The Impact of Community-based Health Education in the Management of Primary Health Care in the Nigerian Population

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Abstract

Introduction: Primary health care (PHC) is based on practical, scientifically sound and socially acceptable methods that are universally accessible to individuals and families in the community.

Aim: To determine the impact of community-based health education (CBHED) in the implementation of the PHC program in Bauchi state, Nigeria.

Methodology: The study employed a cross-sectional survey research design. 20 development areas were studied and each of these wards had one PHC centre. The study consisted of two groups; a provider survey (health workers) and a household survey (community members). 317 questionnaires were administered, but only 312 were returned. A 25-item questionnaire had three sections: demographics, level of participation and acceptance. Data was analysed using the Statistical Package for Social Sciences, version 21.0. A chi-squared test was used to determine the relationship between the levels of education and acceptance of community-based health education in primary health care at p < 0.05.

Result: 136 (43.6%) were men, while 176 (56.4%) were women. The age distribution indicates that the majority of the study respondents were within the age range of 25–41, n = 181 (58.0%). There was no relationship between the age of the study participants and their level of participation in CBHED in PHC (p < 0.005). There was no relationship between the source of information and participation in PHC (p < 0.05).

Conclusion: There is a need to also extend the CBHED approach to other health-related services which would target community-level implementation.

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1. Introduction

Primary health care (PHC) is based on the concept of needed care rather than all possible care for individuals who may not be in need of care.[1] The Nigerian PHC scheme was commissioned with the assistance of the United Nation Development Program (UNDP), the World Health Organization (WHO) and the United Nations International Children Education Fund (UNICEF) with the objectives of initiating the provision of adequate and effective health care and facilities for the entire population as a forerunner for the introduction of a national health service. Its aims are also to provide infrastructure for preventive programs, such as control of communicable diseases, family planning, environmental health, nutrition services, health education, mental health, dental health, school health, health statistics and community services, to correct the imbalance between preventive and curative care, to establish a health care system which could be best adapted to the local conditions of Nigeria, and also to resolve the health problem related to the level of technology available in the country.[2,3] Health education is an integral component of a community-based health program. Mobilization of individuals and the community to create health awareness is an important tool for the realization of health for all.[4,5,6] This also highlights that community participation results from effective community motivation and mobilization, and therefore constitutes an effective strategy for implementing sustainable primary health care as well as for achieving integrated rural development.[6,7] A community-based health education program is an essential tool for the implementation of primary health care and therefore it is important that health education is carried out both at the group and individual level in the community, since it utilizes the local potential during the process of learning, with community involvement, using local social culture communication media along with empowering the local community.[8,9,10]

One of the basic and effective ways to deliver community-based health education is through the use of information, education and communication. That includes posters, handbills and job aids.[10] A study to ascertain the impact of a community-based health awareness campaign on breastfeeding among lactating women in Chandigarh shows that only 64.3% of them felt that breastfeeding should be initiated within the first hour after birth. The finding also showed an improvement in the post-breastfeeding awareness campaign of 79.5%.[11] The idea of the primary health care scheme is to ensure that both rural and urban dwellers not only have access to meaningful health care, but also that they actively participate in the implementation of every facet of the program. However, the process of educating the community on prevailing health problems and methods of controlling them is considered to be the most important component of primary health care.[12] The indispensable role of health education, which involves mobilizing and motivating the community to take actions that would improve their health, cannot be overemphasized. Indeed, health education is considered by many as the first and most important component of primary health care. This is true of a developing country where ignorance and superstition prevail.[4,13]

Health education is defined as the translation of what is known about health into desirable individuals' and community behaviour patterns by means of an education process.[14] In the context of primary health care, health education is an intervention or an activity that aims at assisting people to actively participate in health matters relevant to their personal and community health on a sustainable basis. The Declaration of Alma-Ata (1978) defined health education as a process aimed at encouraging people to be healthy, to know how to stay healthy, to do what they can individually and collectively to remain healthy, and to seek help when needed.[14,15]

Health education is an important component of disease control programs and it aims at behavioural changes in individuals and the community. Various intervention programs were carried out which were aimed at improving primary health care programs through a systematic health education.

The aim of the study is to determine the impact of community-based health education (CBHE) in the implementation of a primary health care program in the Bauchi Local Government Area of Bauchi State.

