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Assessment of Community Participation in Healthcare Programmes by Local Communities in Northern Nigeria

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Abstract:

Health care service is the main focus for all the developed and developing nations. Provisions of health facilities to all citizens is something that has been declared by the world health organization in Geneva 1978 at the international conference on primary health care Alma-Ata. However, the state of the health care systems in Nigeria is something to be worried looking at the high rate of infant and maternal mortality that usually occurs at the rural or local areas. This is sometimes attributed to lack of participation of local communities in the health care programmes organised by the government and other non-governmental organisations. Therefore, this paper assessed the level of community participation in health programmes organised by health care centres in northern Nigeria. The paper covers three (3) states of Bauchi, Kano, and Nasarawa from North East, North West, and North Central respectively. The paper is a survey research and uses primary data which were collected by means of structured questionnaires and focus group discussion (FGD). The results were analysed using simple percentage and presented using tables. The results were categorised based on demographic data and questions related the objectives of the research. The results show that community people in the selected states usually participate in health programmes

at individual levels, traditional leaders as well as religious leaders. Traditional leaders have the highest participation in all the three states with 95% of the responses followed by individual with 94%. Participation of religious leaders is less with 44%. The results also indicate vomiting and diarrhea as the most commonly sign of most diseases among children in the rural areas with 89% response in all the three states. The paper recommends that government and NGOs should create more awareness and sensitization to local communities on utilizing health facilities as well as using indigenes of local communities among the health workers for ease familiarization and acceptability. It aslo recommends periodic meeting between health workers, traditional and religious leaders for mutual understanding towards providing health services to local communities.

Key words: Community Participation, Health Care Programmes, Local Communities, Northern Nigeria, Primary Health Care

1. INTRODUCTION

Global health systems continue to be championed by biomedical scientists and health experts whose technocratic solutions to ill health provide community members with few opportunities to appropriate these solutions to local realities. The tendency was challenged by the 1978 Alma Ata Declaration which established community participation as a core principle of primary health care. Despite the revolutionary significance of the Alma Ata Declaration in viewing primary health care through the lenses of equity, social justice, and participation shifts favoring community participation in international health policy, it has been slow and saw a decline in the late 1980s and 1990s. However, efforts have been spearheaded by the 2008 Lancet special edition to celebrate the 0 year anniversary of Alma Ata and the 2008 WHO report on Social Determinants of Health which revitalizes the message that community participation is key to the delivery of health care [1].

Many countries including Nigeria through their Community-based Health Planning and Services (CHPS) Programme have since taken active steps to involve community members in addressing health problems at the community-level. Inadequate health services including immunization coverage continues to hamper the health of the children of northern Nigeria and this remains the cause of thousands of preventable deaths. Routine immunization against diphtheria, tetanus, measles, whooping cough, polio and tuberculosis are perhaps one of the most cost-effective interventions for reducing childhood illness and mortality, especially with the addition of other vaccines such as Cerebrospinal Meningitis (CSM) and Yellow fever in endemic and epidemic areas and Tetanus Toxoid (TT) injection for pregnant women. Though immunization has improved since 2003, Nigeria has one of the lowest coverage in the world especially northern part of Nigeria. Northern Nigeria is one of the region that suffer much in terms of participation of local communities in health programmes. This may be attributed to level of literacy as well as their beliefs on western nations [1].

Since the global target of Health for All was declared in 1978, primary health care (PHC) has been adopted and accepted globally to serve as the approach for achieving this goal. The world will only become healthy when the goal of Health for All is achieved. This include the developed and developing nations alike, the poor and the rich, the literate and the illiterate, old and young, women, and children [2].

The state of healthcare systems in Nigeria over the years had remains less than what is expected. A worrisome statistic on the world's infant and maternal mortality shows Nigeria with about 10 percent. Moreover, the Federal Government of Nigeria has made several attempts to rebuild the health sector through series of reforms. Deliberate efforts have been made to initiate and sustain health sector reforms over the past years which predicated upon the fact that the

sector is characterized by poor quality of public sector health services, resulting in poor health outcomes when compared with basic health indicators [3].

Community participation is very important when rendering health services to any region, this makes the whole exercise easier and successful. Primary Health Care (PHC) centres were located at various local or rural areas in Nigeria. Most international health organizations render their services to communities through these PHC centres. Participation of communities into health programmes require active involvement of traditional and religious leaders. These set of people have respect by the local communities and people value anything that comes from them. Health workers and other government agencies should collaborate and work together with these local leaders towards achieving the goal of making the local communities participate into any health programmes. Other factors that may hinder success of health programmes include poor access of road to rural areas and poverty rates of citizens.

