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Impact of Alternative Communication Model in Mobilizing Smallholder Farmers for Participation in Child Healthcare in South East Nigeria

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Abstract

The study examined the impact of alternative communication methods in mobilizing rural dwellers for participation in child healthcare. It was conducted in South East Agro-Ecological Zone of Nigeria. Multi stage sampling technique was used to select respondents for the study. Four states in the zone were selected for the study; these were two states that participated in a UNICEF communication project, Community Dialogue and two others that never participated in the project. Two Local Government Areas were selected from each state. Two communities were selected from each of the sampled LGAs. Randomly, twenty five respondents were sampled from each of the selected communities. This gave a total sample size of 200 respondents for each group of respondents. A set of structured questionnaire was used to collect data for the study. Frequency count, percentages and Paired t-test were used to analyse the data collected from the study. Result of the study showed that greater number of respondents that participated in the UNICEF community dialogue had better knowledge and understanding of information on community participation in child healthcare and were more attitudinally disposed towards it. Result of the t-test for a difference in attitude and behaviour of the two groups of respondents towards community participation in child healthcare showed that at 1 per cent, significant difference exist in the attitude and behaviour of the two groups of respondents. It was recommended that media houses and agencies concerned with rural social change should adopt traditional communication in information dissemination.

Keywords: Traditional communication, Rural, Participation, Mobilization, Impact

1. Introduction

Nigeria is prided as the most populous nation in West Africa and is assumed to have the largest and most vibrant economy in the sub-region. Unfortunately, over 50% of the population are small holder farmers who dwell in remote rural areas. Characteristically, the rural communities are sparsely populated with inadequate or inaccessible social and infrastructural facilities such as schools and healthcare systems. The rural dwellers often have very marginal family income and most times survive under debilitating and austere conditions.

The rural dwellers are the worst victims of most health problems. They are the worst victims of the problems of HIV/AIDS, malaria, tuberculosis, hepatitis B, pneumonia, polio, diarrhea, whooping cough, chicken pox, measles, diphtheria, tetanus and malnutrition. These ailments are the major causes of neonatal, infant and maternal mortality [1]. It is known that rural communities in Sub-Saharan Africa have the highest prevalence of infant and maternal mortality. A review by UNICEF showed that although 22 % of the world's children are born in sub-Saharan Africa, 49 % of all deaths of children under five years occurred in the region in 2006. The review further alleged that an average of 1 in every 6 children born in the rural areas of Sub-Saharan Africa die, before age five.

In the middle and low income countries of Africa, the effects of malaria and HIV/AIDS are debilitating [1]. Pregnant women and their unborn children are the most vulnerable. Of course malaria is noted as the prime cause of low birth weight in new born, anemia and infant deaths. A report by United States Embassy in Nigeria showed that in Nigeria malaria causes more than a million deaths each year [2]. In the country an estimate of 3.1 million people are living with HIV/AIDS, with a prevalence of 4.1% and accounts for 10% of the global HIV burden. HIV/AIDS is the major factor contributing to the

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declining life expectancy rate from 54 years in 1991 to 48 years in 2010 [3]. People living with HIV are also frequently co-infected with other diseases such as TB, sexually transmitted infections, hepatitis, malaria, and others which complicate diagnostic and treatment interventions. Tuberculosis, whooping cough, hepatitis B, measles, meningitis, poliomyelitis, tetanus and yellow fever are leading causes of infant mortality. Over twelve percent of children born in Nigeria die from these diseases before they reach the age of one while most of those who survive become disabled for life [4]. The Centre for Global Development (CGD) reported that these ailments can be prevented through routine immunization and vaccination or by simply adopting behaviour practices that will promote better health outcomes [5].

World over, it is known that immunization is the best and very cost effective way of protecting children and pregnant mothers against most of the world's ailments [6]. Globally, over two million deaths can be delayed yearly through immunization [6]. The Nigerian government through the National Programme on Immunization (NPI) has designed several programmes to ensure complete and total immunization of all children of age 0-5 years as well as the pregnant mothers. Imperatively, it was for this reason that the Federal Government of Nigeria as far as 1984 insisted that every Nigerian parent needs to understand the value of immunization and importance of vaccinating children before they fall ill of any of the diseases preventable with vaccination [7]. Every mother needs to understand why she must take her child to the clinic, not just once, but repeatedly to complete all the required doses because only then the child is fully protected. Every family member needs to learn to correctly prepare and use the salt-sugar solution and practice ORT at home. They also need to practice healthy habits in order to avoid diarrhea [7].

