FEDERAL MINISTRY OF HEALTH

DFID Department for International Development

PARTNERSHIP FOR TRANSFORMING HEALTH SYSTEMS (PATHS) II:
OUTPUT 5 QUALITATIVE RESEARCH STUDY DESIGN

STRENGTHENING CITIZENS' CAPACITY FOR PREVENTION, TREATMENT AND MANAGEMENT OF PRIORITY HEALTH CONDITIONS THROUGH EFFECTIVE PUBLIC HEALTH COMMUNICATION

Report of a Qualitative Baseline Survey of Kano State, Nigeria

December, 2009

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EXECUTIVE SUMMARY

Designed around five major outputs, the Partnerships for Transforming Health Systems (PATHS 2) has the goal of ensuring that Nigeria's own resources are effectively and efficiently used to achieve the Millennium Development Goals (MDGs). Output 5 of the programme is targeted at strengthening the *capacity of citizens to make informed choices about prevention, treatment and management of priority health conditions* through thorough understanding and application of strategic health communication principles and practices.

A qualitative survey, this study utilised in-depth interviews (IDIs) and Focus Group Discussions (FGDs) as the major sources for eliciting data from respondents in Kano State. The formative research enabled an assessment of the knowledge, attitude, perceptions and practices (KAPP) of target audiences in line with the goals of PATHS 2 Output 5. Data were collected in four communities in the State (Yakasai, Dukawa, Shukwai and Yankifi), selected from two local government areas (Kano Municipal and Kunchi), reflecting the rural-urban diversity of the State. The interviews and discussions were conducted mainly in Hausa, the local language, and transcribed and analysed using standard protocols. The respondents included in- and-out-of-school adolescents, in-and-out of school children, parents, physically challenged persons, Community Health Extension workers (CHEW), Traditional Birth Attendants (TBA), and leaders of religious and traditional communities. A total of 31 interviews and 37discussions were held in Kano State.

Derived from four principal domains, identified for data collection viz., Knowledge, attitude, perceptions and practices (KAPP); health communication interventions; media dynamics; and alternative platforms; the results indicate a strong and urgent need for actions that promote responsibility for health at the individual, household and community levels; as well as actions that broker equality and social inclusiveness across a broad spectrum of population subgroups. KAPP results show a general awareness of health conditions and regard for health needs and responsibilities by respondents across categories of the geo-space, gender and age. On health communication intervention, the investigation identified that most persons rely on health workers, health centres and chemists[1] in their communities. Such health communication as is obtained at home is generally low; while now and then people may get some health information at school and during special events. These sources were found to be inadequate in coverage and content, especially with respect to preventive health behaviour. On prevalent media dynamics, the results are quite clear that radio has played a major role in information access but individual conditions, including poverty, have served to exclude some segments of the population from making use of this widespread medium. However, the traditional mechanisms of communication have been more effective when used with greater exposure and attention. In relation to alternative platforms, the results vary but there is a general under-utilisation of folk media and social clubs, including religious groups and activities, in health information intervention.

Against this background, there is a need to focus on cultural conditions and practices such as gender roles that determine consumption patterns inhibiting healthy living at the community levels. The goal of this aspect of intervention is to pull up the KAPP of the people and shore up preventive health-seeking behaviour. There is a need to re-orientate the people to take responsibility for their own health, while deliberate efforts are made to address the lapses in the public health system at the community level. Health workers training should be improved to change their attitude towards the people, while parents should be more responsible in preventive health actions at the community level. Platforms must be created for stakeholders

[1] A chemist is a person who sells patent medicines in a shop, usually but not always a trained pharmacist. A chemist is also the drugstore where such medicines can be bought.

to meaningfully dialogue and interrogate cultural practices and conditions in order for them to understand and apply strategic health communication principles and practices. Finally, inclusive folk media alternatives must be urgently identified through participatory processes, and the people empowered with necessary information to facilitate their preventive health-seeking behaviour.

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List of Abbreviations and Acronyms

AM	Amplitude Modulation
ANC	Antenatal Care
BBC	British Broadcasting Corporation
BCC	Behavioural Change Communication
CHEW	Community Health Extension Workers
FGD	Focus Group Discussion
FM	Frequency Modulated Band
FRCN	Federal Radio Corporation on Nigeria
HCDC	Health Care Delivery Systems
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HW	Health Workers
IDI	In-depth Interview
ITN	Insecticide Treated Nets
KMC	Kano Municipal Council
KAPP	Knowledge Attitude Perception and Practice
LGA	Local Government Area
MDGs	Millennium Development Goals
MoH	Ministry of Health
NHC	National Health Conference
NTA	National Television Authority
ORS	Oral Rehydration Salts
PATHS 2	Partnerships for Transforming Health Systems 2
SSA	Sub Saharan Africa
TB	Tuberculosis
TBA	Traditional Birth Attendants
VOA	Voice of America
WHO	World Health Organization

GLOSSARY

Access: The unimpeded right or act of entering or reaching a place, person, group or thing, such as a community or health facility.

Alternative Communication Platforms: Communication forms other than radio, television, cable, and various forms of print media; include drama, town hall meetings, peer to peer communication process, internet, and mobile telephony.

Chemist: Someone who is trained to prepare drugs and medicines /who works in a shop where patent medicines are sold; a shop where medicines and toiletries are sold.

Community Dialogues: Process of discussion and/or decision-making among different community actors who have different interests, opinion and values that are at stake in a particular situation at a particular time; often facilitated by an independent third party specifically trained to support the process.

Development Communication: Strategic integration of strategic communication in development projects. Strategic communication is a powerful tool that can improve the chances of success of development projects. It strives for behaviour change not just information dissemination, education, or awareness-raising. While the latter are necessary ingredients of communication, they are not sufficient for getting people to change long-established practices or behaviours.

Drug vendors: People who hawk drugs on the streets, in public transport and from house-to-house.

Health: A state of complete physical, mental, psychological, social and spiritual well being, and not merely the absence of diseases or infirmity.

Health Communication Interventions: Specific communication initiatives aimed at equipping beneficiaries with requisite information to improve their health status.

Health Delivery System: Mechanisms for providing health services to the target beneficiaries with a defined locations

Health Intervention Alternatives: Sources of healthcare other than mainstream healthcare provided by doctors, nurses and other medical personnel in hospitals (e.g. herbal medicine and faith healing)

Health Seeking Behaviour: Things people do to prevent diseases and detect diseases in an early stage, and dealing with same in order to remain healthy; implies patient's early recognition of disease symptoms, presentation to health facility and compliance with prescribed treatment.

Healthcare Providers: Various categories of workers who provide health services and care. May refer to both public and private health services providers including those who provide herbal medical care or faith healers.

Health Workers: Personnel working within a health facility.

Herbalist: Someone who sells and administers potions from herbs, leaves and other items from the flora and fauna as treatment for the infirm.

