

The Role of Health Education on Community Attitudes in the Acceptance of Family Planning Services among the O-kun Yoruba, Kogi State, Nigeria

LE RÔLE DE L'ÉDUCATION SANITAIRE SUR LES ATTITUDES DE COMMUNAUTÉ DANS L'ACCEPTATION DE SERVICES DE PLANISME FAMILIAL PARMIS L'O-KUN YORUBA, L'ÉTAT DE KOGI, LE NIGERIA

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Abstract: Despite the much publicized efficacy of citizens or beneficiary participation in community-based programs, there have been several reported cases of abysmal failure in many health services in the developing nations. Recent literature on this subject has suggested the adoption of certain health education principles as intervening variables for their prospects in enhancing participatory health development. This study, therefore, aims at investigating the role of health education in the acceptance of family planning services among rural dwellers in some selected communities in O-kun Yoruba, Kogi State, Nigeria. Data for the study were generated mainly through multi-stage sampling technique, by the use of structured questionnaire administered to 225 (married) respondents randomly selected from 5 communities in Ijumu Local Government Area (LGA), in Kogi state, Nigeria. Methods of data analysis were mainly by the use of non-parametric statistics including simple frequency distributions, mean and cross tabulation techniques. Findings from the study revealed that in the acceptance of family planning services among the O-kun Yoruba in Kogi State, Nigeria, the role of health education as a potent intervening variable for participatory development in family planning cannot be over-stressed. Nevertheless, even at that, the findings revealed that the people for whom health programs are designed should not only be treated as rational beings but also should be involved in the critical stages of project formulation, planning, evaluation and decision making.

Key words: Family Planning; Health Education; Health Services; Community Participation; Health Development

Résumé: En dépit de beaucoup d'effet annoncé de citoyens ou de participation de bénéficiaire dans les programmes à base de communauté, il y a eu plusieurs a annoncé les cas d'échec épouvantable dans beaucoup de services de la santé dans les pays en développement. La littérature récente sur ce sujet a suggéré l'adoption de certains principes d'éducation sanitaire comme les variables intervenant pour leurs perspectives dans le fait d'améliorer le taux de participation sur le développement de santé. Ainsi, cette étude vise à enquêter sur le rôle de l'éducation sanitaire dans l'acceptation de services de planisme familial parmi les habitants ruraux dans certaines communautés choisies dans O-kun Yoruba, l'État de Kogi, le Nigeria. Les données pour l'étude ont été produites surtout par la technique d'échantillonnage à plusieurs étages, par l'utilisation de questionnaire structuré administré à 225 mariés au hasard choisis parmi 5 communautés dans la Région de Collectivité locale Ijumu (LGA), dans l'état de Kogi, le Nigeria. Les méthodes d'analyse de données étaient principalement en employant des statistiques non paramétriques comprenant des techniques simples de tabulation de distributions de fréquence, moyenne et croisée. Les résultats de l'étude ont indiqué que dans l'acceptation des services de planification des naissances parmi l'O-kun Yorubadans l'état de Kogi, Nigéria, le rôle de l'éducation sanitaire comme variable intervenante efficace pour le développement participative dans la planification des naissances

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*Received 20 January 2011; accepted 15 March 2011

ne peuvent pas être surchargés. Néanmoins, même à cela, les résultats ont indiqué que les personnes pour qui des programmes de santé sont conçus devraient non seulement être traitées en tant qu'êtres rationnels mais également devraient être impliqués aux étapes critiques de la formulation, de la planification, de l'évaluation et de la prise de décision de projet.

Mots clés: Planification des naissances; L'éducation sanitaire; Services de santé; Participation collective; Développement de santé

1. INTRODUCTION

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.

In most developing nations of the world today, the health status of the majority of the citizenry is very pathetic. Life expectancy is far less than 50 in most of these countries, while mortality and morbidity rates are still very high. Diarrhea and respiratory illness, exacerbated by malnutrition and several communicable diseases still prevail in these countries. The effect of these is enormous health problems resulting in reduced productivity (WDR, 1995; Lucas and Gilles, 2009). Some scholars have argued that the emergence of community participation in health is an antidote to deficiencies in the existing health development.

The thrust of the preceding paragraph therefore is that health services are in some places near non-existing; and where they exist, such services are very poor.