It has been stated that HIV/AIDS can be prevented through individual and social behaviour changes such as the adoption of marital faithfulness, abstinence and use of condom [8]. When individual behaviour changes are aggregated, reduction in the prevalence of HIV/AIDS pandemic within the communities becomes realistic especially when sufficient number of members of the community experiences such change. The World Health Organisation in its report noted that the prevalence of malaria in Africa can be reduced by adopting various free to low cost interventions to address its major causes [9]. The report listed these interventions to include hygiene promotion, micro nutrient supplementation, use of insecticide-treated mosquito nets and therapeutic treatment with cheap and effective medicine.

Individual and social change towards health issues such as immunization of children against child killer diseases, HIV/AIDS prevention and malaria control in rural communities cannot be achieved where the people remain passive recipients of health services. This calls for the participation of rural community members in the provision of healthcare services. Severally emphases have been made on the need for community participation in child healthcare [10]. Community involvement or participation is often explained as a shift in emphasis from external agencies supplying health services, to the people o f a community becoming active participants in their own healthcare. This means that the community members become partners in healthcare by generating their own ideas; assessing their needs, by involvement in decision making process, planning, implementing, and even evaluating the care they receive [10]. Community participation plays an important role in rendering effective primary healthcare in the community [11]. The community can participate in many ways and at every stage of primary healthcare delivery such as in the assessment of the situation, the definition of problems and the setting of priorities, and can then help to plan activities and co-operate fully when these activities are carried out. Community participation could be seen in three forms, these include:

1. Contributive participation: occurs when the community participates in predetermined projects and programs through contributions of labour, cash or material.

2. Organization participation: involves the creation of the appropriate structures to facilitate participation.

3. Empowering participation: involves groups or communities, particularly those that are poor or marginalized, developing the power to make real choices concerning health care services, through having an effective say in or having control over these programmes [10].

The ability to acquire and use information is fundamental to the successful mobilization of people for participation in any form of primary healthcare service scheme [12]. Communication is an

undisputable tool in the prevention of risk behaviour that could result to ailments, promotion of better health and managing epidemics. It is indispensably required for informing, influencing and motivating individuals, institutional and public audiences about important health issues. Modern mass communication tools of radio, television, newspapers and magazines and specialized tool like internet may not be adequate in mobilizing the people for participation in healthcare delivery. This is true since greater percentage of Nigerian rural dwellers are marginally educated thus speak and understand only their local dialects. The use of modern mass media for information delivery in the rural areas is said to be inappropriate and inadequate. The use of such inappropriate communication and information delivery system in rural communities may constrain efforts to mobilize the rural people for participation in primary healthcare delivery [12]. Alternative communication models such as traditional theater, marks and puppet performances, tales, proverbs, riddles and songs are endogenous and may be more appropriate for mobilizing the rural people for action [13]

The rural people are passive and rarely participate in decisions and actions that are geared towards improving their health status. Most communication packages aimed at awakening their interest and attitude for participation in health service delivery follow the top down approach which is inherent with the conventional mass media. This study therefore examined the impact of alternative communication patterns in mobilizing the rural community members for participation in child healthcare.

2. Materials and Methods

The study was carried out in South East Agro-Ecological Zone of Nigeria to examine the impact of alternative communication models in mobilizing smallholder farmers for participation in child healthcare in South East Nigeria. There are nine states in the zone; these are Abia, Akwa –Ibom, Anambra, Bayelsa, Cross-river, Ebonyi, Enugu, Imo and River states. The region lies between latitude 4.200and 7.250 North and longitude 5.250 and 8.510 East and has land mass of approximately 110,000 km which is almost 11.86 percent of the total land area in the country [14]. The Zone has a total human population of thirty million, seventy nine thousand, six hundred and sixty one (30,079,661) people [15].

Multi stage sampling technique was adopted for the study. In the first stage, four states in the zone were purposively selected. These included two states that participated in a UNICEF communication programme (community dialogue) and two other states that never participated in the communication programme. In the second stage, two Local Government Areas were selected from each of the sampled states. Later two communities were selected from each of the sampled Local Government Areas; this gave a total of four communities for each state. Twenty five respondents were randomly sampled from each of the selected communities. The sample size for each group of respondents (states that participated and those that never participated in UNICEF community dialogue) was 200. The states selected for the study were Imo, Ebonyi, Abia and River states. Imo and Ebonyi States represented states that participated in the programme while Abia and River States represented those that never participated.