Information Sharing: Process of exchanging facts, data, thoughts and feelings for mutual health benefits.

Media Dynamics: The ways in which different media act and interact in order to produce action, movement and change.

Media Participation: A relationship between audience and various categories of journalists and experts working within the media sector, in which the audience are seen to be actively engaged in programme decision-making process, design, production airing and feedback systems; acknowledges the role of audience in proposing programme, shaping and enriching the content, although for the mass media, the ultimate decision of technical designs and input still rest in most cases with the "experts" who undertake the final packaging and airing of such programmes.

Private Health Facilities: Privately-owned and manned health facilities, although the operations of such facilities are regulated in most cases by the established government regulations.

Public Health Workers - Staff or personnel of government-owned health facilities, hospital and clinic

CHAPTER ONE: INTRODUCTION

1.1 Background

This report describes the results of data collected for a baseline qualitative survey conducted in four communities in two local governments of Kano State under Output 5 of the PATHS2 project. The report is organised around the core issues that guided data collection—knowledge, attitude, perceptions and practice; health communication interventions; media dynamics; and alternative platforms. This first chapter provides an overview of the study process, situating the work in the context of the project. In addition, the chapter also highlights the objectives of the study and concludes with an outline of the report.

Designed around five major outputs, the Partnerships for Transforming Health Systems (PATHS 2) has the goal of ensuring that Nigeria's own resources are effectively and efficiently used to achieve the Millennium Development Goals (MDGs). Output 5 of the programme is targeted at strengthening the *capacity of citizens to make informed choices about prevention, treatment and management of priority health conditions* through thorough understanding and application of strategic health communication principles and practices.

1.2 Objectives

The formative baseline research has the following objectives:

1. To conduct a cross-sectional investigation of media habits, access to health information, and media participation among target groups;

2. To identify prospects of health communication interventions through the use of relevant media for reaching the respective target groups;

3. To identify existing alternative platforms for health communication interventions and information sharing and dialogue among target groups;

4. To assess processes, levels of participation, social inclusiveness, effectiveness, and opportunities for communication interventions in the identified alternative platforms;

5. To examine knowledge, attitudes and perceptions of target groups towards health workers, health care delivery systems, and selected health conditions and activities affecting general health and wellbeing, and assess their health-seeking behaviour in those terms.

1.3 Scope

The programme is aimed at strengthening, influencing and improving health service delivery and it focuses on many health indices including those of maternal and child health at household and community levels in the four states of Kaduna, Kano, Jigawa and Enugu. PATHS 2 is a Department for International Development (DFID) funded project collaborating with the Federal Ministry of Health (FMoH) at the national level, the state ministries of health (SMoH) in the four Focal States and a host of other partners.

In line with best practices and in order to achieve Output 5 of the programme, there was a need to establish a baseline against which to track programme progress, as well as monitor and evaluate performance. The present report is the outcome of the survey conducted in Kano State.

The rest of this report is made up of four chapters. Chapter 2 focuses on the methodology used in the study, while Chapter 3 presents the findings. A discussion of the findings follows in Chapter 4, and Chapter 5 summarises the findings, provides recommendations and concludes the report.

CHAPTER TWO: METHODOLOGY

This chapter focuses on the methodology used in study. It discusses the study design, study population, study area, instruments, quality assurance and methods of data analysis.

2.1 Study Design

1. A qualitative methodological design was adopted for the study. Within the focal state of Kano, two local governments were selected using the rural-urban criterion. In-depth Interviews (IDIs) were conducted with various individuals in each of the communities, including traditional rulers, religious leaders, Community Health Extension Workers (CHEWs), Traditional Birth Attendants (TBAs), women of 60+ years with children who are married, parents of adolescent children, and physically challenged persons. Focus Group Discussions (FGDs) were held amongst Married fathers (20-59 years of age) of children aged ≤5 years: farmers, traders or office workers; Married mothers (15-49) of children ≤5 years: farmers, traders or office workers; In-school adolescent females; out-of-school adolescent females; in-school adolescent males; out-of-school adolescent males; in-school male children (aged 8-12);i n-school female children (aged 8-12); out-of-school male children (aged 8-12); and out-of-school female children.

Data collection instruments were developed for the targets groups of the study. The instruments were pre-tested. A methodological workshop was held to train the field officers and assistants. Data were later collected at the different sites in the State coordinated by the officer in charge of Behavioural Change Communication (BCC) in Kano, Hajila Nabila Ismail, aided by eight field assistants. The collected data were transcribed and translated into English for the purpose of analysis.

Data analysis procedures led to coding, development of categories, and exploration of relationships. The write-up includes quotations where appropriate. Five domains were eventually created for data analysis.

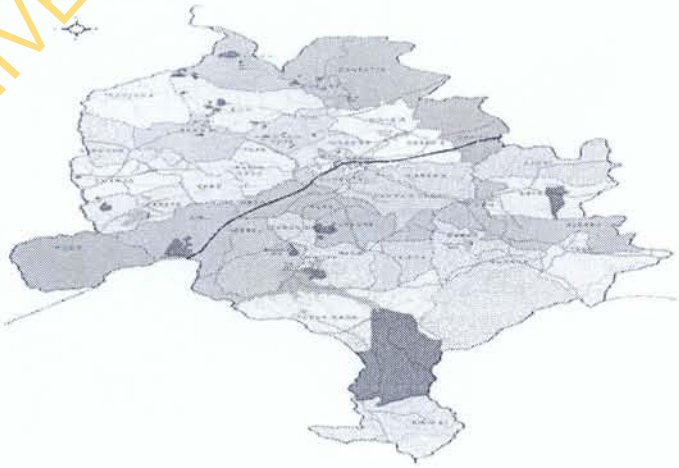
1. Knowledge Attitudes and Perceptions and Practice (KAPP)
2. Health Communication Intervention Dynamics
3. Media Issues and Dynamics
4. Alternative Platforms
5. Other significant Results.

2.2 Study Area

The study area is Kano State. Located in the North-West political zone of Nigeria and created in 1967, the population of Kano State is 51 percent male and 49 percent female. It is by far the most densely populated state in the north of Nigeria with 281 persons per square kilometre (average population density for all of Nigeria in 1991 was 96 persons per square kilometre). The population is predominantly rural but around one-quarter of the people live in urban areas, mainly in the city of Kano which is the third largest city in Nigeria. Kano is predominantly peopled by the Hausa/Fulani ethnic group, and has a rich cultural past, which has been jealously guarded since the 14th century. Kano is comprised of 44 local government areas (LGAs), being the state with the largest number of LGAs in the country.

Map of Nigeria Showing Kano State

Two local governments were selected in the State: Kunchi Local Government (rural) and Kano Municipal Council (urban).