As defined in the Alma Ata declaration, primary health care is the essential care based on practical, scientifically sound and socially acceptable methods and technology, 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 [4]. However, there is long tradition of community participation and contributions to all kind of health services in northern Nigeria. This include clinic and hospitals, general practice service and preventive health programmes. Though there are cases of blockage or refusal of participation into health programmes, this usually occurred as a result of improper awareness to the local communities as well as non-

inclusion of the traditional and religious leaders of the affected communities.

Therefore, this research aimed at assessing the level of community participation in health programmes organized by health care centres in northern Nigeria. The paper choses three (3) states of Bauchi, Kano and Nasarawa from North East, North West, and North Central respectively. The paper has the following objectives:

i. To determine the acceptability of PHC programmes by the local communities in northern Nigeria.
ii. To determine the level of contribution by the local communities during immunization programmes.
iii. To identify communicable diseases that usually affects local communities in northern Nigeria.

2. METHODOLOGY

The paper is a survey research and uses primary data. The data were collected using structured questionnaire and interactions with the selected local communities from the three states of Bauchi, Kano and Nasarawa in northern Nigeria. The questionnaire items were developed based on the objectives of the research and were distributed among the communities consisting of young mothers, fathers, traditional healers and community leaders. A total of three hundred (300) questionnaires were distributed to the three (3) states, 100 for each. The results were analysed using simple percentage and presented in a form of tables.

3. RESULTS AND DISCUSSION

A total number of three hundred (300) Questionnaires were distributed with one hundred (100) to each State. Out of which two hundred and sixty-eight (268) were successfully completed

by the respondents and retrieved as follows; ninety-one (91) from Bauchi State, ninety-four (94) from Kano State and eighty-three (83) from Nasarawa State. Therefore, the results were analysed based on the two hundred and sixty-eight (268) responses that have been successfully completed and returned.

Table 1: Sex Distribution of Respondents

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Male	51	56	55	59	49	59	155	58
Female	40	44	39	41	34	41	113	42
Total	91	100	94	100	83	100	268	100

Table 1 above has shown the sex distribution according to the three (3) states covered for the research work. The male respondents were 51, 55, and 49 representing 56%, 59% and 59% of the three (3) states of Bauchi, Kano and Nasarawa respectively. The female respondents were 40, 39, and 34 representing 44%, 41%, and 41% of Bauchi Kano and Nasarawa respectively. This is accordance with the number of returned questionnaires per state. The table shows the total number of 155 representing 58% as male respondents while 113 representing 42% as female respondents in all the three (3) states.

Table 2: Age Distribution of Respondents

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Below 20 years	14	15	12	13	13	16	39	15
20-30 years	46	51	49	52	39	47	134	50
Above 30 years	31	34	33	35	31	37	95	35
Total	91	100	94	100	83	100	268	100

Table 2 shows the age distribution of respondents according to the three (3) states of Bauchi, Kano and Nasarawa. The ages were range into three categories of below 20 years, 20 – 30 years, and Above 30 years. The table shows the responses of participants below 20 years in the three states of Bauchi, Kano

and Nasarawa are 14, 12, and 13 respectively. This represent 15%, 13%, and 15% as well. The response of participants between 20 to 30 years in these states are 46, 49, and 39 which represent 51%, 52%, and 47% respectively. Then, the response of participants above 30 years are 31, 33, and 31 which represents 34%, 35% 37% respectively. The total number of respondents below 20 years of age in all the three states is 39 which represent 15%, the respondents between 20 to 30 years in all the three states is 134 representing 50%, and finally the respondents above the 30 years in the three states is 95 representing 35%.

Table 3: Distribution Based on Educational Background (Level)

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Primary	20	22	21	22	18	22	59	22
Post-primary	31	34	36	38	28	34	95	35
Tertiary	27	30	29	31	23	28	79	30
None of the above	13	14	08	9	14	16	35	13
Total	91	100	94	100	83	100	268	100

Table 3 shows the distribution of respondents based on educational qualification across the three states of Bauchi, Kano and Nasarawa. Respondents with primary school qualification according to the states are 20 representing 22% in Bauchi, 21 representing 22% in Kano, and 18 representing 22% in Nasarawa. This gives total of 59 respondents representing 22% for the whole returned questionnaires. Respondents with post-primary qualification in the three states are 31 representing 34% in Bauchi, 36 representing 38% in Kano, and 28 representing 34% in Nasarawa. This also gives total of 95 respondents representing 35% of the entire respondents. Respondents with tertiary education qualifications in the three states are 27 representing 30% in Bauchi, 29 representing 31% in Kano, and 23 representing 28% in Nasarawa. This gives total of 79 representing 30% of the entire respondents. The table shows number of respondents that does not belongs to any educational qualification category as 13 representing 14% in

Bauchi, 8 representing 9% in Kano and 14 representing 16% in Nasarawa. Finally, total number of 59 respondents representing 22% in all the three states are primary school holders, 95 respondents representing 35% are post-primary school holders, 79 respondents representing 30% are tertiary schools graduate, and 35 respondents representing 13% does not belongs to any educational qualification category.

