apply behavioural techniques for self management. This is in consonance with a relatively popular definition of education given by J. D. O' Connors (1971) and cited by Nweke (1989):

“education, provides men and women with a minimum of skills necessary for them to take up their place in the society and seek further knowledge, provides the vocational training that will enable them to be self supporting”:

Study objectives

1. To investigate the role of health education principles in health programs among the Fulani rural dwellers in selected communities in Kogi west, Nigeria.
2. To highlight the various socio-cultural barriers to participating health development among the study population.
3. To suggest ways by which health education towards improved health status can be enhanced among the Fulani rural dwellers in Kogi west community.
4. To highlight the implications of (i-iii) above for health development generally among the rural and urban Fulani dwellers in Nigerian communities.

Materials and methods

Social survey of a descriptive type was used for this study. Data for the study were generated through the stratified random sampling technique, by the use of structured interview schedule administered to 235 Fulani- speaking rural dwellers living in the outskirts of some ijumu communities in kogi west, Nigeria. This data instrument was used because virtually all the respondents are illiterates. The researcher was assisted by 3 research assistants in the administration of the structured interview schedule to the latter as well as in the sensitization of the study population to imbibing basic health education principles. These assistants were final year sociology students of kogi state university who understood and could speak the Hausa-Fulani language which the Fulani respondents could speak fluently. The study lasted for 12 months, a time frame which enabled this researcher to know the effect which the health education intervention may have had on the latter in the adoption of modern health care delivery techniques.

For the purpose of this study, only five (5) of the most cited health education principles were found most relevant. These are:

Principles of educational diagnosis, hierarchy, participation, relevance and principle of reinforcement. Methods of data analysis involved the use of non-parametric statistics including simple frequency distribution, mean and the statistical pooled percentage model.

Study Area

The study was conducted in 3 different Fulani settlements located at the outskirt of Iyara, Kabba, and Aiyetoro communities in kogi west senatorial district of kogi state, Nigeria. The people of kogi west senatorial district constitute an ethnic group of the Yoruba nationality in Nigeria. They are the third largest ethnic group in kogi state, Nigeria. The Hausa-Fulani are found in scattered settlements at the outskirts of most communities in Ijumu land. The Hausa-Fulani in the study area are characterized by relatively simple lifestyle in terms of food, shelter and clothing. Majority of them are known for nomadic life, but always still in touch with the pre-industrial, pre-literate, socio-economic life-style.

Quality control

Through validity tests and pre-tests, this study was subjected to some quality control by two senior lecturers in the Department of Sociology kogi State University Anyigba. A reliability co-efficient of 0.80 was obtained using Pearson product moment correlation co-efficient.

Data Analysis and Results

The data in Table one above shows the distribution of respondents in reference to their perceived degree of importance of health education principles. The table reveals that out of the 5 principles so highlighted in this study. It is participation that attracted the highest score in terms of importance (105). Hierarchy, reinforcement and relevance attracted 98, 86 and 85 respectively. This finding is not incongruent with those of some earlier researchers such as Nyemetu (1999), Morgan (1993) and Philip (1993) who have also established, among their study population, a predominant preference for participation in certain health related programs.

Table 2 shows a clearer picture, through the pooled percentage analysis, the unique place of the principle of participation in community-based health programs among the Fulani under review. For instance, the principle of participation elicited 76 in terms of pooled percentage degree of importance. This is the highest, followed by the principle of hierarchy (60).

This is not surprising because part of the oral interview with the respondents revealed that the majority of the study population had a sense of neglect and powerlessness each time certain health officers came around to sensitize them to embrace orthodox health programs such as immunization. The local Fulani described health workers who came their way too paternistic.

A critical look at Table 3 above reveals that as high as 57% of the respondents agreed that health education had impact on modern health care services generally. This means that the impact of health education on health generally in the study community is highest on the index of modern health care services. Close to that index is community based programs which attracted a score of 52%. Only 39% were of the view that health education had any impact in the area of immunization services. One inference that one can draw from this analysis is that health education as a major intervention in the communities has made a tremendous difference in the utilization of modern health care services as against the hitherto seeming limitation of the rural Fulani dwellers in the communities studied, to isolated disease specifics. This suggests that it is not only in immunization, family planning or preventive health services alone that were reportedly being patronized by the Fulani rural dwellers, but modern health care services generally. This finding has been corroborated by the works of Schultz (1984), Behm(1979) and Paloni (1981) who indicated that female education

is a relevant substitute for actualizing the utilization of treatment for childhood illness and diseases. Jegede's (1988) study among the south-west Yoruba of Nigeria has also shown a positive relationship between mothers' level of education or awareness and the use of immunization in the study communities.

