Rural Farmers' Attitude towards Health Extension Programmes in Gokana Local Government Area, Rivers State

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Abstract: This work was designed to assess farmers' attitude towards Health Extension Programmes (HEPs) in Gokana Local Government Area of Rivers State. Structured interview schedule was used to retrieve data from farmers in five (5) different communities in Gokana local government area namely, Biara, B-dere, Bodo city, Bua-Yeghe and Mogho. Data were collected from twenty (20) farmers in each of the above mentioned communities which summed-up to one hundred (100) farmers using the simple random sampling technique, but ninety seven (97) of them responded. The data collected were analysed with percentages, mean scores and Analysis of Variance (ANOVA). Results showed that females (56.7%) participated more than the male (43.3%) in HEP in GOLGA, majority of the farmers were married; most of the farmers were in their middle age (46 years). The farmers obtained their health information through traditional and modern means of information dissemination. Some major HEPs practiced by the farmers in the studied areas were vaccination, eating of balance diet, immunization, family planning, breast feeding, infant care, use of clean water, etc. Hypotheses one and three showed that there were no significant difference in the levels of awareness and adoption of health extension programmes in the communities studied while hypothesis two showed that there was a significance difference in the levels of satisfaction with health extension programmes in the communities. It was therefore recommended that government should enhance effective health extension programmes in the study areas, among which are: allocation of adequate budget to health centers, construction and completion of health centers to reach all GOLGA communities.
Keywords: Farmers' Awareness, Adoption, Health Practices

INTRODUCTION

Health is considered in its broader sense as a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity [1]. It could also be seen as a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture and personal responsibility [2].

In 1948, a universal declaration of human rights was made. In this view, certain rights such as those to health or life, liberty and the pursuit of happiness cannot be granted or denied by any government because they are fundamental, inalienable human rights, which all of us, being human already have. The fundamental rights to health of every human being are goodhealth of all people. The connection between health, peace and security is self-evident when diseases coupled with poverty and other social ills destabilize governments. Example is the case of Ebola virus outbreak 2014 in Nigeria. The achievement of any state in the promotion of state of health will be of value to all its citizenry.

Health Extension Programme (HEP) can be seen as an innovative community based health care delivery system aimed at providing essential promotional and preventive health care services to rural dwellers [3]. The health and agricultural extension services aim at developing the rural community and the people therein. These can be combined with leadership and strategic planning sessions to help the administrators and community leaders, while Health Extension Officers, also known as Health Extension Workers (HEWs), are a category of health care providers found in some communities or areas including Gokana Local Government Area of Rivers State and Nigeria. They usually work in health centres in rural and medically underservedareas, where they see and treat patients and provide a range of community health services. Extension health workers (officers) are responsible for patient care, the administration of community health services [4]. Rural extension is now a common activity in most countries of the world, and it is a basic element in programmes and projects formulated to bring about change in rural areas. The word extension can be considered as a service or system which assists farm people, through educational procedures, in improving farming methods and techniques, increasing production efficiency and income, bettering their standard of living and lifting social and educational standards [5].

As agricultural development in Gokana Local Government Area moves forward, the knowledge and technological need of farmers and farm household continue to increase. In an area where farmers or households have low level of literacy and more of traditional farming systems, extension programmes will generally be more educationally focused, aims primarily at human resource development in such area. A greater population of men, women, youth and children are involved in agriculture and as well suffer from different ailments. Their level of literacy serves as a good determinant to how they live and collaborate with health agents. The rural households also increase mental health problems. Hence, there is need for appropriate health service centres which could provide precise quantitative and qualitative information on the impact of disease infections such as HIV/AIDS, Sexually Transferred Diseases (STDs), tuberculosis (TB), cancer, malaria, ebola, hepatitis B nad C. On agricultural production, such surveys should also collect information on various ailments especially HIV/AIDS related morbidity, mortality and how it affects the availability of trained staff, and the coverage of extension services.