The level of participation of the people in child healthcare was categorized into three levels which are high, medium and low. Participation in child healthcare was assessed by collecting information on behaviour changes towards some messages on child healthcare. The questionnaire item was rated on a 5 point scale of strongly disagree= 0, disagreed= 1, undecided= 2, agreed= 3 and strongly agreed=4 was used to measure the responses. The levels were obtained by dividing the five spaces in the Likert's five point scale (0, 1, 2, 3 and 4) into three parts. This gave a unit interval of 1.67. The unit interval was successively subtracted from the maximum point (5) downward to obtain lower class marks of 3.33, 1.67 and 0.00 respectively. On this basis, mean acceptance within 3.33-5.0 of a particular message (change in attitude and behaviour) in the study was considered as "high", mean acceptance of a massage within 1.67-3.32 was assumed to be medium while mean acceptance within 0.00-1.66 was considered low.

Paired t-test was used to compare the level of participation in child healthcare between the two groups of respondents.

3. Results and Discussion

Knowledge of messages on community participation in child healthcare

their knowledge of the messages on community participation in child healthcare (Table 1). The table shows that 71.7 percent of the respondents from the states that participated in UNICEF community dialogue had knowledge of how community members can participate in child healthcare activities of primary health centres. However 37.7 percent of those from Abia and Rivers States (which are states that never participated in the dialogue) had knowledge of the messages on community participation in child healthcare provision.

The result on the table shows that respondents from the states where UNICEF conducted the dialogue (Imo and Ebonyi states) on the need for involvement of community members in child healthcare using traditional communication media had better knowledge and understanding of the messages than those from Abia and River states where community dialogue was not conducted. The higher number of respondents that had better knowledge and understanding of the messages on community participation in child healthcare from Imo and Ebonyi state is an indication that traditional communication pattern is very effective in enhancing audience' knowledge and comprehension of health messages and thus promote their participation in child healthcare. This is in line with the assumption that there is no participation without communication [16]. Traditional media imbibe dynamic, interactional, and transformative process of dialogue between people, groups, and institutions that enables people, both individually and collectively, to realize their full potential and be engaged in activities that will promote their own health and welfare.

Table 1. Knowledge of messages on community participation in child healthcare

Items	**Participating States**	**Non-Participating States**
Do you know that there is the need for every community member to be involved in primary healthcare delivery?	84 ***42.0***	166 ***83.0***
How would the local authorities and other community members participate in healthcare delivery?	75 ***37.5***	136 ***68.0***
How would the community health workers collaborate with community members for effective healthcare delivery?	66 ***33.0***	128 ***64***
Grand Total	226 ***37.7***	430 ***71.7***

Figures in bold Italics are percentages

Attitude of participants towards caring for a sick child

The study examined the attitude of the respondents towards community participation in child healthcare. The table shows that all the respondents that participated in the community dialogue agreed (94.5% strongly agreed while 5.5% just agreed) that child healthcare and provision of primary healthcare services should be the responsibility of all community members, none of the respondents disagreed to this and none was undecided. As well the entire respondents from Imo and Ebonyi states, where UNICEF conducted community dialogue agreed (93.0% strongly agreed and 7.0 agreed) that community heads and other local authorities should participate in child healthcare by monitoring and supporting the activities of primary healthcare workers. On whether community members should support the activities of primary healthcare providers in various possible ways, all the respondents agreed to this (92.0% strongly agreed while 8.0% just agreed). None of them disagreed and none was undecided. On the issue of the relationship that should exist between the community members and health workers, 93.5% strongly agreed that there should be harmony and coordination in the activities of the health workers and local community authorities, 6.5% of them agreed to this while none disagreed to this and no one was undecided. Generally respondents that participated in the UNICEF community dialogue had better attitudinal disposition towards the involvement of community members in child healthcare and primary healthcare delivery.

The result shows that the participants have positive attitude towards the both parents contributing to caring for sick children as an effective approach of enhancing child healthcare. Of course Interpersonal communication, mass media, and traditional media all play a role in efforts to help individuals and communities adopt and advocate for healthy attitudes and behaviours. Together, they reinforce messages and remind audiences of the desired attitude and behaviours. They bring together different groups to achieve a common goal and equip them with information and skills to achieve it [17, 18].