Limitations of Community Participation in Health Projects

The view that community participation is a political process which empowers people to have a 'say' in decision-making about health is subject to debate. The reason for this view is that quite often, this 'empowerment' is a cosmetic one. Even when the ordinary people are involved in the early stage of health planning, they are hardly carried along during project monitoring, implementation and evaluation (Fonaroff 1983, Oakley 1989, Gonzalez and Mayfield 1994).

Further, some of the assumptions of community participation in health activities in most developing countries may not be realistic. For instance, it is not known the extent to which the ordinary people can have some control over health workers who are supposed to serve their needs. It is also quite uncertain the real extent of improvement in the quality of decision-making through the participation of the ordinary people in health action. In Nigeria in particular, such factors as corruption, ignorance, leadership and bureaucracy have negative impact on the success of health participatory efforts. Besides, as this study revealed, some cultural factors and belief systems such as religion, taboos and magico-religious value systems have tended to obliterate the participation of the local populace in most traditional societies in health projects. Also there has always been the reported risk of not communicating the right message to the people in the process of organizing them in a strategy to solve an identified problem.

Summary and Conclusion

In this empirical study of the role of health education in participatory rural health development projects in Nigeria, certain definitions and positions relevant to this study have been carefully examined and discussed. This study has revealed that it is not all the health education principles often cited in most relevant literature in the adoption of participation in health projects that are appropriate for many communities especially in traditional societies where superstition and folklores still hold sway. The unique importance of the participation principle in community-based health projects, out of all other principles, has been particularly

instructive in this study. This analysis has further reinforced the finding in some earlier related works to the effect that education generally is a potent instrument for enlisting people's participation for behaviour change. This thesis is considered highly applicable, to one or the other degree, in all societies-rural or urban, developing or developed. This study has also suggested that health education is not only possible among rural dwellers but also that it can be effected with relative ease in rural communities through empathy, non-judgemental attitude and sympathetic understanding by health workers to the rural dwellers disease burden.

The uniqueness of this study however lies in the fact that where and when rural communities embrace some level of health education with reference to health matters, they tend to imbibe its 'tenets' holistically. This informs, to a large extent, why the impact of health education among the study population was highest on the index of modern health care services generally (MCHS). Such impact was not limited to either immunization or family planning services or preventive health services singularly. Based on the above findings, it is recommended that even though there is no 'perfect model' for community participation in health development programs, any plan for beneficiary participation in health matter by the local populace must take into cognizance several circumstances and factors, especially the unique socio-cultural context in which health education principles actions are being taken into consideration. Besides, the people for whom health programs are designed should not only be treated as rational beings by health planners but also should be sufficiently involved in the critical stages of project planning, evaluation and decision making.

Participation as a behaviour change will certainly not terminate all the problems on ground in the health arena because of some of the problems earlier on mentioned in this discourse. However, a carefully planned health education package built into appropriate participation strategies for health development, and backed up by sufficient political will by the state, including the presidency, will definitely take the country nearer her health dreams for the Millennium Development Goals.

Table 1: Distribution of respondents in reference to their perceived degree of importance of health education principles.

Code	Health Education Principles	DEGREE OF IMPORTANCE					Total
		5	4	3	2	1	
01	Participation	105	60	45	25	0	235
02	Hierarchy	98	40	23	21	53	235
03	Educational diagnosis	83	40	27	82	13	235
04	Relevance	85	15	53	76	6	235
05	Reinforcement	86	10	45	5	89	235

Source: Author's Field Survey (2010-2011)

Code: (For Table 1)

5 = Very great importance 4 = Great importance

3 = some importance 2 = little importance

1 = not important

The relative importance of each of the health education principles to the respondent was computed by finding the pooled percentage (PP) of each component

PP = $\frac{TS}{N}$

$$\frac{\text{-----}}{N(5-1)} \quad .100$$

Where:

PP = pooled percentage

TS = total score obtain by multiplying each scale by corresponding and then adding these together.

N = Total number of respondents

Table 2: Distribution of Respondents showing prioritization of the different principles of health education Principles through pooled percentage (%)

Code	Health education principles	PP Degree of importance (%)
01	Principles of participation	76
02	Principle of hierarchy	62
03	Principle of educational diagnosis	54
04	Principle of relevance	47
05	Principle of reinforcement	35

Source: Researcher's survey, (2010-2011)

Table 3: Distribution of respondents by their perception of the significance of health education in health programs.