2. Methodology

A cross-sectional survey research design was used for the study which included 20 wards, each of which had one primary health centre. The study consisted of two groups; a provider survey (health workers) and a house-

hold survey (community members). For the provider survey, 8 primary health centres (4 urban and 4 rural) were selected, and 2 health workers per facility were selected, amounting to a total of 16 health workers interviewed for the study. For the household survey, a total of 317 households were surveyed. The inclusion criterion included heads of households or the surrogates (wives) that were exposed to health education in the community. A closed-ended self-structured questionnaire was used to collect data for this study. The questionnaire was independently checked by two senior community health officers before being administered and was also interpreted in the Hausa language for those who did not speak English. It comprised of 3 sections and 30 questions. Section A collected information on demographics and other details like the level of education, religion, marital status and occupation. Section B included questions on the knowledge of the CBHE program in PHC and questions on information and participation in PHC. A separate questionnaire was designed for both the provider and the household survey.

A multistage sampling technique was used for the study. First, the Bauchi Local Government Area was stratified into urban and rural wards (clusters). Secondly, a cluster sampling was used to select 4 wards from the rural and urban wards, making a total of 8 wards that participated in the study. Thirdly, a simple random sampling method was used to select 8 health centres for the study, since each ward has only one primary health centre and a purposive sampling was used to select 2 health workers for each facility. This was done because there are few health workers who are responsible for health talk. For the beneficiaries of the PHC program (households), a simple random sampling method was used to select 39 households from each ward, which gave a total of three hundred and seventeen (317) households. Only 312 successfully filled out and returned the questionnaires. In the study, only the heads of households or their surrogates who have been exposed to health education/health talk were interviewed.

Ethical clearance was obtained from the College of Medicine of the University of Nigeria, Enugu campus. Data was analysed using the Statistical Packages for Social Sciences (SPSS), version 16.0. Descriptive statistics was employed and the Chi-squared test was used for inferential statistics. The statistical significance was set at P < 0.05.

3. Results

Table 1 shows the demographics of the respondents. It also shows that most participants in the study were female – 176 (56.4%). The age distribution indicates that the majority of the study respondents were within the age range of 25–41, n = 181 (58.0%) followed by < 25 years, n = 57 (18.3%) and 42–59 years, n = 47 (15.1%). The least number of respondents was from the age range of 60–76 years, n = 17 (5.4%) and above 77 years, n = 10 (3.22%). The table also indicates that, in terms of religion, Islam was predominant, n = 278, (89.1%). The majority of the respondents were married – 278 (89.4%), followed by single persons – 17 (5.5%). The table also shows the educational level of the study respondents. Those with Arabic education – 257 (82.6) formed the majority, followed by primary – 227 (73.2%), and then secondary education – 188 (60.5%). The least of them had a diploma – 86 (27.7%), followed by 39 (12.6%) participants who had a university degree, and 15 (4.8%) uneducated participants.

In terms of the respondents' occupation, the majority were employed in the formal sector – 79 (25.3%), followed by traders – 76 (24.4%) and farmers – 44 (14.1%). The smallest portions of respondents were self-employed – 43 (13.8%), housewives – 38 (12.1%), students – 16 (5.1%), idle – 12 (3.8%) and retired – 4 (1.3%).

Table 2 indicates from whom the respondents got information about CBHED in PHC. Health workers in the community provide the majority of information – 266 (88.1%), followed by health centres – 261 (86.4%), and then community leaders – 131 (43.4%). Members of various associations – 50 (16.6%), the town crier – 41 (13.6%) and drug retailers – 39 (12.9%) were the least common sources of information.

Table 3 shows how often the respondents received health education in the health facility they attended. Those that indicated occasional delivery of health education are most frequent – 165 (52.9%), followed by situations when there is a health problem – 90 (28.8%) and an ongoing health program – 18 (5.8%).