Therefore, the purpose of the study was to assess the extent to which rural farmers were involved or benefited from the health extension programmes or services in Gokana LGA of Rivers state with the view to finding answers to the following research questions. What are the personal characteristics of the respondents in the study area? To what extent are farmers aware and satisfied with health extension services or programmes in the study area? What are the sources of health informational services to farmers in the study area? What are the levels of farmers' adoption of health extension services in the study area? And what problems are faced by the health extension programmes in the study area?

METHODOLOGY

The survey was carried out in Gokana LGA (GOLGA) of Rivers State. Its headquarter is at Kpor with an area of 126km^2 and a population of 301,828 [6]. Gokana is divided into sixteen (16) communities; the population of the study compriesd both male and female farmers' across the sixteen (16) compmunities in GOLGA. However, five (5) communities namely: Bua-yeghe, Biara, B-dere, Bodo city and Mogho were purposively selected based on their intensive farming and were beneficiaries of Rivers State health facilities. Twenty (20) farmers were randomly selected from each of the five (5) communities, giving a total of 100 farmers that were used for the study. Data were gathered through administered questionnaire, personal interviews and discussions with the farmers. Data were analyzed using percentages, mean scores and ANOVA. A four point likert type scale was used to determine the levels of awareness and satisfaction of the respondents based on health extension programmes in the study area and extent of adoption of the health extension

programmes in the area.Two hypotheses were tested using Analysis of Variance (ANOVA) which state thus: There is no significant difference in the level of farmers' satisfaction in health extension programmes in Biara, B-dere, Bodo city, Bua-Yeghe, and Mogho in Gokana Local Government Area of Rivers State, and there is no significant difference in the level of farmers' adoption of health extension programmes in the stated communities.

RESULTS AND DISCUSSION

Table 1 reveals that majority (56%) of the respondents were females while 43.3% were males indicating that the females participated more in Health Extension Programmes in GOLGA. This could be so because most females get more health information during their ante-natal and family planning programmes. The mean age of the farmers was 46 years. The implication is that majority of the farmers were in their middle age**.**A higher percentage (33%) had General Certificate Examination (GCE)/ West African Certificate Examination (WACE), 27.8% had HND/B.Sc/B.Ed, while 10.3% had no formal education, indicating that there is moderate improvement in the educational attainment of GOLGA citizens. Also, the results showed that 41.2% of the respondents acquired health services by self sponsored, 30.9% family sponsored, 10.3% Government sponsored, 7.2% church sponsored and 5.2% for volunteers and organizational sponsored, respectively. This means that majority of rural farmers in GOLGA take care of their medical bills by themselves. Furthermore, the result established that 58.8 percent were farmers, 18.6% were civil servants while 11% and 8.2% were traders and artisan, respectively. Majority (54%) of the respondents were married, indicating that the respondents were responsible men and women who have the responsibility of providing basic needs for their family.

Famers' sources of health information in Gokana

Table 2 establishedthat majority (62.89%) of the farmers in GOLGA received health information through town-crier while 59.79% of the respondents received theirs through radio. Also, 55.67% of the farmers got health information through Health Extension Workers. Other sources include fellow farmers (51.55%), friends and neighbours (57.73%), churches (63.92%), etc. Both traditional (town- crier) and modern ways of dissemination of information were used in the study area. The town – crier goes round the community, passing the message of the local leader and extension health workers to their subjects. Radio according to Isife *et al*[7] is an important mass media communication tool used to disseminate information in the rural area. This was confirmed by Albert [8] who observed that radio and television are ICT tools available in the rural areas through which information is disseminated to the people. The health extension workers provided health information to the farmers' households mainly during vaccination and immunization exercise.