1.1 Family Planning Services

Family planning is part of the primary health care (PHC) elements in Nigeria. Family planning services include practices that help individuals or couples to attain the following objectives (Alakija, 2000);

- i. To avoid unwanted births
- ii. To bring about wanted births
- iii. To regulate the intervals between pregnancies
- iv. To control the time at which births occur in relation to the ages of the parents, and
- v. To determine the number of children in the family.

Generally, family planning is aimed at encouraging the building of healthy families and protecting the health of mothers and children.

The acceptance of family planning among most rural dwellers in Nigeria has been quite problematic. Socio-cultural factors such as belief systems, religious persuasion, norms and values of the people, illiteracy and so forth have been major impediments along the path of a successful adoption of family planning services in Nigeria. Even with citizens or beneficiary participation in community-based programs, such as family planning, there have been several reported cases of failure in program implementation in underdeveloped societies (Metiboba, 2009). Recent literature on this subject has suggested the adoption of certain health education principles as most likely intervening variables for enhancing participatory health development in family planning (Huff and Kline, 1999; Lucas and Gilles, 2009)

1.2 Education and participation

Even though health education is designed to help people improve their personal habits and to make the best use of the health services, this dream does not usually come true in most rural communities in the developing world. Quite often, the people for whom health services are designed are virtually left out in the planning, implementation, and evaluation of such programs. Where there is little or no community involvement in program design and implementation, there would be lack of community interest for the utilization of those health facilities (Jegede, 1998). This is why the role of the community in the planning, organization, operation and control of health services has been a major issue in primary health, and which is highlighted in the Alma Ata Declaration.

Primary health care is essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978, 2001).

Community participation therefore is defined as a process involving the mobilization of people, in order to increase their willingness to respond to development programs, as well as encouraging local initiatives (Oakley, 1989). Alakija (2000) posits that participation allows communities to exert effective administrative supervision over health service and also makes use of part-time unremunerated village workers.

2. COMMUNITY ATTITUDES

Community participation may not succeed in many traditional societies or communities where people hold on to age-long superstitions, customs and traditions. Community attitude may negate the effectiveness of any specific intervention (including participation). This is why the role of health education is considered quite germane to the success of any participatory program in health development.

According to Lucas and Gilles, the range of community attitudes to a specific health measure may be classified into five levels:

- i. Self-reliance
- ii. Active Collaboration
- iii. Indifference
- iv. Passive resistance
- v. Extreme hostility with violent rejection.

3. STUDY OBJECTIVES

- i. To investigate the role of health education in participatory family-planning programs among the O-kun Yoruba Nigeria.
- ii. To identify the various socio-cultural barriers to the acceptance of family planning services among the study population.
- iii. To examine the rankings of health education vis-à-vis community-based family planning services,
- iv. To highlight the implications of (i-iii) above for health development in O-kun land in particular and Nigeria generally.

4. MATERIALS AND METHODS

Social survey of a descriptive type was used for this study. Data for the study were generated mainly through multi-stage sampling technique, by the use of structured questionnaire administered to 225 (married) respondents randomly selected from 5 communities in Ijumu Local Government Area (LGA), in Kogi state, Nigeria. This researcher was assisted by 3 research assistants in the administration of the questionnaire. These were sociology undergraduates who understood and could speak the local language of the people. Community leaders including school teachers, religious leaders, village heads and local health officers were first identified in the 5 communities under study. 25 of these opinion leaders across the mentioned strata were involved in focus group discussions (FGDs). They formed a veritable source of initial primary data for the study. 198 respondents (88 per cent) from the 5 communities turned in their completed questionnaires, which is considered statistically significant to continue with the study. 25 per cent of the sampling frame in each community was of the female sex. Majority of the respondents were men because in a patriarchal society such as the O-kun community, the decision to use family planning services rests mainly on the men. Questionnaires were administered before and after the intervention (introduction) of health education principles to the study population (one month interval). This was to determine the effect of the intervention program on the respondents' community attitudes with reference to the acceptance of family planning services. Methods of data analysis were mainly by the use of non-parametric statistics including simple frequency distributions, mean and cross tabulation techniques.