Table 4: Distribution on Marital Status of the Respondents

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Married	28	31	41	44	27	33	96	36
Single	42	46	43	46	39	47	124	46
Divorce	05	5	03	3	08	10	16	6
Widow	16	18	07	7	09	11	32	12
Total	91	100	94	100	83	100	268	100

Table 4 gives description of respondents according to their marital status. Married respondents in the three states of Bauchi, Kano and Nasarawa are 28, 41, and 27 respectively which also represent 31%, 44%, and 33%. The unmarried (single) are 42 representing 46% in Bauchi, 43 representing 46% in Kano, and 39 representing 47% in Nasarawa. Divorce category has 5 representing 5% in Bauchi, 3 representing 3% in Kano, and 8 representing 10% in Nasarawa. Widows has 16 representing 18% in Bauchi, 7 representing 7% in Kano, and 9 representing 11% in Nasarawa. The total number of married respondents in all the three states are 96 representing 36% of the entire respondents, single has 124 representing 46% of the entire respondents, divorce has 16 representing 6% of the entire respondents, and widows has 32 representing 12% of the entire respondents.

Table 5: Access to the Healthcare Organization by the Communities

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Yes	76	84	82	87	73	88	231	86
No	15	16	12	13	10	12	37	14
Total	91	100	94	100	83	100	268	100

Table 5 provide description on the level of accessibility of the local community to the health care organizations within their localities. According to the results collected, 76 respondents representing 84% in Bauchi have agreed that they have access to healthcare organizations in their localities while 15 respondents representing 16% said they don't have access to the healthcare organizations. 82 respondents representing 87% in Kano have access to healthcare organizations while 12 respondents representing 13% doesn't have access to healthcare organizations within their localities. 73 respondents representing 88% in Nasarawa have access to healthcare organizations while 10 respondents representing 12% doesn't have access to healthcare organizations in their localities. Out of the 268 responses received, a total of 231 representing 86% of local communities in the three states of Bauchi, Kano and Nasarawa have access to healthcare organizations within their localities such as primary healthcare centres, maternity etc. The remaining 37 respondents representing 14% of the three states doesn't have access to healthcare organizations.

Table 6: Acceptability of Healthcare Programme by Communities

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Yes	53	58	56	60	57	69	166	62
No	38	42	38	40	26	31	102	38
Total	91	100	94	100	83	100	268	100

Table 6 presents the level of acceptability of healthcare programmes by the local communities organized by the healthcare organizations. 166 respondents representing 62% of the three states of Bauchi, Kano and Nasarawa agreed that local communities accept health programmes organised by the healthcare organizations within their localities. 102 respondents representing 38% of the three states doesn't agree with the acceptability of the local communities in terms of health programmes. Based on state wise, 53 respondents

representing 58% in Bauchi agreed with the acceptance of healthcare programmes by the local communities while 38 respondents representing 42% did not agree; 56 respondents representing 60% in Kano agreed with the level of acceptance by the local communities while 38 respondents representing 40% did not agree; 57 respondents representing 69% in Nasarawa agreed with level of acceptance by the local communities while 26 respondents representing 31% did not agree.

Table 7: Participation of Traditional Rulers in Healthcare Programme in the Communities

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Yes	87	96	87	93	80	96	254	95
No	04	4	07	7	03	4	14	5
Total	91	100	94	100	83	100	268	100

Table 7 presents the level of participation and engagement of traditional leaders in healthcare programmes within the local communities. In Bauchi state 87 respondents representing 96% agreed that traditional leaders usually participate or engage themselves in healthcare programmes organized in their localities while 4 representing 4% did not agree. 87 respondents representing 93% in Kano also agreed that traditional leaders engage themselves in any health programme organise by healthcare organisations in the local communities while 7 representing 7% did not agree. In Nasarawa state 80 respondents representing 96% have agreed that traditional leaders usually participate in health programmes in their local communities while 3 representing 4% did not agree. In general, 254 respondents of the three states representing 95% agreed that traditional leaders participate into health programmes organize by healthcare organizations in local communities, while 14 respondents representing 5% of the three affected states did not agree.

