

ASSESSMENT OF GENDER ATTITUDES TOWARDS COMMUNITY HEALTH PROGRAMMES IN RURAL RIVERS STATE, NIGERIA

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ABSTRACT

The work assessed gender attitudes towards community health programmes (CHPs) in rural Rivers State, Nigeria. The rural area selected was Ikwerre Local Government Area. Interview schedule was used to elicit data from 100 respondents using purposive sampling technique from selected five (5) communities out of the ten communities that made up Ikwerre Local Government Area. Data collected were analysed using percentages, mean scores, Correlation Regression and analysis of variance (ANOVA). Result shows that majority (17.0%) of the females were between 25-35 years while majority (17.0%) of the males were between 36-45 years, married (53.0%), have participated in CHPs between 1-5 years (37.3%) and received information mainly from town crier (44.2%). The types of community health programmes available were; antenatal (7.9%), immunization/vaccination (9.4%) and breast feeding (8.9%). Both males and females were aware of breast feeding (\bar{x} =2.71), antenatal (\bar{x} =2.80) and immunization/vaccination (\bar{x} =3.32). The female expressed satisfaction on breast feeding (\bar{x} =2.62) and antenatal (\bar{x} =2.78) while the males expressed satisfaction on medical check-up (\bar{x} =2.54). Both males and females participated in the use of mosquito nets (\bar{x} =2.72). The females adopted breast feeding (\bar{x} =2.64), while the males adopted medical check-up (\bar{x} =2.52). The result showed that awareness and participation do significantly influence the adoption of community health programmes in the study area. Factors inhibiting gender attitudes towards CHP's are: inadequate health facilities (\bar{x} =3.33), and poor location of health centres. The study recommends that governments should enhance effective community health programmes to reach all KELGA citizens.

Keywords: Gender, attitudes, community health programmes, participation

INTRODUCTION

Issues bothering on health is considered in its broader sense, and it is been given variegated approach over the centuries. It is today an affair that dominates our ways of living as an organism. In short, its concern is recently term both as a household (domestic) and individual concerns. Both the individual and group of individuals have taken cognizance of the need to have proper awareness over the issue of health importance. It was on this note that World Health Organization viewed it as a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity (WHO, 2004). In similar view, Bircher (2005) when commenting on the importance of health and calling for adequate awareness, maintained that health is a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demand of life commensurate with age, culture and personal responsibility.

Nigeria is a conglomerate nation with the most populace black nations in the world whose

development level is rated among the developing nations-states. We depend on oil exploration and other activities such as agriculture for the country's growth. Amidst this, one of the most fundamental challenges facing the country today is the attempt to ensure that all Nigerians have adequate knowledge of their immediate environment and to ensure a save-living environment of her citizens. Thus, there is a great need to educate our rural people by giving them awareness on how to have a healthy environment. However, in the interest of giving a wider publicity awareness of all issues in connection to health matters, several factors have remained militating against this success. These challenges have remained one of the problems facing the people of Ikwerre ethnic group in Rivers State today. More so, the awareness campaigns in Ikwerre kingdom seem to make little impact on the life of men and women living within this area. Hence, the need to examine gender attitude towards health programmes disseminated to these areas of study is of paramount in this research study as well as suggesting possible

solutions as way forward in tackling these challenges.

Gender could be defined as those socio-culturally defined roles and psychological characteristics ascribed to female and male by various societies (Olurade, 2002). It is the various functions played by men and women in the society and the relative power they wield (Oyejide, Samuel and Osuji, 2001; Goldbery and Perry-Jenkins, 2004). In the radical critique, it is the place of women in relation to economic production which ultimately determines male/female differences. In this sense, it can be argued that 'gender' is analogous to class relationships (Hogan, 2006). The attitude of most gender towards Community Health Programmes (CHPs) in Ikwerre Local Government Area in Rivers State is rated low and negative. Hence calls for urgent attention, awareness and orientation in order to take proactive and adequate measure in curbing the menace and danger of health challenges within the land area. Since the people living within this area is said to be recorded with health problems such as malaria, High Blood Pressure, Diabetes, Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), Sexually Transmitted Infection (STI), Sexually Transmitted Disease (STD) among others which mostly resulted in early death, this has given alarming concerned, which require proper information so as to control and reduce widespread diseases within the local government areas. Community health programmes is a strong mechanism which should be generally and educationally focused, aims primarily at educating the people on the need to live a healthy life and to avoid or guide against unhealthy life. It was based on the above foundation that this study was designed to:

- i. describe the personal characteristics of gender in the study area;
- ii. identify types of community health programmes in the study area;
- iii. examine the level of genders' awareness and satisfaction of community health programmes;
- iv. determine the extent to which gender adopts the various community health programmes; and
- v. ascertain factors inhibiting genders attitude towards community health programmes and services in the study area.