4.1 Study Area

This study was conducted in 5 communities in O-kun land of Kogi State, Nigeria. The O-kun people are a sub-ethnic group within the Yoruba nationality. Located in the western senatorial district of Kogi State, O-kun group refers to a distinct socio-linguistic unit of Yoruba cultural group.

4.2 Quality Control

The study was subjected to some quality control tests such as validity tests and pre-tests. This was carried out by lecturers in the Department of Sociology, Kogi State University, Anyigba, Nigeria. A reliability co-efficient of 0.85 was obtained, using Pearson Product Moment Correlation Co-efficient.

4.3 Data Analysis and Results

Table 1: Distribution of Respondents by Their Pre-Intervention Community Attitudes to Family Planning Acceptance

Community Attitudes	COMMUNITIES											
	Iyara		Ekinrin -Adde		Aiyetoro-gbedde		Iyah-gbedde		Ogidi		All Comm.	
	F	%	F	%	F	%	F	%	F	%	F	%
Self reliance	4	(9.5)	2	(4.9)	2	(5.1)	1	(2.9)	2	(4.9)	11	(5.6)
Passive resistance	15	(35.7)	20	(48.7)	15	(38.5)	11	(31.4)	18	(43.9)	79	(40.0)
Active collaboration	5	(11.9)	3	(7.3)	7	(18.0)	6	(17.1)	5	(12.2)	26	(13.13)
Indifference	11	(26.2)	12	(29.3)	13	(33.3)	14	(40)	12	(29.2)	62	(31.3)
Extreme hostility and rejection	7	(16.7)	4	(9.8)	2	(5.1)	3	(8.6)	4	(9.8)	20	(10.1)
Total	42	(100)	41	(100)	39	(100)	35	(100)	41	(100)	198	(100)

Source: Researcher's Survey 2010

Table 2: Distribution of Respondents by Their Post-Intervention Community Attitudes to Family Planning Acceptance

Community Attitudes	COMMUNITIES											
	Iyara		Ekinrin -Adde		Aiyetoro-gbedde		Iyah-gbedde		Ogidi		All Comm.	
	F	%	F	%	F	%	F	%	F	%	F	%
Self reliance	10	(23.8)	6	(14.6)	5	(12.8)	8	(22.8)	6	(14.6)	35	(18.0)
Passive resistance	9	(21.4)	13	(31.7)	7	(17.9)	12	(39.4)	11	(26.8)	32	(26.3)
Active collaboration	14	(33.3)	13	(31.7)	19	(48.8)	8	(22.8)	14	(34.2)	68	(34.3)
Indifference	7	(16.7)	9	(22.0)	8	(20.5)	6	(17.1)	10	(24.4)	40	(20.2)
Extreme hostility and rejection	2	(4.8)	0	(0.00)	0	(0.00)	1	(2.9)	0	(0.0)	3	(1.5)
Total	42	(100)	41	(100)	39	(100)	35	(100)	41	(100)	198	(100)

Source: Researcher's Survey 2010

Table 3: Distribution of Respondents by Their Perceived Impact of Health Education on Community Attitudes for Family Planning

Impact of Health Education	Community Attitudes					
	PR	EHR	IND	AC	SR	All Comm.
Very significant	0.55	0.62	0.50	0.45	0.48	53
Significant	0.58	0.58	0.60	0.61	0.73	48
Not quite significant	0.63	0.80	0.64	0.55	0.41	45
Insignificant	0.40	0.75	0.58	0.42	0.37	25
Undecided	0.35	0.73	0.54	0.39	0.37	27
Mean \bar{x}	0.50	0.74	0.57	0.48	0.47	198

Source: Researcher's Survey, 2010

P = 0.05

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 1:

PR = Passive resistance

EHR = Extreme hostility and rejection

IND = Indifference

AC = Active collaboration

SR = Self-reliance

Code 2:

8 – 10 = very Significant

5 – 7 = Significant

3- 4 = Not Quite Significant

1 – 2 = Insignificant

0 = Undecided

To measure the respondents' perception of the significance of health education on community attitudes for family planning services, they were asked to rank the impact of health education on the various community attitudes on a scale of preference between 0 and 10.