Table 1: Demographics features of the respondents

Variables	Frequency	Percentage	Mean
Age (years)			
16-25	7	7.2	46years
26-35	16	16.5	
36-45	41	42.3	
46-55	20	20.6	
56 and Above	13	13.4	
Sex			
Male	42	43.3	
Female	55	56.7	
Marital status			
Single	12	12.4	
Married	53	54.6	
Divorced	7	7.2	
Separated	25	25.8	
Educational Level			
No formal education	10	10.5	10.9
FSLC	23	23.7	
WASCE	32	33	
HND/B.Sc/B.Ed	27	27.8	
Master	3	3.1	
Doctorate	2	2.1	
Occupation			
Civil services	57	58.8	
Health practitioners/health work	8	8.2	
Trading	18	18.6	
Student	3	3.1	
Artisan	11	11.3	
Source of Health Service Acquisition			
Self-sponsored	40	41.2	
Family sponsored	30	30.9	
Government sponsored	10	10.3	
Church sponsored	7	7.2	
Volunteers	5	5.2	
Organization	5	5.2	

Source: Field Data, 2015

Table 2: Sourced of health information in the study area

Sources	Frequency	Percentage
Television	20	20.62
Fellow farmers	50	51.55
Friends and neighbours	56	57.73
Radio	58	59.79
Churches	62	63.92
Newspaper	14	14.43
Community meetings	30	30.93
Magazine	5	5.15
Local markets	25	25.77
Post Bill	23	23.71
Internet(Hnahset/computer	3	3.09
Health Extension Workers	54	55.67
Town Crier	61	62.89
Total	Multiple Responses	

Sources: Field Data, 2015

Farmers' Levels of awareness of health extension programmes

From the data presented in Table 3, farmers were aware of all the health extension programmes introduced in the area. The health programmes were: vaccination service, eating balance diet, family planning, immunization, use of treated mosquito nets, HIV/AIDS prevention methods and malaria prevention/eradication. Other programmes included routine medical check-up by farmer, use of clean drinking water, breast feeding, antenatal/infant care programme and use of good toilet system. The mean scores of all the variables were above the decision point of 2.50.Since the farmers were aware of all the above mentioned health programmes, it will reduce infant/mother mortality; reduce death associated with malaria, diarrhea and cholera in the communities. When people are aware that a particular technology would do them good, they adopt it. According to Albert and Isife [9], they opined that when people are aware of technology/knowledge, they are moved to take an action.

Farmers' levels of satisfaction with Health Extension Programmes in the study areas

Table 4 shows that the farmers were satisfied with all the health extension programmes delivered to them in their areas especially for family planning (m = 3.07), immunization (m = 3.54), use of treated mosquito nets (m= 3.32), use of clean water (m = 3.22) and breast feeding (m = 3.83). Family planning programmes are adopted by rural households according to Albert and Nne Cosy [10], mainly women as it helps them to space their children and be able to provide for their children. Insecticides treated net is a technology that has been accepted and adopted by rural households; it has helped to reduce malaria cases in the rural areas [9].

ANOVA result showing the difference in farmers levels of satisfaction with the HEPs.

Table 5 shows the ANOVA result on the difference in the levels of satisfaction with health extension progammes in Biara, B-dere, Bodo city, Bua-Yeghe, and Mogho communities in Gokana Local Government Area of Rivers State. The table indicates that the calculated F value is 6.450,while the tabulated F value is 2.503 with a probability value (PV) of 0.0002. Since $F_{cal} = 6.450 > F_{tab}$ (0.05, 4, 70) = 2.503, the null hypothesis was therefore rejected. The study therefore concluded that there is a significant difference in the levels of satisfaction with health extension progammes in the communities studied. The reason could be that the health extension programmes were not provided evenly in the communities.

Table 3: Farmers' Levels of awareness of Health Extension Programmes in the study areas

