Full Length Research Paper

Extent and ranking of social factors in participatory health development among the “O-kun Yoruba” of Ijumu, Kogi State, Nigeria

Steve Metiboba¹* and Olukemi Grace Adebola²

¹Department of Sociology, Kogi State University, Anyigba, Kogi State, Nigeria.
²Department of Educational Foundations, Federal College of Education, Okene, Kogi State, Nigeria.

Accepted 2 March, 2010

Participation as a process has been widely recognized and accepted as both a basic right of people and of crucial importance to the success of development efforts generally. In recent times, a link has been made between participation and programs designed to improve people’s health. The general objective of this study is an investigation of the extent to which social factors such as education, income, occupation, etc., do trigger community participation in health programs as well as the ranking of such social factors. Data for the study were generated mainly through multi-stage sampling technique, by the use of questionnaire administered to 235 respondents randomly selected from 7 communities in Ijumu LGA of Kogi State, Nigeria. Preference based analysis (PBA) was used as the technique for data analysis in this work. The major findings of this study are that social factors including occupation, religion, marital status, education, etc., but most importantly income, are strong determinants of community participation in health care services delivery and utilization. The paper therefore recommends that all stakeholders in health should treat human beings as rational beings, taking cognizance of their attitudinal dispositions, psychology, norms and values as well as their cultural and social milieu.

Key words: Social factor, community participation, health development.

INTRODUCTION

A review of the literature on participation reveals a disagreement as to whether participation is essentially a process, a program, a technique or a methodology. A cursory examination of the variety of interpretations suggests that there is no single form of participation that is relevant to all situations. It is also observed that different forms of participation have profoundly different consequences (Oakley and Marsden 1985).

The term “community participation” (CP) is used loosely in many nations today for different primary health care (PHC) activities which cut across the economic, learning and political spheres. The economic dimension of community participation is believed to dominate even when community members contribute resources such as materials, money, labour to health care system.

In most relevant literature, community participation is believed to be one of the activities most crucial in modern times for promoting health and preventing disease in any population. It is a formidable task, which requires an organized effort characterized by an understanding that many factors determine health behaviour. (Young and Klinge, 1996). Community participation in this study therefore, is regarded as one of the health strategies aimed at influencing health behaviour. Health behaviour is an action which an individual could embark upon before, during or after the occurrence of an illness or disease.

Beyond the foregoing, it is known also in several relevant literature that social factors play a major role in health related actions especially among multi-cultural populations (Igun, 1989; Jegede, 1998; Oakley, 1989; Oke, 1993). However, in most known published works on this or related subject, it is not known the extent to which some of the social factors, such as income, education, occupation, etc. determine participatory health
development. This study, therefore, attempts to bridge this gap.

**STUDY OBJECTIVES**

Based on the study’s statement of problem highlighted above, the following now constitute the specific objectives of the paper:

i. To determine those social factors that influence community participation in health programs in the study area.

ii. To determine the extent of people’s participation in community-based health activities in the study area.

iii. To investigate the respondents’ ranking of social factors that influence their health behaviour.

To highlight implications of social factors that influence community participation in health development in Nigeria. In arriving at the desired end-point therefore, this study relies mainly on empirical data (primary) generated from a sample of 235 respondents randomly selected from 7 communities in Ijumu Local Government Area, Kogi State, Nigeria.

**Theoretical framework for participation in health programs**

Several theories have been highlighted in most relevant literature on this subject with regards to factors accounting for participation in health projects. Among these theories are diffusion of innovation theory, community action, symbolic interactionism and rational action theories. For the purpose of this study, the rational action theory has been adapted based on its assumption that to act rationally or to have a good reason for acting, it is necessary not merely that we should believe the action but also that this belief should itself be rational if only, to achieve a suitable end (Simon, 1976).

In participatory health development, drawing from the logic of the rational action theory, it is assumed that given the end, there are certain sources of behaviour which may be understood as necessary means for the attainment of these ends. We can also assume that in any community effort, the actor has the sort of complete knowledge of the situation which a scientist might have attained. Moreover, based on the theory of rational action, it is believed that having this knowledge of the means and ends in participatory health development, the actor employs the sort of logical reasoning for carrying out his action (Rex, 1961).

The rational theory is considered particularly relevant for this study because when we apply it to health matters, it assumes that human beings engaging in health behaviour or action are capable of formulating any ends which they choose and that they are able clearly to understand those ends. This theory is also important to this work because it also rightly assumes that having the ends in view; human beings put in place certain health behaviour which is deemed necessary means for the attainment of these ends.