Table 8: Participation of Religious Leaders in Healthcare Programme in the Communities

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Yes	40	44	38	40	41	49	119	44
No	51	56	56	60	42	51	149	56
Total	91	100	94	100	83	100	268	100

Religious leaders also participate in health programmes in local communities like their traditional leaders' counterpart. This can be seen in Table 8 above. In Bauchi state 40 respondents representing 44% agreed that religious leaders do participate in health programmes while 51 representing 56% did not agree. In kano state as well, 38 respondents representing 40% agreed that religious leaders engage themselves in any health programmes organise by the healthcare organisations within the localities while 56 respondents representing 60% did not agree. For Nasarawa state, 41 respondents representing 49% agreed that religious leaders participate in health programmes while 42 respondents representing 51% did not agree. To sum it all, 119 respondents representing 44% agreed that religious leaders do participate in health programmes within the local communities of the three states while 149 respondents representing 56% did not agree. However, the low participation of religious leaders in healthcare programmes within the local communities is something to be worried. Looking at the role these categories of people played within their localities, the entire response indicates that 56% of the religious leaders do not participate in healthcare programmes. The local people usually respect and value the views of these leaders. In some cases, it is even the religious leaders that discourage the people from participating into the health programmes due to their beliefs and perceptions on the western nations.

Table 9: Participation of Community Development Associations/Non-Governmental Organizations (NGOs) into the Healthcare Programme in the Communities

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Yes	83	91	89	95	79	95	251	94
No	08	9	05	5	04	5	17	6
Total	91	100	94	100	83	100	268	100

Other community associations and non-governmental organisations (NGOs) do participate into health programmes in local communities. This can be seen in Table 9 above. Majority of the respondents believed that health programmes in local communities are carried out by the associations and other non-governmental organisations, this can be seen by the response of 251 respondents which represent 94% of the entire questionnaires returned in the three states. 17 respondents representing 6% did not agree with that.

Table 10: Individual Participation (Vigilant) in Healthcare Programmes by the Communities Members

Response	Bauchi Frequency	%	Kano Frequency	%	Nasarawa Frequency	%	Total	Percentage (%)
Yes	71	78	73	78	68	82	212	79
No	20	22	21	22	15	18	56	21
Total	91	100	94	100	83	100	268	100

There is participation of individuals as well which can be seen in Table 10 above. 212 respondents representing 79% agreed that individuals within the local communities render certain help and assistance to community health workers while rendering health services to the local communities. 56 respondents representing 21% did not agree.

Finally, the last objective of this research is to identify some of the communicable diseases that usually affects local communities in northern Nigeria. The data were collected by means of Focus Group Discussion (FGD) with the local communities. The responses of the various rural groups from the three selected states of Bauchi, Kano and Nasarawa with

238 respondents representing 89% indicated vomiting and diarrhea as the most commonly sign of most disease by virtually all the groups among children in the rural areas. Malaria, measles, chickenpox, (Dankanoma, chiwon damuna, anal candidiasis) whooping cough, tetanus, bilharziasis, malnutrition, pneumonia and sickle cell are the childhood diseases identified by the various groups in their communities. Malnutrition, malaria, anal candidiasis, pertussis, tetanus and diarrhea and vomiting are said to be most dangerous in the various communities.

4. CONCLUSION AND RECOMMENDATIONS

Health services are very important to society. Government and international organisations including NGOs usually helps in providing health services and facilities to citizens at various levels and localities. However, participation of local communities is the paramount important. This research has assessed the level of participation and engagement of local communities in health programmes within the selected localities in northern Nigeria.

The results of the study have shown significant participation of local communities in the three selected states of Bauchi, Kano and Nasarawa. The results show the participation of traditional and religious leaders in creating sensitization and awareness to the local communities on health programmes. The result further disclosed participation of individuals towards aiding health programmes in local communities. This come in form of helping the health workers in terms of shelter, food and other basic things that might be required by the health workers.

Despite significant participation of these local communities in health programmes, there certain people that usually turn away from health programmes and facilities. They

don't believe with the health services provide by the healthcare centres. They usually resort to traditional medicines and remedies. The research finally makes the following recommendations:

i. Government and other NGOs should create more awareness and sensitization to local communities on the need to be utilizing health facilities within their local communities.
ii. There is need to engage the indigenes of the local communities within the health workers for ease familiarization and acceptability.
iii. There is need for periodic meeting between the health workers, traditional and religious leaders for mutual understanding towards providing health services to the local communities.

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