METHODOLOGY

The study was carried out in Ikwerre Local Government Area (LGA) of Rivers State, Nigeria. Ikwerre LGA has its head quarter at Isiokpo. The LGA has large massive land and is endowed with mineral resources. Thus, the major occupation of the people is farming, fishing, hunting etc. Ikwerre LGA is made up of twelve (12) communities and towns. These communities include: Isiokpo, Omagwa, Omudeme, Elele, Omuanwa, Apani, Ipo, Omerelu, Igwuruta, Ubima, Ozuaha and Aluu. Five

communities were purposively selected based on the presence of Health Centres. Twenty respondents were randomly selected from each of the selected communities giving a total of 100 respondents. Primary data were collected using interview schedule and collected data were analysed using descriptive and influential statistics. A four point Likert type scale was used to determine the level of satisfaction of the respondents, extent of adoption and challenges to health extension programme in the study area based on the health extension programmes in the study area. The assigned weighted values are as follows; Highly Satisfied (4); Satisfied (3); Dissatisfied (2); Highly Dissatisfied (1). The responses with weighted mean scores of 2.50 and above were considered as satisfactory, while responses less than 2.50 were regarded as not satisfied.

RESULTS AND DISCUSSION

Entries in Table 1 show that majority (30.2%) of the respondents were between 36-45 years. The mean age is 37 years. This implied that the respondents were active vibrant men and women who are in their productive age. Half (51%) of the respondents were female, while 49% were male respectively. This indicates that female participated (in terms of utility) more than males in community health programmes. According to Isife, Albert and Yeemah (2015), more females participated in Health Extension Programmes in Gokana Local Government Area. Majority (53.0%) of the respondents (males (25.5%) and females (27.5%)) are married. This implies that the respondents who participated in community health programmes were married; responsible men and women who are in their reproductive age. A higher percentage (86.7%) of the respondents was educated- they can read and write. Education helps gender to have knowledge on the importance of health which encourages them to participate in health programmes that are beneficial to them. The mean year of participation is 7 years. This implies that gender have participated in community health programmes available in the study area for seven years, making them to have enough knowledge on health programmes in the area. Majority (34.6%) of the respondents (males (16.3%) and females (18.3%)) were self-sponsored. Gender that participated in community health programmes sponsored themselves (in terms of funding). This could be attributed to an effective collaboration of stake-holders network that include: participants, family, volunteers, local government, state government and federal government. Gender obtained information from town criers. This implies that majority of the community health program users in Ikwerre ethnic group receive information through the traditional means, thereby making town crying the most effective means of information in the study area.

Table1: Gender distribution of the demographic features of the respondents

Characteristics	Female	%	Male	%	Total %	Mean
Age (Years)						
16-25	12	12.2	10	10.2	22.2	37 years
26-35	15	17.0	13	12.2	29.2	
36-45	13	13.2	14	17.0	30.2	
46-55	5	5.1	7	7.1	12.2	
56-65	5	5.1	6	6.1	11.2	
Total	50	50.0	50	50.0	100.0	
Marital Status						
Single	17	17.3	14	14.2	31.5	
Married	27	25.5	27	25.5	53.0	
Divorced	3	3.1	6	6.2	9.3	
Separated	3	3.1	3	3.1	6.2	
Total	50	50.0	50	50.0	100.0	
Educational Level						
Non-Formal Education	9	9.2	4	4.1	13.3	
First School Leaving Certificate	6	6.1	19	22.4	37.7	
WASC/GCE	15	15.3	11	9.2	15.3	
B.Sc.	15	15.3	12	10.2	24.5	
Diploma/NCE	5	5.1	4	4.1	13.3	
Total	50	50.0	50	50.0	100.0	
Years in Participation of Community Health Programme						
1-5 years	20	20.1	15	17.3	37.3	7years
6-10 years	17	17.3	22	18.3	35.6	
11-15 years	6	6.1	6	6.1	12.2	
16-20 years	5	3.1	2	2.1	5.2	
21 & Above	4	4.1	5	5.1	9.2	
Total	50	50.0	50	50.0	100.0	
How Community Health Programme was Acquired						
Self-Sponsored	18	18.3	18	18.0	34.6	
Family Sponsored	6	6.1	5	5.0	11.1	
Federal Government	2	2.1	3	3.0	5.1	
State Government	7	7.2	7	7.0	14.2	
Local Government	5	4.1	4	4.0	8.1	
Church Volunteers	6	6.1	6	6.0	12.1	
Total	50	50.0	50	50.0	100.0	
Sources of Health Information						
Television	4	4.0	4	4.0	8.0	
Radio	7	7.0	9	9.0	16.0	
Newspaper	4	4.0	4	4.0	8.0	
Magazine	4	4.0	4	4.0	8.0	
Post bill	8	8.0	8	8.0	16.0	
Internet	3	3.0	3	3.0	6.0	
Town crier	20	20.0	18	18.0	38.0	
Total	50	50.0	50	50.0	100.0	