**Social factors and participation in health development**

The relationship between community members’ demographic and social economic characteristics and their reported level of community participation in health projects is supported by several empirical works. For instance Rosenstock’s (1966), Caldwell (1979), Peddy and Caldwell (1983) revealed that social factors such as income, place of residence, transportation, occupation, education and even age are related to health behaviour.

Other works such as those of Kolawole (1982), Morgan (1993), Philip (1993) and Nyemetu (1999) have also established a relationship between participation and certain variables of health care. Some studies have also revealed that age is positively related to health facilities utilization (Caldwell, 1979; Peddy and Caldwell, 1983). Jegede (1998) study of the utilization of immunization services in southern Nigeria also established a positive relationship between mother’s level of education and the use of immunization in the study communities. Okafor’s (1984) study in Togo also found that a relationship existed between patient income and their ability to utilized health facilities. Other empirical studies on the relationship between women’s use of immunization services and their earnings have also supported the assumption that there is a significant relationship between community members’ demographic characteristics and their level of community participation in health projects and that there is a strong relationship between community members’ socio-economic characteristics and their level of participation in health project. It is also instructive to note that Eugenia (1989) study also discovered that many women in South East Nigeria stay away from vaccination because of their inability to pay for the vaccination cards especially if they have lost the former one or it’s forgotten at home.

**METHODOLOGY**

Data for the study were generated mainly through multi-stage sampling technique by the use of questionnaire administered to 235 respondents randomly selected from 7 communities in Ijumu local government of Kogi State, Nigeria. The questionnaire was designed to elicit information from the respondents on different areas of health care services in which an individual or a community may be willing to participate. Techniques of data analysis consisted mainly of univariate and preference based analyses (PBA). PBA is used in this analysis since expectations provide a problem of choice (preference) for people to act or not to act. Preference-based
analysis is used in this study therefore for prioritizing the major social factors influencing participation in health care services or projects.

Seven social factors in community participation for health development were ranked. These seven social factors were identified from relevant literatures by seven communities for this study. The mean preference score of each social factor by each community was used as a criteria for ranking. The individual preference score of each social factor was summed up and averaged at each community level to obtain the mean preference score. The criteria for ranking the social factors by the respondents include the extent to which each of the social factors can induce the community members to the following:

- a) Attending community rallies/meetings.
- b) Contributing money to health projects.
- c) Donating labour. Land or materials to health projects.
- d) Utilizing health facilities.
- e) Getting involved in project planning and decision making.

The ranking order of each social factor gives identification for the independent variables (X1 - X7) in each community.

**DATA ANALYSIS AND RESULTS**

**Discussion of findings**

An examination of the respondents’ perceived benefits of community participation in Table 1 shows that 135 (57%) of total respondents claimed that their perceived benefits of participation in community health projects would bring them economic benefits. 51 (22%) said such participation would give them health (social) benefits. An explanation for the obvious predominance of respondents who claimed they would participate in Community-based health projects if they attracted economic returns could be justified on the account that health behaviour, like most of human behaviour generally is on economic-rational basis. When people choose an alternative among several possible health behaviour actions, they formulate ends for themselves, which they can clearly understand. It is from these alternatives that they choose a behaviour which is understood as necessary means for the attainment of those ends.

Table 2 shows that each community was asked to give a score between the ranges of one to ten to each of the social factors (in ascending order of priority). The table shows the ranking of each social factor by communities and it clearly reveals that there is no uniformity in the ranking of most of the social factors by the communities. This indicates that most of the communities valued differently the role of different social factors in community participation for health development.

However, a close look at Table 2 also indicates that there was a kind of uniformity in the communities’ ranking of three of the social factors. These are: income, education and community norms and values. Five of the communities (A, C, E, F and G) ranked income 1st, while the other 2 ranked it 2nd and 5th respectively. Four of the communities (A, C, F and G) also ranked education 2nd while the other 3 (B, D and E) ranked it 3rd, 1st and 3rd respectively. Likewise, community norms and values were ranked 3rd by 4 communities (A, C, F and G) while the other 3 (B, D and E) ranked it 1st, 2nd and 2nd respectively. The mean preference scores of these social factors is an indication not only of the influence or extent of each of the social factors on participatory health development, but also the effects of rational action on health behaviour.