Impact of Health Education	Health Programs					No. of Respondents
	MHCS	IMS	FPS	PHS	CBHP	
Very significant	0.35	0.25	0.30	0.77	0.77	35
Significant	0.87	0.60	0.52	0.48	0.65	50
Not quite significant	0.55	0.53	0.48	0.53	0.35	75
Insignificant	0.68	0.38	0.28	0.38	0.32	39
Undecided	0.40	0.20	0.22	0.33	0.51	36
Mean(x)	0.57	0.39	0.36	0.49	0.52	47

Source: Researcher's survey, (2010-2011)

P = 0.5

For simplicity, a score of 0.5 or 50% is considered significant, while one below 0.5 or 50% is considered low or insignificant.

Code (2):

MHCS = modern health care services

IMS = immunization services

FPS = family planning services

PHS = preventive health services
CBHP = community based health programs

References

Adebayo S. A. (1992) Application of Preference-Based Heuristic Model to Community Participation in Health Care: Case Study of Kwara State, Nigeria (An Unpublished Thesis, University of Ilorin, Ilorin, Nigeria).

Behm, H (1979) Socio-Economic Determinants of Mortality in Latin America, Proceedings of the Meetings of Mortality. Mexico City. 19-25 June, 140-165

Dewey J. (1916) Democracy and Education. New York: Mac. Millian Company Limited
Huff M. and Kline V. (1999) Promoting Health in Multicultural Population. California: Sage Publications.

Fonaroff A. (1983) Community Involvement in Health System for Primary Health Care, Unpublished WHO Document, SHS/83:6.

Gonzalez J. and Mayfield (1994) "Community Participation in Health Projects: An Assessment of Sectoral and Regional Trends", Final Draft, World Bank, Washington, D.C.

Jegede, A.S (1998) African Culture and Health, Lagos; Stirling – Harden Publishers (Nig.) Limited

Johnson K. (1987) "Designing Community Financing in Two Developing Countries", Socio-economic Planning Science, Vol. 21 No 2.

Kogi Health Management Information System (KHMIS, 2002) Lokoja, Kogi State, Nigeria.

Lucas O, and M. Gilles. (2009) Short Textbook of Public Health Medicine for the Tropics. Revised 4th Edition (Pp330-332,353-360). London: London Book Power

Metiboba S. (2005) "Social Factors, Community Participation and Health Development among the O-kun Yoruba of Ijumu in Kogi State, Nigeria". An unpublished Ph.D Thesis, University of Ilorin, Ilorin, Nigeria.

Moench M. (1993) Farmers Participation in Water Management" in Gujarat World Bank Publication, Washington, DC.

Morgan, L. (1993) Community Participation in Health; the Policies of Primary Health Care in Costa Rica, Cambridge University Press.

Norton A. and Stephen T. (1994) "Participation in Poverty Assessments". Participation's Source Book, World Bank, Washington, DC.

Nweke R. (1989) Approaches to the Teaching and Practice of Philosophy of Education. Agbor: Entre Books Limited.

Nyemetu, R. (1999) 'Mobilizing Popular Participation in Development Planning' Training Module Prepared for the Development Policy Centre Ibadan.

Oakley P. (1989) "Community involvement in Health Development: An Examination of the Critical Issues". World Health Organization, Geneva.

Palloni, A. (1989) Mortality in Latin America; Emerging Pattern. Population of Development Review. 7;623-649

Pearce A. and Stiefel M (1979) Inquiry into Participation: A Research Approach: United Nations Research Institute for Social Development.

Philip R. Gerson (1993) "Popular Participation in Economic Theory and Practice"; HRO WORKING Papers, No. 18, World Bank, Washington, D.C, (Dec. 1993)

Tumwine J. (1989) "Community Participation as Myth or Reality: a Personal Experience from Zimbabwe" Health policy and Planning Vol.4, No.2, pp.157-161.

WHO/UNICEF (1990) "Community Financing of Health Services for the improvement of Primary Health Care, Pan African Conference on Community Financing" (Joint WHO/UNICEF Meeting, Kinshasa, 25-28 June).

World Bank (1996) "Nigeria: Poverty in the Midst of Plenty, The Challenge of Growth with Inclusion", (A World Bank Assessment Report No. 14733. UN).

Young M. & Kingle R.S. (1996) "Silent Partners in Medical Care: A Cross-Cultural Study of Patient Participation", Health Communication. 8(1), 29-53.