Source: Field Survey, 2016

Type of Community Health Programme in the study area

From result in Table 2 showed that more (7.70%) of the respondents agreed or confirmed that immunization/vaccination were available in the study area. Followed by Antenatal (7.30%), family planning (7.10%), malaria prevention with prescribed drugs (6.60%), eating balance diet (5.90%), HIV counseling and testing (5.40%), HIV/AIDS

prevention (5.30%), routine medical check-up (5.20%) infant care program (5.10%), environmental sanitation (5.10%), prevention of Lassa fever (5.6%), breast feeding (4.50%), Hepatitis B/C prevention (4.20%) and cervical cancer prevention (3.90%). This implies that immunization/vaccination and antenatal dominated the community health program available in the study area.

Table 2: Types of Community Health Programme in Ikwerre

Type of CHPs	Apani	Elele	Igwuruta	Isiokpo	Omuanwa	Total Respondents	%
Antenatal	12	14	12	10	16	64	*7.30
Breast feeding	8	6	5	5	6	30	4.50
Cervical cancer prevention	5	7	5	6	5	28	3.90
Eating Balance Diet	4	10	5	8	8	35	5.90
Hepatitis B/C prevention	6	5	8	5	5	29	4.20
Immunization/Vaccination	25	25	23	25	25	123	*7.70
Prevention of laser fever	5	6	5	4	6	20	5.6
Infant care programme	2	5	7	5	6	25	5.10
Malaria prevention with prescribed drugs	4	5	6	7	5	27	6.60
Routine medical check-up	6	2	5	5	4	22	5.20
Environmental sanitation exercise	5	4	3	3	3	18	5.10
Family planning	3	3	5	5	2	18	*7.10
HIV counselling and testing	5	2	3	5	4	19	5.40
HIV/AIDS prevention campaign	8	4	6	5	3	26	5.30

Source: Field survey 2016.

Multiple Respondents

The statistical analysis using General Linear Model in a two ways Anova with two factors (Community and Types of Community Health Programme) revealed significant different in the perception of the respondents on the type of community health programme in the study area. This is shown Table 3

which indicates a p-Value of 0.001 for types of Community health programme. Since the significant value $P=0.001$ is less than 0.05 ($P<0.05$) level of significant, we therefore, reject the null hypothesis and accept the alternative

Table 3: ANOVA showing the perception of the respondents to types of community health programme

Source of Variation	DF	SS	MS	F	P-Value
Community	10	0.74928	0.18732	3.41	0.009
Type of CHPs	13	7.84566	1.12081	20.41	0.001
Community*Type of CHPs	28	2.56427	0.09158	1.67	0.017
Total	783				

Source: Field Survey, 2016

Decision rule at significant level ($P<0.05$)

Gender awareness on Community Health Programme

From results in Table 4 show gender awareness on Community Health Programme in the study area. Majority (97.9%) of respondents were aware of breast feeding followed

immunization/vaccination (89.8%), routine medical checkup (87.7%), malaria prevention with prescribed drugs (86.7%) and antenatal and using clean water (83.6%), HIV/AIDS prevention (65.3%), using good toilet system (64.2%), campaign on the use of treated mosquito nets (64.2%), eating balance diet (63.2%),

and environmental sanitation (64.2%). This indicates that the respondents were aware of all the community

health programmes in the study area.