Administrative Map of Kano State

2.3 Study Population

(a) The baseline qualitative investigation was conducted in two local governments (Kano Municipal Council and Kunchi Local Government). In each local government, two communities were selected, giving a total of four. The communities selected for Kunchi Local Government are Yankifi (rural) and Shuwaki (urban); while those for Kano Municipal Council are Dukawa (rural) and Yakasai (urban).

In all, a total of 37 discussions and 31 interviews were conducted across the four communities. The profiles of the communities are discussed below.

2.4 Community Profiles

(a) Yankifi Community

Yankifi is a rural community, situated in the Yandadi political ward of Kunchi Local Government. The people exploit the river near them by taking to fishing, and *Yankifi* literally means "the fish people". The people were relocated some 50 years ago, owing to the construction of a dam. Some people in the community are blacksmiths and women are known to be involved in small scale food processing.

There are about 15 Koranic schools in the community, and one junior secondary school for males. The community also has a health post and just one functioning bore-hole. The community is not connected to the national grid.

The community is close-knit and every member is aware of the private issues in every family house. Issues ranging from community development to child welfare, from social ceremonies and political issues to marital affairs are openly discussed among all members of the community in their different social groups and classes. Members of Yankifi community are all related by birth or marriage. The marriage age for the girls is 13 years while for males it is 17.

One of the common problems of the community is waste disposal as refuse is disposed mainly behind houses.

Some children in Shuwaki community, Kunshi LGA Kano State

The household chores which the woman assumes at marriage are quite enormous, so on that account some consideration is given to the physical size and vigour of female child who is about to get married. Most marriages are arranged by parents.

(b) Shuwaki

Shuwaki Community is the largest community in Kunchi Local Government. It is located 62Km northwest of Kano metropolis. The Community is bordered by Malikawa Garu community of Bichi Local Government to the west, Unguwar Gertai to the north, Yandadi to the east and Matan Fad to the south, all in Kunchi LGA. It is said that the first settler came from the far north in Katsina and met a lot of bitter leave plant in the area (*Shuwaka* in Hausa). Hence the place-name "Shuwaki", which is the plural of the word. In 1950 some people from the neighbouring community of Malikawa Garu moved to Shuwaki community and ruled it under the leadership of the grandfather of the current village head. The community has experienced steady growth in economy and labour.

The people of Shuwaki are predominantly Hausa-Fulani, and they practise Islam. Predominantly farmers, cattle rearing is also common given the Fulani background of the people. A handful of women in Shuwaki are employed as teachers and administrative staff in the local government departments. Women attend to the household chores which includes house cleaning, laundry and all other home management. "Talla", street hawking, is a major chore the girls engage in. The girls who do the hawking are traditionally called 'yan talla'. Talla is a kind of partnership between mother and daughter. Profits gained from Talla are

utilised during the girl's wedding for her Kayan daki. There is a handful of Igbo people who have settled as traders in Shuwaki.

Young Hawker, "Yan-Talla" in Shuwaki Community, Kunshi LGA

There are up to eight schools in the community, including primary and secondary schools. But it has to be mentioned that none of these secondary schools takes female students. There are also several koranic schools in the community. The community has a Primary Health Centre with nurses, and referral is made from there to the hospital at Bichi, the headquarters of the neighbouring local government. The community has about 13 boreholes.

(c) Dukawa

Dukawa is a settlement in Fuskar Gabas, Kano Municipal Council, which is situated within the renowned Kano ancient walls traditionally referred to as *'badalla'*. The history of Dukawa settlement dates back to about 800 years ago. Occupations in the community include trading and goats rearing, especially carried on by women. The name of the community was derived from the famous occupation of the settlers in the community, which is traditionally known as "Dukanci (traditional Hausa leather works). Dukawa was carved out of Darma, Kofar Wambai and Zango settlements. Historically, Dukawa was originally under the leadership of a district head, but that authority was replaced by an appointed Sarkin Dukawa Usman. Dukawa is bordered by Zangon bare, Bari, Darma, Sharifai, Fero and Yan awaki communities. Dukawa consists of only indigenous Kano people. Thus the inhabitants of Dukawa are Hausa Muslims. It is the custom in the community that females get married at the age of 16-18 years of age. It

is a customary obligation for parents to furnish their daughters matrimonial home and to give her as part of her dowry large quantities of a variety of foodstuffs.

The community has several koranic schools and no formal western schools. The community is served by public borehole taps and water vendors are a very common sight. The community boasts a dispensary and a significant presence of chemists.

(d) Yakasai

Yakasai (Fuskar kudu) community is as old as the ancient city of Kano. It has three political wards. History has it that people from a tribe called '*Wangara*' arrived Kano city as hunters hundreds of years ago. After many years of hunting, when they decided to leave, they chanted '*Yakasai*' –meaning "We will come back" in local dialect. When the emirate council was moved from its initial location of Dala—home to the Dala Hills in Kano—it was relocated to Yakasai. A reason for the selection of Yakasai is its proximity to the palace as a residential area for the Emir's children. The name "*Anguwar Sarakai*" which literally means "the residential area of the Kings", is another name for Yakasai. In addition to the Hausa and Fulani indigenes, traders from the south-eastern parts of Nigeria have also settled in the community. Yakasai is bordered by Zango to the north, Kankarofi and Durumin Zungura to the south, Kofar Mata to the east and Durumin Iya to the west. Yakasai, as a political ward in KMC, is divided into Yakasai A and Yakasai B. Yakasai 'A' has ten traditional settlements, namely, Lungun Kan Tudu, Gyanawa, Jajaye Lungun Bata kulki, Kurna, Lungun Mabuga, Gidan Sarkin kida, Kabarin Wali, Lokon Ahlan and Lungun Kuka.

Majority of the homes in Yakasai are polygynous. The norm is for the man to cater to the needs of his wives and several children. Quite a number of the women in Yakasai are working mothers. They combine this with housekeeping and child upbringing. The health-seeking behaviour of the women is optimal. With a preference for orthodox medicine, they seek antenatal care in pregnancy clinics and visit Health facilities in times of illness. During delivery, they prefer skilled delivery in Health Facilities.

The community has public water and there are many boreholes. Direct connection of water to a household is influenced by the social class and or affluence of the head of the household. However, waste management is a major problem in the community.

2.5 Quality Assurance

The data analysis process began with a methodological meeting held in Kaduna from 6th to 10th October 2009. Responsibilities were assigned and a timetable was agreed upon. Those assigned to write-up the Kano report were R.A. Okunola, A.A. Bagara and J.G. Eteng. The available instruments were shared out amongst the three data analyst. Analysts were made to supply weekly reports to enable the monitoring of progress in the analysis process and ensure standardisation. A follow-up review meeting was held in Abuja from 6th to 8th November 2009. At the Abuja meeting, lead data analysts were identified to synthesise reports at the state level. R.A. Okunola became the lead analyst for Kano State. A finalisation meeting was held in Abuja between Friday 4th to Monday 8th of December 2009 of lead data analysts and the lead consultant. State reports were taken and inputs made. The national report was later constructed from the various state reports.