5. RESULTS AND DISCUSSION

Table 1 above shows the distribution of respondents before the introduction of health education principles to community attitudes for family planning among the study population. The table reveals that Indifference was as high as 33.3% in Aiyetoro-gbedde, 29.3% in Ekinrin-Adde and Ogidi 29.2%. Extreme hostility and rejection for family planning before health education intervention was 16.7% in Iyara, 9.8% respectively in Ekinrin-Adde and Ogidi. For all the communities under study, it is interesting to note that active collaboration for family planning services only stood at 13.1% as against 40% of the respondents that expressed passive resistance. Even as high as 31.3% in all the communities put together showed indifference before health education intervention.

Table 2 shows the distribution of respondents by their post-intervention community attitudes to family planning. Whereas passive resistance has drastically come down from 37.5% (see table 1) to 21.4% in Iyara (see table 2), in Ogidi it reduced from 43.9% to 26.8%. on the index of indifference, in all the communities, there were tremendous reductions (Iyara from 26.2% (Table 1) to 16.7% (Table 2) Aiyetoro 33.3% to 20.5%, Ogidi 29.2% to 24.4%. Extreme hostility was reduced in Iyara from 16.7% to 4.8%, Ekinrin-Adde 9.8% to 0%, Aiyetoro from 5.1% to 0%, Iyah-gbedde from 8.6% before intervention to 2.9% after intervention. For all the communities, the total percentage of the respondents who expressed indifference before intervention was as high as 31.3% which came down to only 20.2% after health education intervention. Also, the variable of extreme hostility and rejection among the respondents was 10.1% for all the communities before the introduction of health education principles to family planning; this was reduced to only 1.5% after health education intervention.

One significant inference one can draw from this analysis is that health education is a potent intervening variable between participation and family planning services among the rural dwellers. In this particular study for instance, health education has drastically influenced the health behaviour of a rural people with seemingly unfavourable attitudes to family planning practices. This is not unexpected because quite over 70% of these rural dwellers are predominantly illiterates. This finding is in agreement with the findings from empirical works of Kolawole (1982), Morgan (1993), Jegede (1998), Nyemetu (1999), Metiboba (2005), which revealed that personal factors such as income, occupation and education, etc are related to health behaviour. Jegede's (1998) study of the utilization of immunization services in Southern Nigeria also established a relationship between mother's level of education and the use of immunization in the study communities. Findings from this study are also in consonance with the health belief model as proposed by Rosenstock (1966) that the beliefs and attitudes of people are critical determinants of their health related actions as well as advancing the view that individuals in their choice of health action behave rationally.

A cursory look at Table 3 above reveals that as high as 74% of the respondents agreed that health education had impact on extreme hostility and rejection attitudes in respect of family planning. This is to say that the impact of health education on participatory family planning is highest on the index of extreme hostility and rejection. 57% of the respondents claimed that health education had impact in the area of indifference in the attitudes of the respondents. 50% of the respondents reported that health education had impact in the area of passive resistance. The obviously predominant proportion of respondents who claimed that health education had impact in the area of extreme hostility and rejection as far as family planning is concerned is not surprising because cultural factors and magico-religious beliefs coupled with illiteracy have tended to turn negative the attitudes of the people in the study area against certain orthodox health programmes.

As it has been observed from tables 1 and 2, the role of health education in particular would most likely continue to have a positive impact on some of the age-long negative community beliefs towards modern health practices in the communities.

6. SUMMARY AND CONCLUSIONS

This study is an empirical work which has brought to the fore the fact that community participation may not perform all the magic of transforming or changing the world-view of the local populace in health development, especially, in the developing nations. In this study in particular, it has been demonstrated that in the acceptance of family planning services among the O-kun Yoruba in Kogi State, Nigeria, the role of health education as a potent intervening variable for participatory development in family planning cannot be over-stressed.

This work has revealed that several socio-cultural factors in rural areas where superstitions still hold sway are serious impediments to the acceptance of family planning services. It has also been discovered in this study that the people for whom health programs are designed should not only be treated as rational beings but also should be involved in the critical stages of project formulation, planning, evaluation and decision making. Also, it should be noted that health behaviour is always a rational one including those of the rural dwellers. This analysis is a clear testimony that social factors including education are strong determinants of participation in community health programs.

This paper, therefore, suggests that health planners and all stakeholders in health policy and health development, especially, in developing societies should take cognizance of the fact that the rural populace should be effectively mobilized through adequate publicity, awareness and health education programs to effect the favourable attitudes for health behaviour desired of them.

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