Table 4: Gender awareness of Community Health Programme in the study area

CHPs	Female	%	Male	%	Total %
Antennal care programme	46	*46.94	36	36.73	83.67
Breast feeding	48	*48.98	48	*48.98	97.96
The use of treated mosquito nets	38	38.78	25	25.51	64.29
Eating Balance diet	30	30.61	32	32.65	63.27
Environmental sanitation exercise	35	35.71	28	28.57	64.29
Family planning	41	41.84	40	40.82	82.65
HIV counseling and testing	30	30.61	32	32.65	63.27
HIV/AIDS prevention campaign	31	31.63	33	33.67	65.31
Immunization/Vaccination	48	*48.98	40	40.82	89.80
Infant care programme	30	30.61	32	32.65	63.27
Malaria prevention with prescribed drugs	40	40.82	45	*45.92	86.73
Routine medical check-up	41	41.84	45	*45.92	87.76
Use of clean water	40	40.82	42	42.86	83.67
Using good toilet system	32	32.65	31	31.63	64.29

Source: Field Survey, 2016

Multiple Response

Gender satisfaction on Community Health Programme

Entries in Table 5 show that the males and females express satisfaction in breast feeding (\bar{x} =2.71), antenatal (\bar{x} =2.80), immunization/vaccination (\bar{x} =3.39), malaria prevention with prescribed drugs (\bar{x} =2.62), using clean water (\bar{x} =2.84), HIV/AIDS prevention (\bar{x} =2.94), using good toilet system (\bar{x} =2.80), campaign on the use of treated mosquito nets

(\bar{x} =2.73), eating balance diet and environmental sanitation (\bar{x} =2.69) and family planning (\bar{x} =2.65).

Gender was satisfying with the community health programmes in the area indicating that the health programmes in the area were beneficial to the rural people. However, in medical check-up, the females (\bar{x} =2.48) were not satisfied with it while the males expressed satisfaction (\bar{x} =2.52).

Table 5: Mean distribution of gender satisfaction on Community Health Programme

S/N	Community Health Programmes	MEAN	MEAN	GRAND MEAN
		N=50 FEMALE	N=50 MALE	
1	Antennal care programme	2.82	2.78	2.80
2	Breast feeding	2.78	2.64	2.71
3	Campaign on the use of treated mosquito nets	2.70	2.76	2.73
4	Eating Balance diet	2.68	2.70	2.69
5	Environmental sanitation exercise	2.70	2.68	2.69
6	Family planning	2.65	2.65	2.65
7	HIV counselling and testing	2.67	2.67	2.67
8	HIV/AIDS prevention campaign	2.90	2.98	2.94
9	Immunization/Vaccination	3.40	3.38	3.39
10	Infant care programme	2.33	2.30	2.31
11	Malaria prevention with prescribed drugs	2.64	2.60	2.62
12	Routine medical check-up	2.48	2.52	2.50
13	Use of clean water	2.84	2.84	2.84
14	Using good toilet system	2.80	2.80	2.80

* ≥ 2.50 = Satisfied

*Source: Field survey, 2016.

Gender Adoption rate of Community Health Programme

Results in Table 6 show that both males and females adopted campaign on the use of treated mosquito net

(\bar{x} =2.62), eating balance diet (\bar{x} =2.59), environmental sanitation exercise using good toilet system are (\bar{x} =2.51), family planning (\bar{x} =2.85) and the use of clean water (\bar{x} =2.51). Only the females adopted in breast feeding (\bar{x} =2.84), immunization/vaccination (\bar{x} =3.40) and antenatal (\bar{x} =2.62) while the males adopted HIV/AIDS prevention campaign (\bar{x} =2.57), campaign on the use

of malaria prevention with prescribed drugs and the use of clean toilets (\bar{x} =2.54), respectively. This implies that gender adopted family planning, campaign on the use of treated mosquito net and the use of clean water in the study area. Albert, Isife and Jaja (2015) in their study on adoption of insecticides treated nets, observed that the health technology was adopted by rural people.