CHAPTER THREE: RESULTS

This chapter presents the findings of this study and is divided into four major parts as derived from the four domains identified – Knowledge Attitude, Perception and Practice (KAPP); Health Communication Dynamics; Media Dynamics and Alternative Platforms.

3.1 Knowledge Attitude, Perceptions and Practices

- With respect to knowledge, respondents generally demonstrated a high knowledge of health issues in their community. In addition to this, there is an awareness of the duties expected of the various health workers in their communities as majority of the people have either gone to the health facility before or have taken or accompanied relatives to such heath facilities.

- Three major healthcare systems were identified by respondents in the various communities—traditional, western, and spiritual. Discussions revealed that people patronise all these systems concurrently depending on the perceived seriousness of sickness and the social status of the patients or of their parents. Further discussion on the health delivery system showed that chemists are common and are closest to the people. Public health facilities were said to often be far away, creating challenges for would-be users, especially as you move from the urban to the rural and remote areas.

- The general health problems highlighted in the community include malaria, cholera, tuberculosis, diarrhoea, cough, and typhoid fever. What respondents said about their health problems varied by geographical location and by gender. However, some of these diseases such as malaria, diarrhoea and cough are found in the urban and rural areas. The most rampant of these health problems is malaria.

- Also cited as common diseases are chest pain and eye problems. More discussants raised the problem of HIV/AIDS in the urban community than the rural area. An elderly woman interviewed Yankifi listed the common diseases in the community to be "mostly meningitis, common cold and eye trouble".

- Aside from these general observations, an interesting picture emerges if one goes by gender and age categorisation. For example, HIV/AIDS was mentioned mostly by male adolescents, whooping cough, typhoid fever and cholera mostly by female adolescents. HIV/AIDS was mentioned more by adolescents, and more in the urban centres. It appeared that most of the female respondents could not differentiate very well between TB and whooping cough. Also meningitis, headache stomach ache, scabies, bilharzia were reported mostly by male adolescents in the rural area and by the traditional rulers of the rural communities.

- However, the male adults in both rural and urban communities showed more knowledge than other respondents of the prevalence of non-communicable diseases such as hypertension, diabetes, kidney failure, ulcer, measles and rheumatism. Both

male and female adolescent displayed more knowledge of and concern over communicable diseases. Some female adolescent respondents reported sprit jinns as one of their health concerns (Spirit spouses).

- Furthermore, one health problem that was mentioned by discussants in every one of the communities is the problem of child delivery and maternal mortality. Usually in the rural areas, when complications develop for women at birth, the option is mostly to refer them to higher medical facilities which are generally far from the community. This distance from the reference hospitals generally results in grievous outcomes for the expectant mothers.

- Another major health problem is related to hygiene. Inadequate water supply affects the toilet habit of the people, as observed among most adolescents in both Kano Municipal and in the rural areas surveyed in the State. This lack of water makes modern flush toilets unpopular. Children and adult prefer to pass their excreta in the bush where they also dispose of their refuse.

- Respondents generally recognised the importance of good nutrition for healthy living. They equally stressed the importance of clean water and emphasised the need to keep the environment clean, as well as the observance of basic hygiene rules. It is within this context that a male in-school respondent from Shuwaki argued thus: "If you eat good food, you wear clean clothes, you take your bath regularly, and you wash your clothes, you will feel good and healthy."

- It was found that there were some activities engaged in by people in the community that negate healthy living. These include dumping of refuse in gutters within the community, leaving bushes to grow around homes, children playing under water hydrants during rainfall, leaving food uncovered, and working in muddy areas. These activities usually occur more in the rural areas. In the case of the urban centre, dumping of refuse into the drainage is one common problem.

- The people were generally found to be fatalistic, believing that God (Allah) is the ultimate provider of health. This was demonstrated in comments such as "Allah provides health; Allah brings health; and everything comes from Allah". However, when ill heath occurs it is the head of the household that should be responsible for taking care of such members affected. In the absence of the husband, the mother is expected to take over this responsibility.

- Health-seeking behaviour was noticed to vary with the nature of the illness, with the urban residents having a better advantage especially as regards availability of and access to public health. Health conditions that often warrant going to the hospital include TB and complicated child delivery. Concerning diarrhoea and cholera, respondents said that patients are taken to hospital immediately. They are given oral rehydration solution and some concoction (herbal treatment). If the condition of the patient gets better, then there is no need for further action; if not, then the patient is taken to hospital in the nearby village or moved to the general hospital.

- The pathway to get solution to health problems begins with consultation with the head of the household or an elderly person that is immediately available. In the case of children or youth, they generally report first to their mother, though it is the father

that takes the final decision on the pathways for seeking treatment. Discussions generally show that chemists are often the first point of call when domestic self-medication has failed.

- Attitude has been shown to be a major influence on behaviour. In this context, the attitudinal disposition of the people is expected to be a vehicle facilitating health-seeking behaviour or an impediment to it. Respondents were generally not happy with orthodox medical staff. For example a male respondent in Kano submitted thus:

> ...but truly the nurses embarrass people. Also there is no drug. Even if there is, they are so costly that you can't afford it. Some doctors don't even attend to the person that comes to the hospital. There are no adequate machines for test and a lot of problems that government must attend to... if the government can provide the basic needs, you will see a lot of progress.

- Indications are clear that there is a population pressure on the public health system.

- Arising from this pressure and directly related to it is the emergence of corruption and favouritism among health workers. When there is scarcity of public utility or service, corruption begins to surface as people try to "to beat others to it". One in-school adolescent spoke on the reality of this problem:

> Well, we thank God, one can distinguish people by their appearance. If you take a patient to the hospital and the staff see somebody who looks better dressed than you, they will treat him first thinking that he will give them some token amount, but sometimes they are good.

- In general, respondents said they argued that the healthcare delivery system should be more responsive and affordable to them. Some respondents complained of the distance between them and health facilities, and others remarked on the fact that these facilities are not adequate to meet the demand for their services. The challenges are the barriers to patronage of the orthodox healthcare delivery, and they have served to create a negative attitude in potential clients of orthodox medicine. These challenges in the long run increase the social cost of medicare and could lead to the search for alternatively "cheaper" medicare, which such persons often find in vendors of patent medicines.

- However, respondents generally agreed that identified health conditions ought to be taken to relevant health systems for treatment. There was a consensus that as soon as symptoms of any disease begin to manifest, immediate steps should be taken to seek treatment, as part of the personal responsibility of the patient. In the case of communicable diseases, they was the consensus that adequate treatment need be given to avoid their spread.

3.2 Health Communication Interventions

This section will present results on Health Communication Interventions (HCI) in the communities under focus.