HEALTH EXTENSION PROGRAMME (HEP)	BIARA (n=20)	B.DERE (n=18)	BODO-CITY (n=20)	BUA-YEGHE (n=20)	MOGHO (n=19)	Pooled Mean
Vaccination Service	3.44	1.15	3.75	3.50	1.70	2.71
Eating balance diet (Nutritional Information)	3.22	1.95	3.50	3.00	2.00	2.73
Family planning	3.61	3.25	3.00	2.50	3.00	**3.07**
Immunization	3.83	3.10	3.80	3.75	3.20	**3.54**
Campaign on the use of treated mosquito nets?	3.27	3.75	3.20	3.00	3.40	**3.32**
HIV counseling and testing	2.38	2.45	3.00	3.00	2.60	**2.69**
Routine medical check-up	3.16	2.25	3.00	3.50	2.60	**2.90**
HIV/AIDS prevention campaign	3.60	2.65	3.20	2.80	2.70	**2.99**
Malaria prevention, eradication and campaign with prescribed drugs	3.16	2.10	3.80	2.80	2.00	**2.77**
Environmental sanitation exercise	4.00	3.20	3.30	4.00	2.10	**3.32**
Use of clean water	3.50	2.20	3.70	3.72	3.00	**3.22**
Antenatal care programme	2.27	2.00	3.00	3.30	2.90	**2.69**
Infant care programme	3.33	2.70	3.10	2.90	2.00	**2.81**
Breast feeding	4.00	3.15	4.00	4.00	4.00	**3.83**
Using good toilet system	3.16	3.00	2.50	2.50	3.00	**2.83**

*Mean Scores ≥2.50 = Aware; ≤ 2.50 = Not Aware
Source: Field Data, 2015

Table4: Farmers' levels of satisfaction with health extension programmes in the study areas

Health Extension Programme (HEP)	BIARA (n=20)	B.DERE (n=18)	BODO-CITY (n=20)	BUA-YEGHE (n=20)	MOGHO (n=19)	Pooled Mean
Vaccination Service	3.44	1.15	3.75	3.50	1.70	2.71
Eating balance diet (Nutritional Information)	3.22	1.95	3.50	3.00	2.00	2.73
Family planning	3.61	3.25	3.00	2.50	3.00	**3.07**
Immunization	3.83	3.10	3.80	3.75	3.20	**3.54**
Campaign on the use of treated mosquito nets?	3.27	3.75	3.20	3.00	3.40	**3.32**
HIV counseling and testing	2.38	2.45	3.00	3.00	2.60	**2.69**
Routine medical check-up	3.16	2.25	3.00	3.50	2.60	**2.90**
HIV/AIDS prevention campaign	3.60	2.65	3.20	2.80	2.70	**2.99**
Malaria prevention eradication and campaign with prescribed drugs	3.16	2.10	3.80	2.80	2.00	**2.77**
Environmental sanitation exercise	4.00	3.20	3.30	4.00	2.10	**3.32**
Use of clean water	3.50	2.20	3.70	3.72	3.00	**3.22**
Antenatal care programme	2.27	2.00	3.00	3.30	2.90	**2.69**
Infant care programme	3.33	2.70	3.10	2.90	2.00	**2.81**
Breast feeding	4.00	3.15	4.00	4.00	4.00	**3.83**
Using good toilet system	3.16	3.00	2.50	2.50	3.00	**2.83**

*Mean Scores ≥2.50 = Satisfied; ≤ 2.50 = Not Satisfied

Source: Field Data, 2015

Table 5: ANOVA result showing the difference in farmers levels of satisfaction with the HEPs

Source of variation	Ss	df	MS	F	p-value	F_{crit}
Between Groups	7.856387	4	1.964097	6.450453	0.000177	2.502656
Within Groups	21.31428	70	0.30449			
Total	29.17067	74				

Source: Computed from SPSS

Farmers' levels of adoption of Health Extension Programmes in Gokana

The result in Table 6 established that farmers in the studied areas adopted all the extension health programmes delivered to them except for routine medical check- up (m= 2.07), HIV/AIDS prevention campaign (m= 2.07) and malaria prevention eradication and campaign with prescribed drugs (m= 2.38). The adopted extension health programmes include; vaccination service (m= 2.78), eating balanced diet (m= 2.86), family planning (m= 2.75), immunization (m= 3.39), the use of treated mosquito nets (m= 2.88), HIV counseling and testing (m= 2.58), environmental

sanitation exercise (m= 3.57), use of clean water (m = 3.14), antenatal care programme (m = 2.94), infant care programme (m = 2.85), breast feeding (m = 3.61) and the use of good toilet system (m = 2.81). This could be due to the fact that the period/hours the medical centres were opened to public, was the time most farmers are in their farms. Also, the HIV/AIDS prevention campaign on the use of condom or complete absentee from sex until after marriage was not adopted because farmers found it difficult to use condom. The communal way of sharing farm fools has also affected HIV/AIDS prevention campaign.