Table 4 shows gender and religion of the health workers that participated in the study; there was an equal proportion of male and female respondents (100%). The selection of health workers was done purposively because there were very few health workers in each facility. The table indicates that the gender distribution

Table 1. **Demographics of the study participants**		
Variables	No. of Respondents (N = 312)	Percentage
SEX		
Male	136	43.6%
Female	(176)	56.4%
Total	**312**	**100%**
AGE		
< 25	(57)	18.3%
25 – 41	(181)	58.0%
42 – 59	(47)	15.1%
60 – 76	(17)	5.4%
Above 77	(10)	3.22%
Total	**312**	**100%**
EDUCATION		
No education	(15)	4.8%
Arabic	(157)	50.3%
Primary	(27)	8.65%
Secondary	(38)	12.2%
Diploma	(36)	11.5%
Degree	(39)	12.5%
Total	**312**	**100%**
RELIGION	N = 312	
Islamic	(278)	89.1%
Christianity	(34)	10.9%
Total	**312**	**100%**
MARITAL STATUS	**Frequency N = 312**	**Percentage**
Married	278	89.4%
Single	17	5.5%
Divorced	7	2.24%
Widowed	10	3.2%
Total	**312**	**100%**
OCCUPATION	**Frequency (N = 312)**	**Percentage**
Farming	44	14.1
Trading	76	24.4
Employed in formal sector	79	25.3
Self-employed	43	13.8
Retired	4	1.3
Housewife	38	12.1
Student	16	5.1
Idle	12	3.8
Total	**312**	**100%**

Table 2. **From whom the respondents received health education (sources of health education)**		
	Count	Percentage
Health worker in the community	266	88.1
Community leaders	131	43.4
Members of associations	50	16.6
Town crier	41	13.6
Health centre/*Asibiti*	261	86.4
Drug retailers in my area	39	12.9

Table 3. **How often does a respondent receive a health talk?**		
	Frequency	Percentage
Every day	10	3.2
Occasionally	165	52.9
Health problem	90	28.8
Ongoing program	18	5.8
Don't know	5	1.6
Can't remember	24	7.7
Total	**312**	**100**

Table 4. Gender and religion distribution of health workers

Gender	Frequency n = 16	Percentages (%)
Male	8	50
Female	8	50
Total	**16**	**100**
Religion	Frequency n = 16	Percentages (%)
Islam	13	81.2
Christianity	3	18.8
Total	**16**	**100**

Table 6. Participation in primary health care by marital status, source of information and age

Marital Status	Participation		Chi Square	P-Value
	No	Yes		
Married	14 (5.0)	264 (95.0)	2.923	0.087
Single	2 (22.2)	7 (77.8)	4.567	0.033
Divorced	1 (20.0)	4 (80.0)	1.872	0.171
Widowed	0 (0.0)	8 (100.0)	0.508	0.476
Source of information	Participation		Chi Square	P-Value
	No	Yes		
Health workers	15 (88.2)	245 (83.9)	0.226	0.476[f]
Friends	11 (64.7)	177 (60.6)	0.113	0.475[f]
Relations	5 (29.4)	132 (45.3)	1.624	0.153[f]
Seminar	1 (5.9)	41 (14.0)	0.910	0.299[f]
Print media	3 (17.6)	77 (26.4)	0.637	0.316[f]
Mosque/Church	3 (17.6)	68 (23.4)	0.296	0.421[f]
Radio/TV	13 (76.5)	251 (86.0)	1.162	0.223

Table 12. Age * Participation

Age	Participation		Chi Square	P-Value
	No	Yes		
Under 25	5 (29.4)	46 (16.5)	1.877	0.149[f]
Between 26 – 41	9 (52.9)	171 (61.3)	0.469	0.330[f]
Between 42 – 59	3 (17.6)	44 (15.8)	0.042	0.525[f]
Between 60 – 76	0 (0.0)	17 (6.1)	1.099	0.355[f]
77 and above	0 (0.0)	1 (0.4)	0.061	0.943

Table 5. Acceptance of CBHE in primary health care by marital status, source of information and age, level of education and occupation