- Information flow within the family was found to be strong both in the rural and urban communities, though the strength of the influence of the family institution is stronger in rural communities. Even though age is revered, the prospect for dialogue across generations in the communities is very high. A respondent argued:

> First of all, your parents are one of the reasons you are alive, and deserve respect, secondly elderly members of the community are your parents' mates or even their senior and they deserve respect too, thirdly your senior brother and sister deserve respect because he/she is your elder too.

- A high level of interaction and thus communication dynamics exist between the community members and health workers of the various health systems in the community, creating good prospects for information flow especially in the rural areas where access to the mass media is relatively limited.

- Interaction with teachers, especially for the in-school children, further enhances information flow on health issues in the communities under focus. An in-school respondent said: "we discuss with our teachers". This point to the importance of teachers in any intervention programme in communities. This leaves us with a challenge as regards the out-of-school adolescents. There is a need to identify platforms for this category. Such platforms may be found in the koranic schools that abound in all the communities under focus, and will require collaboration with council of *ulamas* in the communities.

- Peer influence through interaction in the village square, school compound and market places, especially in the rural communities, offers opportunities for health intervention dynamics in the communities under study. Peer influence is particularly strong for the out-of-school male adolescents who are often found hanging around together.

- Use of radio is widespread in the four communities under focus; and the use of other electronic media, especially the TV, was more widespread in the urban areas. Respondents listed five radio stations operating currently in the State—Radio Kano AM and FM, Freedom Radio, Pyramid radio and Ray Power. Radio Kano AM was the most frequently cited by respondents. Other radio stations transmitting from outside the State were mentioned by respondents, including Radio Nigeria Kaduna, Hausa Service of the BBC, VOA and Radio France International.

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pportunities for community intervention exist in abundance in the communities. Such interventions can be realised through the collaboration of various actors and

institutions like parents, elderly ones, traditional rulers, and health workers. These key actors are no doubt ready and willing to take up this responsibility.

3.3 Media Dynamics

This section deals the results on use of media in the communities under study. It examines media dynamics in terms of the media habits of the people, media participation, relevance of different media and alternative media. It is pertinent to note the importance of media in human interaction and activities. The media's capacity as sources of information, education and enlightenment cannot be overemphasised. This is why exposure to media contents is expected to have profound effect on individuals' behaviour in relation to health issues.

- Radio was found to be the most popular channel and the most widely patronised communication channel outside the family. An elderly male respondent in Kano Municipal summed up the discussions on this:

  > The radio is the best as everybody, both old and young, use it, and you can use it even without NEPA (electricity) unlike television which cannot work without light.

- It was found that a lot of media exposure has helped in informing the male adolescents on risky behaviours and likely implications. Respondents in urban centres submitted that they have access to information from newspapers, radio, television and the internet. More important are text messages sent to individual phones addressing the issue of HIV/AIDS.

- Generally, respondents were assertive that the information received from different communication channels, especially through the radio (which had earlier been shown to be widespread) influenced their health habits positively. Such radio stations have built some credibility with the audience in their immediate area of coverage that information obtained through them are mostly trusted and followed. The social relevance of many of the programme contents aired adds to the appeal of these programmes; and the use of Hausa language in many of the programmes is of great advantage.

- In addition, radio drama which addresses the issue of HIV/AIDS runs in the community and this serves as vehicle of enlightenment for youths on the dangers of risky sexual practices. NGOs also send text messages to people in the community as a vehicle of communication on health issues.

The consequence of the above is that adequate health awareness should produce positive health habits. This was corroborated by respondents in one FGD. They disclosed that the health information from media can help achieve positive health habits. But many respondents were of the view that even when they begin to display high health-seeking behaviour based on the influence of media messages, there is still the problem that they might not receive

adequate attention from health workers owing to the class question. As expressed by one respondent,

> ....it [media] can help, only that we are afraid how they [health workers] will receive people whether the rich or poor.

Messages conveyed visually have more lasting effect on the memory of the audience. The example can be cited of a film, which starred a Hausa actor well known to the people. It centres on how people can protect themselves against HIV. The message of the film was well received by the audience because it was acted by somebody they saw as a "model". Some of the health drama the community has access to include *Idan Rana ta fito* **(**When the sun rises**).** Respondents showed awareness of the popular films treating health issues. As one respondent answered: "...Yes, there is a drama on healthcare called 'warning' which is by a Hausa actor called Sani Denja. The film is about how you can protect yourself against HIV."

- Health messages are also accessed in the community through posters and bills at health centres. Respondents, especially mothers, readily recounted various posters they have seen and were able to relay the messages contained in such posters. Typical examples mentioned include a poster on the need to use treated nets to avoid malaria and posters promoting exclusive breastfeeding.

In terms of access to information the findings reveal that next to town crier, popular channels include social meetings, naming and wedding ceremonies, peer influence, as well as religious and health programmes. Television was widely seen by the women as something owned by the head of the house '*Megida*'. While others said it was very expensive to afford.

- For the in-school children in Yankifi, majorities were not taught health education and had no health clubs at schools. For those in urban Kano, many of the in-school students said they were taught health education in school. For one male respondent, "I have health education textbook, it was given to us and they [teachers] ask us to be reading it".

For another, "They use to teach us physical and health education. It is about health issues".

- In-school respondents were found to outside the school environment what they learn about health with non-students. This shows that knowledge on health is also being dispersed from school to playground and the homes. One male in-school respondent in noted that "

- We do teach our siblings, parents and even friends who are not in school".

- Many Kano in-school adolescents were more open with their teachers concerning health issues than with their parents. Mothers were also preferred to fathers in the communication of health related matters by the children, especially in-school females. In-school adolescents discuss health more with their parents and teachers than with health workers.

3.4 Alternative Platforms

This section is concerned with findings in relation to various alternative platforms that are available for health information in the community. It will cover media process, opportunity for health communication intervention, information sharing, level of participation, social inclusiveness, and effectiveness.

- There exist in the communities several alternative communication alternatives that can be useful for health intervention communication. These include the town criers, traditional musical groups, cultural and social associations. All these were shown to be in abundance in all the communities under study. As things stand at the moment, the potentials of these folk communication channels have not been properly harnessed. In order to harness their potentialities, we need to take inventory of them and train their practitioners on specific health issues within the context of the objectives of PATH 2.

- Health communication Interventions can also be enhanced through collaboration with health workers and health extension workers. The TBA's and traditional health practitioners can equally be used for health communication intervention by incorporating them into the information framework. These categories of professionals (traditional health practitioners) already command high social ratings amongst the people.

- The religious institutions and activities can equally be used as alternative medium for health communication interventions.

- An emerging trend is the contribution of women to phone-in programmes on health aired on some radio stations.

- From discussions with respondents, it became clear that a great deal of interaction exists amongst the different strata of the society especially with regards to information sharing. Children discuss with their peers on health experiences and information obtained from health workers are freely discussed with parents and friends.

- The gathering of youths in and around the football field and on other occasions held at the community playground can also be explored for health communication intervention.