Table 6: Farmers' levels of adoption of Health Extension Programmes in Gokana

Health Extension Programme (HEP)	BIARA (n=20)	B.DERE (n=18)	BODO-CITY (n=20)	BUA-YEGHE (n=20)	MOGHO (n=19)	Pooled Mean
Vaccination Service	2.88	2.55	2.50	3.25	2.70	2.78
Eating balance diet (Nutritional Information)	2.88	2.44	3.50	3.00	2.50	2.86
Family planning	2.83	2.61	3.10	2.50	2.71	2.75
Immunization	3.44	3.10	3.80	3.50	3.11	3.39
Campaign on the use of treated mosquito nets	2.55	3.22	2.92	2.70	3.00	2.88
HIV counseling and testing	2.11	2.40	3.00	2.50	2.90	2.58
Routine medical check-up	2.77	1.33	1.75	3.00	1.50	2.07
HIV/AIDS prevention campaign	2.66	2.50	1.00	1.90	2.30	2.07
Malaria prevention/ eradication campaign with prescribed drugs	2.38	2.70	1.50	2.50	2.80	2.38
Environmental sanitation exercise	3.44	3.50	3.80	4.00	3.10	3.57
Use of clean water	3.05	2.90	3.00	3.75	3.00	3.14
Antenatal care programme	3.88	2.33	3.10	2.98	2.40	2.94
Infant care programme	3.00	2.83	3.50	2.20	2.71	2.85
Breast feeding	2.77	3.80	4.00	4.00	3.50	3.61
Using good toilet system	2.77	2.50	3.00	3.50	2.30	2.81

*Mean Scores ≥2.50 = Adopted; ≤ 2.50 = Not Adopted
Source: Field Data, 2015

ANOVA showing the difference in farmers' levels of adoption of HEPs in the communities

The information in table 7 shows the ANOVA result on the difference in the level of adoption of health extension progammes in Biara, B-dere, Bodo city, Bua-Yeghe, and Mogho communities in Gokana Local Government Area of Rivers State. The table shows that $F_{cal} = 0.711$ and $F_{tab} = 2.503$ with a probability value (PV) of 0.587. Since the significant value = 0.587 > 0.05 level of significance, the null hypothesis was accepted. Conventionally, the $F_{cal} = 0.711$, while the critical value F_{cal} (o.o5, 4,70) = 2.503. Since = 0.711 < F_{crit}. (0.05, 4, 70) = 2.503, the decision is upheld. It is therefore concluded that there was no significant difference in the levels of adoption of health extension progammes in the study areas.

Table 7:ANOVA showing the difference in farmers' levels of adoption of HEPs in the communities

Source of variation	Ss	df	Ms	F	p-value	F_{crit}
Between Groups	1.094693	4	0.273673	0.711258	0.586981	2.502656
Within Groups	26.93417	70	0.384774			
Total	28.02887	74				

Source: Computed from SPSS

CONCLUSION AND RECOMMENDATIONS

The study established that health extension programmes were implemented in the Gokana Local Government Area of Rivers State. These health extension programmes were made available to the farmers through town-crier, radio, friends and neigbours, fellow farmers, churches and extension health workers. The farmers were aware of all the extension health extension programmes such as breast feeding, immunization, use of treated mosquito nets, vaccination, family planning, environmental sanitation, among others. The farmers were satisfied with the health programmes and so adopted them excep tHIV/AIDS prevention campaign and routine check-up which they were not satisfied with and never adopted.

However, there was no significant difference in the levels of adoption of in the health extension programmesin Biara, B-dere, Bodo city, Bua-Yeghe, and Mogho communities. But generally, difference existed in the levels of satisfaction with the health extension programmesin the communities. It is suggested that to enhance participation and sustainability of the health programmes in the study areas, government should provide enabling environment and facilities such as adequate funding, construction of more health centres across the communities and regularly provide health commodity services to the beneficiaries.

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