Table 6: Gender Adoption of the community health programmes in the study area

S/N	Community Health Programmes	MEAN	MEAN	GRAND MEAN
		N=50 FEMALE	N=50 MALE	
1	Antennal care programme	2.62	2.36	2.54
2	Breast feeding	2.84	2.40	2.67
3	Campaign on the use of treated mosquito nets	2.60	2.66	2.62
4	Eating Balance diet	2.58	2.60	2.59
5	Environmental sanitation exercise	2.50	2.52	2.51
6	Family planning	3.05	2.65	2.85
7	HIV counseling and testing	2.47	2.57	2.52
8	HIV/AIDS prevention campaign	2.40	2.48	2.44
9	Immunization/Vaccination	3.20	2.42	2.81
10	Infant care programme	2.23	2.20	2.21
11	Malaria prevention with prescribed drugs	2.48	2.54	2.51
12	Routine medical check-up	2.28	2.42	2.35
13	Use of clean water	2.50	2.52	2.51
14	Using good toilet system	2.44	2.54	2.49

* ≥ 2.50 =Adopted

*Source: Field survey 2016

Regression/correlation analysis was conducted to test the influence of gender awareness and satisfaction on the adoption of community health programme, and the result in Table 7 revealed a positive statistically significant ($P < 0.05$) relationship (linear model

$Y = 1.69 + 0.38X$). The result also show a positive correlation ($r = 0.38$) which implies that awareness and satisfaction does significantly influence the adoption of community health programme. Thus we reject the above hypothesis.

Table 7: Regression Analysis on awareness/satisfaction and adoption

Predictor	Coef	SE Coef	T	P
Participation	1.68588	0.07148	23.59	0.001
Adoption	0.38197	0.02405	15.88	0.001

*S = 0.896741, R-Sq = 14.7%, R-Sq(adj) = 14.6%,

*PRESS = 1183.88, R-Sq(pred) = 14.41%

*Source: Field survey, 2016

The regression equation is Awareness/satisfaction = 1.69 + 0.382 Adoption

Gender challenges to Community Health Programme in the study area

From the result in Table 8 shows the factors effecting gender across in CHP's as expressed by the respondents indicated that inadequate health facilities (\bar{x} =3.33), financial inability (\bar{x} =3.10) partial program implementation (\bar{x} =3.03), poor location of health centre (\bar{x} =2.88) program inconsistency (\bar{x} =2.88) lack of timely information (\bar{x} =2.63) and

problem of stigmatization (\bar{x} =2.57). While lack of trained health personnel (\bar{x} =2.49), problem of impairment (\bar{x} =2.44), lack of sensitization (\bar{x} =2.40), distance from health post (\bar{x} =2.47), crisis (\bar{x} =2.34), gender related issues (\bar{x} =2.27), community health attitude (\bar{x} =2.21) and traditional belief (\bar{x} =1.97) were not serious factors affecting gender challenges sin CHP's in the study area. From

the above, inadequate health facilities, financial inability, partial program implementation, poor location of health centre, program inconsistency, lack

of timely information and problem of stigmatization were seen as major problems.

Table 8: Mean distribution of gender challenges to Community Health Programme

Challenges	Strongly Agreed	Agreed	Disagreed	Strongly Disagreed	Total Score	Mean Score
Community health attitude	32	99	58	28	217	2.21
Crises	52	87	68	22	229	2.34
Distance from health post	80	78	64	20	242	2.47
Financial inability	368	108	24	4	304	3.10
Gender related issue(s)	68	57	70	27	222	2.27
Inadequate health facilities	208	96	18	4	326	3.33
kidnapping	40	69	60	35	204	2.08
Lack of sensitization	32	111	78	14	235	2.40
Lack of timely information	104	84	52	18	258	2.63
Lack of trained health personnel	72	87	68	17	244	2.49
Traditional belief	28	30	102	33	193	1.97
Partial program implementation	132	99	52	14	297	3.03
Poor location of health centre	148	75	46	13	282	2.88
Problem of impairment	52	117	48	22	239	2.44
Problem of stigmatization	84	102	46	20	252	2.57
Programme inconsistency	100	144	26	12	282	2.88

* ≥ 2.50 = challenge,

*Source: Field survey 2016

CONCLUSION AND RECOMMENDATIONS

Female participated more in the community health programmes in Ikwerre ethnic than the male. They were all in their productive age and receive health information through town criers. There was a significant difference in the perception of the respondents to the various types of community health programmes in the studied communities. The major constraints faced by the communities in the study area to acquiring CHPs were inadequate health facilities, financial inability, partial program implementation, poor location of health centers, program inconsistency, lack of timely information and problem of stigmatization and attitude to community health workers in that order. There is need to construct and complete health centers to reach all KELGA citizens and strengthen logistic management system and provide regular and uninterrupted supply of essential commodities.

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