- Traditional activities, ceremonies and gatherings at the community meeting place also hold out useful prospects for alternative platforms of health communication intervention.

Traditional dancers of the Emirate in an annual Durbar festival in Yakassai Community

The effectiveness of alternative media is no doubt assured. Given their generally folk nature and cultural relevance, the people will no doubt relate to them and freely understand their contents.

CHAPTER FOUR: DISCUSSION OF FINDINGS

This chapter discusses the findings within the context of the four major domains of the study.

4.1 Knowledge, Attitudes, Perceptions and Practices

The knowledge of the people is very important in the kind of health-seeking behaviour they display. Health-seeking behaviour is also a function of the beliefs people hold about diseases. This determines the potential seriousness they ascribe to health conditions in terms of pain or discomfort, time lost to work, economic difficulties or other considerationsS. Generally, respondents in the communities as shown from the findings above, acknowledge the importance of health to their overall well-being. Their submission is aptly captured by a Traditional Birth Attendant (TBA).

> Health is the master of the body. This means if you are healthy, you can drink and eat, perform ablution, bathe. If you are not well you cannot do all these things.

A common adage that ran through all the FGDs is the phrase 'lafiya uwar Jigi'; meaning 'Health is wealth'.

Respondents generally have a clear understanding of the various diseases that there are in their communities. Respondents across space, age and gender freely listed the various diseases and ailments that are common in their communities. A respondent for example contributed thus with regards to the common health problem: "In this community malaria is seriously affecting us. This is our major problem and now is the period of mosquitoes."

Malaria is one of the major health problems in the communities, and it is agreed that children are the most susceptible. Younger respondents have less knowledge on health conditions compared to the adults. Women have more information on maternal and child health than men. This is not unexpected given the primary role of women although the patriarchal system has served to ensure that the power to take decisions on crucial health choices resides in the men. **This raises the need for us to focus communication interventions on women as the primary care givers especially at the household level in society.** Ironically, the knowledge of people with respect to malaria is not directly reflected in their health practices. For instance, people talk of the usefulness of treated mosquito nets but the actual use mosquito nets across the four communities is very low. The gap between

knowledge and practice might not be unconnected with the level of poverty of the people especially with regards to their purchasing power. Thus they rely on alternative sources of health care, which are cheaper. To give another example, all respondents acknowledged the need for environmental cleanliness as a necessary factor to prevent the outbreak of diseases, yet all around their communities are refuse dumps. This incongruence or gap between knowledge and practice **raises the need for Behaviour Change Communication (BCC) at the community level, especially targeting women as primary health providers at the family and household level.**

Furthermore, adolescents were found to engage in the risky health practices of premarital sex, prostitution, smoking of Indian hemp, among others risky behaviours. Higher risky health practices amongst youths should no doubt be expected, and the incidence is generally higher in the urban than in the rural areas. First special attention needs to be paid on this category of persons in the communities in order to change their values and attitudes. **Considerable influence should be brought to bear on parents, especially mothers given their closeness to the children, to show more concern for the safety of their children.** However, the obstacle is patriarchy. The female parent is subordinated by culture and socially excluded. It is our suggestion **that the female members of these communities should be made key agents in the attainment of healthy behavioural dispositions among vulnerable youths.**

In the area of activities affecting well being in the communities under focus, it must put on record that the people themselves recognise various activities and conditions which makes them prone to many diseases and health conditions. For example, a traditional ruler in Shuwaki community said that:

> The first bad habit is lack of personal hygiene, in fact if a person can maintain personal hygiene and that of his environment he can stay long without being afflicted by any disease.

An urban respondent added especially with regards to conditions in the urban setting:

> Drainages in front of our houses are blocked yet we live with that condition, another problem is waste disposal, our people don't take their refuse to main refuse
> disposal site, they dump it everywhere, this brings mosquitoes that cause malaria.

A situation like this calls on individuals to take some individual responsibility for personal hygiene and environmental cleanliness in order to make for prevention of certain illness and diseases

Furthermore, while acknowledging the existence of three major health systems in the community, respondents gave prominence to the modern public health system as the most sought-after. In this context the people placed more emphasis and responsibility on the health workers and other service providers within the healthcare system. They expect much more from this system. During one FGD in Yankifi, a male adult respondent spoke thus:

> For instance, if our hospital operates everyday then of course there is no cause for alarm, we just have to carry the patient there, but for now in this village, one can try herbal medicine before one goes to the hospital.

There are situations, especially in rural communities, where public health facilities are either not available or inadequate. And the people are acutely aware of the shortage.

> Our major problem here is that we don't have a hospital. We buy our drugs from vendors, like when a woman is in labour, we help her with some Islamic medication and by the grace of God, she is delivered safely.

The fact that there is such immense pressure on the public health system means that the people have appreciable health-seeking habits. However, that health-seeking is undermined by the failure of the system to meet the demand for services and medicines. On the issue of pressure, a male in-school adolescent submitted thus:

> Because there are always millions of people wanting to see the doctor, some health workers receive us warmly but some don't. Most of those that receive us coldly are women health workers.

As a result members of the public have come to expect all manner of things from the personnel of the public health system. A female adolescent in Shuwaki respondent has this to say within a comparative perspective:

> In the Private hospital they will attend to you very well, if you buy drug they will give you plenty, as you will pay and then get the services. In government facilities you get free services and at times they don't look after the patients well.

Thus, findings demonstrate that the people are not too happy with the services rendered in the public health system in their communities because of the attitude of its staff. As one traditional ruler in Dukawa put it, this is a situation in which "some people prefer to consult their native doctors".

Indeed, studies have shown in Nigeria that health workers, especially nurses and midwives, are a difficult group of workers in the hospital setting. A respondent expanded on the situation highlighted above:

> People do go to hospital always but it seems they don't get good care from one sickness to another... that is why some people have lost faith in the hospital and they are going back to our normal traditional herbs... you know nowadays, the mosquito is resisting the repellents.

The study shows that the attitude of health workers has contributed to a situation in which people seek health care from other sources; hence the call for reforms in the system which was evident in the comments of respondents both in the rural and urban communities.

Even where they recognise and believe that there are lots of benefits derivable from the public health system, the benefits stemming from such systems are generally perceived to outweigh the costs and inconvenience. This awareness on the part of the people is good and is the pivot of positive, healthy living. However, the health systems need to be brought up-to-date with what people expect from them, and this is a problem especially of the public health system. could be an inhibiting factor. As a result of their frustrations, people in the communities reported going to chemists rather than to hospitals. But even so, though people blame the system and the cost of healthcare, there is the need for people to take some responsibility at the household level for the decisions that are taken in relation to healthcare options.