Table 2. Attitude towards community participation in child healthcare

Attitude of Respondents towards community participation in Child Healthcare	**Strongly Disagreed**	**Disagreed**	**Undecided**	**Agreed**	**Strongly Agreed**	**Mean**
Child healthcare should be the responsibility of all community member	00 (0.00)	00 (0.00)	00 (0.00)	11 (5.5)	189 (94.5)	***3.95***
The local authorities should participate in child healthcare by monitoring and supporting health workers	00 (0.00)	00 (0.00)	00 (0.00)	14 (7.0)	186 (93.0)	***3.93***
Community members can in different ways support the activities of primary healthcare providers	00 (0.00)	00 (0.00)	00 (0.00)	16 (8.0)	184 (92.0)	***3.92***
There should be harmony and coordination in the activities of the health workers and local community authorities	00 (0.00)	00 (0.00)	00 (0.00)	13 (6.5)	187 (93.5)	***3.94***

Figures in Parenthesis are percentages
Figures in Bold Italics are Means

Effect of alternative communication model on attitude and behaviour of people towards community participation in child healthcare

The Likert type five points scale was used to collect data on the attitude and behaviour of two groups of audience i.e. those who participated in the UNICEF community dialogue and those that never participated towards community participation in child healthcare.

The data on the attitude of respondents who participated in the communication project and those who never participated were statistically compare using paired t-test (Table 3). The mean score for the participants in the community dialogue was 3.8550 while that of the non participants was 2.3105. The mean difference for the two groups was 1.54444. These were subjected to paired z-test analysis. The result was significant at 1% percent level of significance as the t-calculated (101.748) was greater than the t- tabulated (2.65).

Also the difference in the behaviour of the participants in the UNICEF promoted community dialogue and non participants were also statistically compared. The mean score for the behaviour of the respondents that participated was 3.7398 while the mean score for those that never participated was 2.7974. The mean difference for the two groups of respondents on community participation in child healthcare was 0.94238. The result was equally subjected to t-test analysis. According to the analysis, the result was significant at 1% percent level of significance as the t-calculated (64.981) is more than the table t (2.65). The respondents that participated in the UNICEF community dialogue had higher level of attitude and behaviour change towards the involvement of community members in child healthcare.

The study agrees with the views that long-term behavioural change induced by mass media messages alone is unlikely to be successful among the rural audience [19]. They proposed that only about 50 per cent of an audience will recall the media message, about half of those will understand the message, half again will accept it as relevant, half again will shift

attitudes, half of those will adopt the new behaviour, half will try it, and half again will maintain the new behaviour. Mass media messages in isolation of participatory forms of communication (such as the community dialogue) usually achieve little; therefore other supportive interventions are essential. These may involve direct, personal interventions. They further asserted that behavioural change communication programmes through community dialogue motivate people either to change unhealthy behavior or to continue healthy behaviour, can and have increased awareness of common reproductive health problems and have influenced attitudes and social norms and addressed myths and misconceptions. They have depicted healthy choices and their benefits. They have moved people to use contraception and to make use of family planning services and HIV testing.

Table 3: t-Test for a difference in the attitude and behaviour participants and non-participants in UNICEF community dialogue

Variables	Mean	Mean Difference	Standard Deviation	t- Calculated	Table-t
Pair I					
Part-Attitude	3.8550				
Nonpart-Attitude	2.3105				
Part-Attitude --- Nonpart-Attitude		1.54444	0.21466	101.748***	2.5
Pair II					
Part-Behaviour	3.7398				
Nonpart-Behaviour	2.7974				
Part-Behaviour -- Nonpart-Behaviour		0.94238	0.20510	64.981***	

Where:
Part-Attitude: Attitude of participants in Community Dialogue
Nonpart-Attitude: Attitude of Non-participants in Community Dialogue
Part-Behaviour: Behaviour of participants in Community Dialogue
Nonpart-Behaviour: Behaviour of Non-participants in Community Dialogue
*** = Indicates variables that are significant at 1%

4. Conclusion and Recommendations

Achieving better health and wellness of life for all children born in the community is a corporate social responsibility that requires the cooperative effort of all community members. This is possible when the media for communicating to the people about their health and actions expected of them is endogenous and takes account of their literacy level and social background. More than the conventional mass media, traditional communication model plays vital roles in sensitizing the people on the need for their involvement in healthcare delivery and gives them proper knowledge and understanding of the specific roles that are required of them in maintaining better health in the communities. With such knowledge and understanding the people can become better attitudinally disposed to develop behavioural patterns that will enable them take issues concerning healthcare service and delivery as communal affair that every community member must be involved in. Albeit, traditional communication alone may not be adequate in communicating health issues especially as rural communities are evolving and becoming complex. It is therefore recommended that media houses and practitioners should integrate the modern mass media and traditional communication patterns in disseminating health issues to the people to enhance better awareness and understanding of issues concerning the health of their children.

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