Marital Status	Participation		Chi Square	P-Value
	No	Yes		
Married	14 (5.0)	264 (95.0)	2.923	0.087
Single	2 (22.2)	7 (77.8)	4.567	0.033
Divorced	1 (20.0)	4 (80.0)	1.872	0.171
Widowed	0 (0.0)	8 (100.0)	0.508	0.476
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Relations	5 (29.4)	132 (45.3)	1.624	0.153[f]
Seminar	1 (5.9)	41 (14.0)	0.910	0.299[f]
Print media	3 (17.6)	77 (26.4)	0.637	0.316[f]
Mosque/Church	3 (17.6)	68 (23.4)	0.296	0.421[f]
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Between 42 – 59	3 (17.6)	44 (15.8)	0.042	0.525[f]
Between 60 – 76	0 (0.0)	17 (6.1)	1.099	0.355[f]
77 and above	0 (0.0)	1 (0.4)	0.061	0.943
Level of education	Acceptance		Chi Square	P-Value
	No	Yes		
No Edu	3 (27.3)	12 (4.0)	12.465	0.000
Arabic Edu	7 (63.6)	249 (83.3)	2.845	0.092
Primary Edu	6 (54.5)	221 (74.2)	2.094	0.148
Sec Edu	4 (36.4)	184 (61.5)	2.817	0.093
Diploma	2 (18.2)	84 (28.1)	0.520	0.471
Degree	1 (9.1)	38 (12.8)	0.129	0.720
Occupation	Acceptance		Chi Square	P-Value
	No	Yes		
Farming	5 (45.5)	38 (13.0)	9.202	0.002
Trading	1 (9.1)	75 (25.0)	1.454	0.204[f]
Employed (for. sec.)	3 (27.3)	76 (25.3)	0.021	0.560[f]
Self-employed	1 (9.1)	41 (13.7)	0.190	0.549[f]
Retired	0 (0.0)	4 (1.3)	0.149	0.700
Housewife	0 (0.0)	38 (12.7)	1.587	0.208
Student	0 (0.0)	16 (5.3)	0.618	0.432
Idle	1 (9.1)	11 (3.7)	0.842	0.359

f = alpha level of significance, p = level of significance

of health workers was eight (8) each, i.e. 50% male and 50% female. The distribution based on religion was 3 (18.8%) Christians and 13 (81.2%) Muslims.

Table 5 shows the acceptance of CBHE in primary health care by marital status, source of information, age and level of education. There was no relationship between the marital status of the study participants and their level of acceptance of CBHED in PHC, since the calculated p-value is greater at alpha level of significance (p > 0.005). The calculated p-value at alpha

level of significance indicates no relationship between the respondents' occupation and their level of acceptance (p > 0.005). The result from Table 5 showed that

health workers and radio/TV programs influence the acceptance of PHC. As seen in the table, there is no relationship between the acceptance of CBHED and the age of the respondent. The calculated p-value is greater at alpha level of significance (p > 0.005).

Table 6 shows that there is a relationship between marital status and participation in primary health care, particularly in single women (p > 0.033). There was no relationship between the source of information and participation in PHC (p < 0.05). There is no relationship between the age of the study participants and their level of participation in CBHED in PHC (P < 0.005)

4. Discussion

The majority of the participants were women (56.4%) and married (89.4%) at the time of the study. This is not surprising since women are the main caregivers in charge of taking their children to health facilities, and in most cases are exposed to primary health care (PHC) services, such as health education. However, women are also easily organized into groups and this makes it easier to reach them with such community-based health programs. This can easily be observed in several studies, such as in a trial study in Ekjut Nepal that evaluated the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes.[22] From the study, it was noted that the majority 308 (98.7%) of the study participants heard about the community-based health education program in the implementation of primary health care. The age of the women who participated in the study was an indication that women were much more experienced in the PHC services. Although many participants had at least Arabic education, secondary and primary education, cross tabulation indicated a nonsignificant relationship (p > 0.05) between educational status and the acceptance of community-based health education in the community.

The level of acceptance of CBHED was found to be high in the study area (96.5%), though acceptance may not translate to participation. This finding demonstrates that a community-based health education program (CBHED) is an essential and significant factor in the implementation of primary health care (PHC) in Bauchi Local Government. Studies showed that community-based health education impacted and enhanced several health programs, such as in the incidence of diarrheal diseases and in breastfeeding awareness campaigns[1,2,3,11]. The level of acceptance could be due to the nature of the program delivered by health workers as well as volunteers who are members of the community. However, in this study, significant sources of information are health workers (84.2%) and radio/TV (85.5%) programs on health which influenced acceptance. However, this finding is not surprising because there have been numerous radio/TV campaigns on health programs. Other studies have also reported the effectiveness of health education through the media.[7,8,9,25] Therefore, this finding suggests the sole involvement of the media in delivering health interventions at all levels. Nevertheless, effective implementation of health information programs on the PHC service is dependent on adequate knowledge and commitment of the PHC health workers. Studies indicate that primary health care workers can successfully implement community-based HIV/AIDS prevention activities, since the health education interventions delivered by PHC workers usually have multiplier effects.[2,11] Another study in the south-western part of the country indicated the same, especially in the use of media-based health education on tuberculosis diagnosis.[24]