Inadequate supply of health personnel, distance of health facilities, expensive healthcare service, lack of potable water, poor sanitation, inadequate drugs and the poor attitude of health workers are major findings of this study that needs to be examined in order to channel resources towards tackling them. According to Nakajima (1995),[2] some of the best opportunities for defending ourselves against health hazards can be found in our everyday living—in the family, in the school, at work place and in community health services. In essence, every individual should be made take a closer look at his/her everyday living and as such **take responsibilities for healthy living. This raises the urgent need to provide the people with information through appropriate inclusive channels, including alternative platforms to be able to make informed choices as the people take initiatives in their pathway to health.**

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[2] Nakajima, H. 1995. The state of the world's health. World health Organisation. March-April:3.

Available spendable cash, geographical distance and cultural variables have co-jointly served to push the people towards chemists and traditional medicine. This has in turn driven the people away from properly accessing the modern health system. The rural areas appear the worst-hit in this context. The urge to take action is thus affected by the poverty level of the people. Medical education in Nigeria remains elitist where most it is mostly within the reach of the upper and middle classes in the society.

Non-Location of health facilities in some of the communities is a source of challenge to the health-seeking behaviour of the people. This is compounded by the dilapidated roads which make even trekking a nightmare. Studies by Stawart and Esterline (1961) has shown that reduction in monetary cost among the low-income groups is usually associated with increased used of health services. **There is therefore the need to fashion out and design pro-poor health service schemes in these communities** to encourage low-income groups which populate the area to patronise licensed healthcare centres rather than the mass use of chemists and drug vendor. The call for systemic reforms, made especially by adult respondents, should be seen in the context of growing poverty and increased withdrawal of subsidy from vital segments of the people's life. There are several follow-up actions which should naturally flow from knowledge. Things such as maintaining clean environment, personal hygiene, use of mosquito nets, prompt report to health systems for several ailments, to mention but a few, should be pursued by the people themselves rather hauling all the problems on the health system, as most respondents did.

Respondents observe corrupt tendencies in the public health system especially in relation to the dispensing of medicines and differential treatment enjoyed by those who can give money or other rewards to health workers. This is the problem of corruption arising from the inadequacies in health facilities and services compared to the size of the clients.

Many respondents were found to be fatalistic with regard to health conditions. This is an attitude that is more common amongst adults. An elderly male respondent in Yankifi said:

> In my opinion, I do believe that one can get infected only by Allah's will and nobody knows when he would be infected. You can go to bed and wake up next morning with diseases.

The fatalism that it is 'Allah that gives health' brings to fore the WHO definition of health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Our health system must take into consideration the spiritual disposition

of the community residents **and engage trusted religious and traditional leaders as part of the comprehensive strategy targeted at fatalistic attitudes and promoting capacity of citizens to make informed choices about prevention, treatment and cure of priority health conditions in the community. This in turn, will help promote individual responsibility in health-seeking behaviour.**

Private healthcare facilities have made some gains where the public sector has lost. However, such patronage of private hospitals and clinics has been minimal given the high financial costs. This is why the waiting areas of traditional health systems and faith healing homes have become jam-packed irrespective of the kind of practice and remedies that are peddled in such places. At this level there is a need **to package advocacy messages to address the need for the people to take responsibilities especially in certain crucial aspects of their health.** This is because there are certain preventive measures against some diseases and infections.

A lot seems to rest on parents and elders, some of whom themselves have limited information. The importance of communication in mobilising people is well recognised. The findings show that the basic media of communication used by the people is the radio. The use of television in households faces some challenges especially with regard to epileptic power supply. Some cultural conditions also inhibit some segments of the population from the use of some of these media. In the rural area for example, printed media use is impeded by the literacy level and cost of purchase. Accordingly, there is an urgent need to break this barrier by **ensuring constant and regular open health campaigns in the communities.** Such a platform will be more inclusive and participatory and impressions obtained through them can last long. The major finding emanating from the discussions thus far is that there is a high level of awareness and understanding among respondents on health and health conditions, however there are certain systemic and individual challenges that inhibit the transfer of this knowledge into practice. Some of these challenges include individual attitudes and fatalism.

4.2 Media Dynamics

Media dynamics in the communities showed the dominant position of the radio over all other forms of mass media of communications. However, the issue still remains: what programmes are they listen to and what influence do these programmes have on the health behaviour of the people? The power of the media is, among other things, influenced by the trust which the audience has in the source.

The use of Mass Media as sources of health information intervention was clearly demonstrated.

The radio topped the list in this regard, while the use of TV is inhibited by class and the instability of power supply especially for the rural areas. As literature has demonstrated, the media can influence the consciousness of the people and thus influence behaviour. From the results, it is seen that gender has an impact on exposure and access to the media, especially television. The use of posters, though widespread, was shown to be inhibited by the cultural disconnect and low level of education.

In the alternative, a lot of folk media were found to abound in the communities which are much more socially participatory. Such media should be tapped for their potentials "to meet" the people in their "cultural world". It is suggested **that the use of Folk media (which is going to be more pragmatic) be adopted as a veritable way to communicate healthy tips to the people.** Folk media have become popular around the world. Folk media, when used to disseminate development and health messages within the context of entertainment and community get-togethers, is more successful than mass media. It is more effective in that it uses a familiar medium and the local language, passes on relevant messages, addresses local issues, needs and problems, uses local talent, artists and available resources, is cheaper than print, projected or electronic media, and exploits local creativity and enthusiasm. Even when modern media have penetrated isolated areas, the older forms maintain their validity, particularly when used to influence attitudes, instigate action and promote change. Extensive experience shows that traditional forms of communication can be effective in dispelling the superstitions, archaic perceptions and unscientific assumptions that people have inherited as part of traditions and which are difficult to modify if the benefits of change are hard to demonstrate. Practitioners of the traditional media use a subtle form of persuasion by presenting the required message in locally popular artistic forms. This cannot be rivalled by any other means of communication. However, the traditional nature of society in these communities could also be a good way to make use of existing channels of authority in them. These include the use of village heads and monarchs as drivers of health messages. In addition, **poster design must be community based in order to make them culturally relevant.**

4.3 Health Communication Interventions

In the area of Health Communication Intervention, the major finding here is that the health facilities and community health extension service constitute the major sources of health

information outside the household, but given their lacklustre performance, medicine stores and or drug vendors have been filling the gap.

Communication within the family, as the primary social group, especially for the upbringing of morally upright children is vital for society's stability. So where a child is not living up to expectation in some crucial aspect of life, the argument is always that the family has failed. Upbringing is seen as an important factor to the kind of person one turns out to be. As one adolescent respondent said:

> Honestly speaking, people that lack training, if you happen to be with this people they will interfere you with negative attitudes like drug abuse, Car snatching and thuggery.

Young respondents still have high regards for their parents and are quick to make it a point of reference in discourse.

> Yes, they need our support especially mothers need to be close to their children, but I believe some are doing that though some negligent ones do not.

Similarly, the TBAs in the community constitute another major source through which people access health information, especially reproductively active women. These TBAs carry the function of information in the course of their movement from house to house to attend to pregnant women. Talking about their activity in community health information, a TBA said:

> ....we also carry with us pictures of good food to show around to help with a safe delivery.