One can infer from Tables 1 and 2 that social factor such as income has so much influence on people’s participation in health projects because with higher income it is more likely for people to be capable of utilizing more of health facilities. Even where community norms and values or education as other social factors influenced people’s participation in development programs, it seems man simply chooses among several alternatives the action that is more suitable for achieving an end.

Another major finding of this study was that the variations observed in the ranking of social factors in community participation may not be unexpected because community participation is situational, varying with the existing or prevailing circumstances in the community.

**Conclusion**

This empirical work has amply demonstrated the fact that social factors, especially income, are powerful determinants of people’s participation in health development activities. The study has also revealed that there is no uniformity in the ranking of social factors in participatory health development by communities due to the fact that community participation as a principle of behavioral change is situational, varying with the prevailing circumstances in the communities concerned. The thrust of the contribution of this study is not only that social factors are strong determinants of community participation for health development, but also that when people evaluate an instance of illness, they tend to use economistic or utilitarian considerations which can eliminate such illness. This also means that human beings do employ rational-economic strategies for survival across societies.

**RECOMMENDATIONS**

Deriving from the findings of this study, it is being recommended that health services providers should take cognizance of the pertinent factors that are necessary for mobilizing the citizenry for community participation in development projects. This is because people do not just participate, without appropriate mobilizing or motivational strategies, in community-based programs in developing societies especially, government and all stakeholders in health should treat human beings as rational beings, taking cognizance of their attitudinal dispositions,
Table 1. Distribution of respondents by their perceived benefit of participation in Community-based health projects.

<table>
<thead>
<tr>
<th>Perceived benefit of CP</th>
<th>Frequency distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Economic</td>
<td>135</td>
</tr>
<tr>
<td>Health (social)</td>
<td>51</td>
</tr>
<tr>
<td>Political</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
</tr>
</tbody>
</table>

Table 2. The ranking of social factors in community participation by communities.

<table>
<thead>
<tr>
<th>Social factors</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kin-group influence</td>
<td>4 (5.00)</td>
<td>5 (3.12)</td>
<td>6 (2.11)</td>
<td>7 (2.16)</td>
<td>7 (2.05)</td>
<td>7 (2.05)</td>
<td>7 (2.10))</td>
</tr>
<tr>
<td>Marital status</td>
<td>5 (4.30)</td>
<td>4 (4.01)</td>
<td>7 (2.05)</td>
<td>6 (3.10)</td>
<td>6 (2.17)</td>
<td>6 (2.14)</td>
<td>6 (2.12)</td>
</tr>
<tr>
<td>Income</td>
<td>1 (6.35)</td>
<td>2 (5.05)</td>
<td>1 (4.22)</td>
<td>5 (3.18)</td>
<td>1 (7.20)</td>
<td>1 (4.35)</td>
<td>1 (6.05)</td>
</tr>
<tr>
<td>Occupation</td>
<td>6 (4.20)</td>
<td>7 (2.10)</td>
<td>4 (3.11)</td>
<td>4 (4.17)</td>
<td>5 (3.16)</td>
<td>5 (2.17)</td>
<td>5 (2.17)</td>
</tr>
<tr>
<td>Magico-religious</td>
<td>7 (3.16)</td>
<td>6 (2.15)</td>
<td>5 (2.15)</td>
<td>3 (5.10)</td>
<td>4 (4.25)</td>
<td>4 (3.19)</td>
<td>4 (3.15)</td>
</tr>
<tr>
<td>Norms and values</td>
<td>3 (5.25)</td>
<td>1 (6.21)</td>
<td>3 (3.25)</td>
<td>2 (6.15)</td>
<td>2 (6.20)</td>
<td>3 (4.01)</td>
<td>3 (5.10)</td>
</tr>
<tr>
<td>Education</td>
<td>2 (5.52)</td>
<td>3 (4.18)</td>
<td>2 (4.02)</td>
<td>1 (6.23)</td>
<td>3 (6.18)</td>
<td>2 (4.13)</td>
<td>2 (5.18)</td>
</tr>
</tbody>
</table>

Source: Author’s survey, (2009).

Finally, but by no means the least, it is recommended that village or community committees and community health workers in multi-cultural populations should not only mobilize community members through adequate publicity and awareness programs but also should sufficiently involve such prospective beneficiaries in the critical stages of project planning, evaluation and decision making.

REFERENCES