This study found immense contribution of CBHED in the implementation of PHC (93.3%). The contribution of CBHED in the implementation of PHC in BLGA is evident, especially in areas of disease control and prevention (96.4%), immunization (96.7%), sanitation activities (94.7%) and water supply (94.7%). This indicates that CBHED is an essential tool in disease prevention and control. The finding is in line with other studies. For example, a study on malaria prevention in Jengre, North Central Nigeria, showed that health education had a positive impact on caregivers' knowledge of malaria and their willingness to access antimalarial treatment when their children had a fever.[8]

In this study, participation in the CBHED program in BLGA was high (94.2%) and satisfactory (94.2%). The study respondents participated in the program mostly as recipients of the PHC services (94.6%) and in some cases as volunteer health workers (31.1%). The participants contributed in disseminating information. However, participation was lower than acceptance which was affirmed earlier, i.e. that acceptance does not translate to practice or participation. The source of information, age and occupation had no significant influence on participation (p > 0.05%). This implicates that

health education approaches are effective for delivering the PHC services.

However, the study found that knowledge and practice of the PHC workers on CBHED in primary health care implementation influence community acceptance and participation in the program.

The majority of the PHC workers were SCHEW (46.7%) and their main focus in their work in the health centres is health education (93.8%) and immunization (81.3%). This was followed by treatment of common injuries (62.5%) and antenatal and child services (53.6%). This explains why the delivery of CBHED in the study area is credible. As demonstrated in the study, the majority of the approaches used to deliver health education were in the form of group education (93.8%) and community education (87.5%).

5. Conclusion

The findings indicate that community-based health education is very effective in implementing primary health care in Bauchi State. However, the study did not seek to determine how the use of CBHED can be improved. There is a need to also extend the CBHED approach to other health-related services which would target community-level implementation.

Conflict of interest: non-existent

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UTJECAJ ZDRAVSTVENOG OBRAZOVANJA U ZAJEDNICI NA UPRAVLJANJE PRIMARNOM ZDRAVSTVENOM ZAŠTITOM U NIGERIJSKOJ POPULACIJI

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SAŽETAK

Uvod: Primarna zdravstvena zaštita (PHC) temelji se na praktičnim, znanstveno dokazanim i društveno prihvatljivim metodama koje su univerzalno dostupne pojedincima i obiteljima u zajednici.

Cilj: Odrediti utjecaj zdravstvenog obrazovanja u zajednici (CBHED) u sklopu provedbe programa PHC-a u saveznoj državi Bauchi, Nigerija.

Metodologija: Provedeno je transverzalno anketno istraživanje. Istraženo je 20 razvojnih područja, a u svakom od tih područja nalazi se jedan centar za PHC. Istraživanje se provodilo u dvije skupine: anketirani su pružatelji usluge (zdravstveni radnici) i domaćinstva (članovi zajednice). Podijeljeno je 317 upitnika, a vraćeno ih je 312. Upitnik se sastojao od 25 pitanja podijeljenih u tri dijela: demografski podaci, razina sudjelovanja i prihvaćanje. Podaci su analizirani uporabom programa Statistical Package for the Social Sciences, verzija 21.0. Hi-kvadrat test primijenjen je za određivanje povezanosti između razine obrazovanja i prihvaćanja zdravstvenog obrazovanja u zajednici u primarnoj zdravstvenoj zaštiti uz p < 0,05.

Rezultati: Ispitano je 136 (43,6 %) muškaraca i 176 (56,4 %) žena. Većina ispitanika u dobnom je rasponu od 25 do 41 godine, n = 181 (58,0 %). Nema povezanosti između dobi sudionika istraživanja i njihove razine sudjelovanja u zdravstvenom obrazovanju u zajednici u primarnoj zdravstvenoj zaštiti (P < 0,005). Nema povezanosti između izvora informacija i sudjelovanja u PHC-u (p < 0,05). Nema povezanosti između dobi sudionika istraživanja i njihove razine sudjelovanja u zdravstvenom obrazovanju u zajednici u primarnoj zdravstvenoj zaštiti.

Zaključak: Potreban je prošireni pristup CBHED-a na druge zdravstvene usluge koji bi bio usmjeren na provedbu na razini zajednice.