Television is also another medium for reaching out to the general public. Although, shortage of power supply poses a great challenge to the medium, respondents even in the rural communities watch television time to time, sometimes in viewing centres were power could be generated using small generators. In this context, the Hausa film industry popularly known as ***kannywood*** could be tapped as a means of reaching out to the general public. For example a host of Kannywood productions have messages on healthy living that be used as a medium to reaching the people. An in-school male adolescent respondent in Kano Municipal Council pointed to this fact:

> There is this film 'JAN KUNNE' of Sani Danja which talked about HIV, it can be included in anything people want to watch.

Posters have been used to disseminate information for a long time in the State. Some of the respondents reported getting information from posters; therefore the medium could be strengthened to reach out to the general public. One male adolescent in-school respondent in Kano Municipal Council spoke of the effectiveness of posters:

We use the messages contained. There was a time I saw a poster that I could not make any meaning out of it. I removed it and took it to somebody who explained it to me. I then took it back.

4.4 Alternative Platforms

In the area of alternative platform, the major finding is that there an abundance of locally based platforms in the form of festivals, community-based drama groups, and community based associations that can be used as transmission channels for health messages. Such associations are closer to the people, and are more likely to be trusted and therefore suitable for health communication interventions. Such alternative platforms are better placed in the behavioural change process.

Existing community structures are also another alternative platform, as indicated by the respondents in the rural communities. These platforms can be found in the traditional council of elders, Council of Ulamas, and community- and often gender-based associations that abound especially in rural the communities.

The existence of various sources of information in the communities has been demonstrated much earlier in the report. That the people use these various sources in accessing health information has also been demonstrated in section 3.3 above. The point here is: to what extent these media reinforce each other in the health information needs of the people? **This question call for the need to create a platform at the community level where this various agencies can collaborate to ensure consistency in health messages that are communicated to the people.**

4.5 Other significant findings

One major significant finding outside the four(4) major domain of the study is the distance of the government from the people and the lack of percolation of the dividend of democracy to the grass-roots especially people with disability. Some basic amenities especially road and water were alleged to be lacking especially at the rural communities and rural LGA's. No wonder then that respondents in such areas argue that: *We want them to construct borehole, in order to get water, whenever going to the toilet* .A situation where *'we buy (20-litre keg of water) from vendors at the rate of twenty naira is co*unterproductive to healthy leaving especially given the poverty level of an average resident in the communities. On the basis of this **there is an urgent need for the state and or local government to improve on the**

level and functionality of public utilities in the various communities. For example, the centrality of water in health learning cannot be overemphasized. The linkage between portable water and good health is very clear. A lot of diseases like diarrhea/ cholera/ typhoid as well as bad hygiene habits can be prevented where portable water is available.

The next chapter will summarise the findings of the study, offer suggestions and provide conclusion

CHAPTER FIVE: SUMMARY AND RECOMMENDATIONS

This chapter summarizes the major findings of this investigation. Furthermore, conclusions and policy recommendations are made. The study measured knowledge, attitudes, perceptionsand practices (KAPP) media habits, access to health information, prospects of health communication interventions, existing alternative platforms for health communication interventions, processes, levels of participation, social inclusiveness, effectiveness, and other health communication dynamics of intended beneficiaries.

5.1 Summary

The study found that:

- respondents in the communities were knowledgeable on the importance of health to their overall well-being and generally have a clear understanding of the various diseases that there are in their communities;
- Some cultural practices and activities inhibit healthy living amongst the people, especially habits and practices bordering on environmental sanitation and personal hygiene;
- There is however a disconnect between the people's knowledge and health-seeking behaviour. While they acknowledge the efficacy of orthodox medicine, their patronage of it is rather low because of a number of factors including bad treatment from health personnel, poor facilities and unavailability of medicines;
- The use of chemists or drug vendor as sources of health information and treatment is very high;
- Information flow within the family was found to be strong both in the rural and urban communities, with the family's influence been stronger in rural communities;
- Opportunities exist in the communities for health communication interventions, especially through the radio and existing health workers and health extension workers. The TBAs and traditional health practitioners have to be incorporated into the drive for improved health communication;
- There exist in the communities several other alternative communication alternatives that can be useful for health intervention communities, especially such platforms that are drawn from cultural modes of communal entertainment and information.

5.2 Recommendations

In the light of the above and various other issues raised in Chapter Four above the following suggestions are made.

- There is an urgent need to make available health information interventions that targets females who are the primary health care givers at the household level. At the same time, the role of the husband (*maigida)*, within the cultural context as the decision maker, must be respected. Such basic health tips must be conveyed in a folk medium like village meetings and social groups often patronised by such women/mothers.

- Given those beliefs and practices of the people that inhibit healthy living, there is an urgent need for PATHS2 to address those interactions between cohorts that affect the physical development of the child such as the nutritional content of their diet. This change is directly to strengthen the capacity of citizens to make informed choices about prevention, treatment and cure of priority health conditions.

- Considerable attention should be given to encourage those social interactions that encourage concern for the safety of their children. This means that parents are responsible for delays in bringing their ill children to health facilities Mothers of vulnerable children have a particular role to play. Towards this end, there is need for increased access to health information using identified community based platforms that enable parents to make informed choices as they shop for health at the community level. This is a joint responsibility of all stakeholders in the health sector.

- There is a need to bring the people closer to the public health system through provision of a platform where regular meetings can be held with health officials at the community level. Such opportunities will help clarify issues and will lead to the development of positive attitudes on the part of all the parties concerned.

- There is an imperative to engage trusted religious and traditional leaders as part of the comprehensive strategy targeted at defusing fatalistic attitudes and promoting the capacity of citizens to make informed choices about prevention, treatment and cure of priority health conditions in the community. This in turn, will help promote individual responsibility in health-seeking behaviour.

- There is a need to organise constant and regular open health campaigns in the communities to complement radio jingles. Such campaigns should focus on peculiar health problems in the community rather the re-orchestration global health problems.

- Poster and ICT designs must be culturally relevant and community-based in order for the people to be able to relate to them and understand the messages contained in them. In this context ICT materials need to be age and category specific. Messages will need to be packaged and channelled within the knowledge context of each specific group. The use in posters and ICT materials of pictures and images drawn from a different cultural or social background while merely changing the words will not carry the same message(s) across different categories of persons. There is a need for us to take cognisance of symbolic interpretations.

5.3 Conclusion

The findings of this study have clearly shown that the ideals of the millennium development goals (MDGs) may be unattainable unless urgent actions are taken to address the challenges raised here and there in this report. While there is abundant evidence that there are problems at the system level, a great deal of progress can still be made if the people are ready to take some responsibilities. What can then be done is for us to take steps to provide information to the people to enable them to make informed decisions.