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**Mobilizing women for rural health**

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**INTRODUCTION**

The Nigerian National health programme which was launched in 1987, has objectives, strategies and action plans based on Primary Health Care (PHC) and is designed to address the preventive, curative, promotive and rehabilitative aspects of health (1).

The novel nature of this package implies that health is a state of complete physical, mental and social wellbeing and not merely absence of disease, and makes community mobilization and participation matters of utmost necessity. It is observed that for the PHC Programme in Nigeria to be successful, women in the rural communities would need to be viewed as one of the principal targets for mobilization. This view is founded on the reflection that the present implementation of this programme is such that rural women are marginalized.

**THE PROBLEM**

The mid 1988 population of Nigeria was estimated at 112.3 million people living in 97,000 communities with 76% in rural areas (2). At least half of this population is made up of women, about 80% of whom are illiterates (2,3,4). Societal norms relegate most Nigerian women to the background, as objects to be seen, admired, sometimes exploited, but certainly not often heard. As one observer put it "women are born, they get married, give birth to children and then they die". It is not surprising therefore that community mobilization and health education teams often direct their activities at village heads, chiefs and literate, well - to - do persons in the communities who are almost always adult males. Most PHC workshops are conducted in urban Areas and delegates are usually important, literate personalities. It remains unclear to what extent the transmission of workshop lectures to the grassroots is effective. It is in fact likely that in some cases such relay hardly takes place. The usual practice is that the village head orders the entire community to converge at a particular

venue for a health project and those who respond are, expectedly, those who are acquainted with the benefits of the project. Rural women do not often respond positively because details of the projects are not made known to them. Rural women cannot effectively participate in health programmes if they are uncertain about, or ignorant of, the necessity for their involvement. In the present implementation of PHC in Nigeria, interactional contact between health officials and the rural women is either lost or underplayed. Community health workers who have been trained to work in rural areas are concentrated in the Urban communities. Rural women who are exposed to interaction of this nature are, therefore, those who can afford the time and funds to reach these health workers.

This being the water supply and sanitation decade, it easily comes to mind that over 80% of communicable diseases in developing countries are directly or indirectly linked to water and sanitation and are preventable (5, 6). Most water and sanitation providers often assume that once improved facilities are provided, domestic and personal hygiene will automatically improve. Unfortunately, this does not usually happen because the custodians of preventive family health (women) are marginalized. Women grow, process, market, store and prepare food and also fetch, store and dispense water. Women, therefore, constitute the most knowledgeable group in matters concerning water and sanitation (7). They also bear the major burden of problems associated with inadequate water and sanitation facilities.

The rural setting is easily associated with health related superstitious beliefs. Such fixed beliefs make rural people wait to become sick (sick role) before taking action rather than taking preventive measures (at risk role). Though these beliefs are often originated by male herbalists and sooth-sayers, they are mainly propagated by women during their numerous gatherings, on farm roads and in markets.

In the Nigerian kinship and descent system, children are more emotionally attached to their mothers than to their fathers because mothers spend more time with their children and more sympathetic to their desires and aspirations than fathers (8). Consequently, whereas fathers are seen as authority figures of families, mothers are main sources of new information (including Health Education) to the children. Besides this, the option of complying with directives related to child health lies with them.

It follows from the above that targeting rural woman for mobilization in Primary Health Care in Nigeria will improve preventive health practices considerably.

### POSSIBLE STRATEGIES

Rural women should be involved in the planning, implementation, sustenance and evaluation phases of all primary health care programmes. During initial baseline data collection, women should be interviewed separately from men to enable them express themselves freely. They should be allowed to identify and understand their health problems. Their involvement in developing the workplan will ensure their continuous input which will guarantee sustenance.

From planning through to evaluation rural women should be included in the village health committees which have proved to be useful in rural health programmes. Some of the village based workers (VBW) should be women. There is a known preference for easily accessible familiar indigenous health workers and women will trust, and feel more comfortable with them.

Rural women have more networks than men have, for interaction among themselves. These include age grades, church groups, social clubs, associations, extended family groups, savings groups etc. These networks provide opportunities which when properly utilized could form the basis for discussions of health programmes. Leaders should be encouraged to emerge from such groups and these leaders should be expected to provide feedback on the programmes.

In order to effectively reach rural women, health education messages and talks should be translated into vernacular. Underlying non-involvement of rural women in health programmes is a high level of illiteracy which prevents them from communicating effectively with health workers. Literacy rate in Nigeria is

estimated at 6% for adult females and 25% for adult males (2,3,4). Only about 50% of the females who are lucky to get into schools do complete their education up to tertiary level. Unfortunately most health workers seem to have preconceived ideas concerning minimum level of education of beneficiaries of health services. Elementary literacy should no longer be taken for granted when dealing with rural women.

It seems very likely that improvement in literacy levels of women in Nigeria will result in improvement of health status of rural dwellers. Recent studies in many countries have shown a strong correlation between high levels of female literacy and low levels of infant (and child) mortality. It has been observed that infant mortality rates (IMR) of educated mothers with seven to ten years of schooling are one third to one fifth lower than those for mothers with little or no education (9,10,11,12,13,14). As Hermione Lovel and Chen (9,15) observe, educated women delay marriage and childbearing thus avoiding high risk early pregnancies, contribute to family income, have better hygiene practices and make effective use of health facilities. It has also been shown that female literacy is not only an indication of general living standards but acts independently in determining infant (and child) health (16) and outweighs rural urban differences income differentials and ethnic origin (17). However, as always rightly observed, improving literacy status of women will not by itself bring about a decline in IMR unless there are changes (e.g. increased access to potable water, good roads and other social services) which will give the women the opportunity to make use of their knowledge.

Centres for non formal education such as adult education groups, vocational training centres, social welfare centres, maternal and child health centres and family planning centres which usually cater mainly for women, should be advised to include health education in their schedule.

It is observed that well planned and well effected health education greatly improves health status of rural dwellers. Health education for rural dwellers should exhaustively cover EPI/ORT/water source protection, personal and household hygiene, environmental sanitation, cleanliness in water use habits, maternal and child health, first aid and other

localized problems. It is important that rural women hear about health programmes if they must participate but it is more important that the quality of what they hear and understand be such as would move them into sustained positive action. It was observed in a recent study that whereas 70% of a group of women had heard of EPI/ORT, only about 1% of them knew how to prepare the salt-sugar solution correctly (5).

Contributions from communities for health projects should not be limited to money and building materials which women cannot afford. They are most willing to make contributions in form of labour and food-stuff. An example exists in a village where women on each market day contributed one yam each and eventually sold the yams to raise money for a village project.

Mechanisms for monitoring and evaluation should be built into project plans and should be simple enough for rural women to understand so they can be involved. For example, rural women will be able to count the number of households that boil and filter water etc. Their contribution to evaluation can be translated into the more sophisticated evaluation procedures.

### CONCLUSION

Preventable communicable diseases form a major portion of health problems of rural dwellers. Removal of ignorance among the womenfolk (by effective health education) will reduce morbidity due to communicable diseases. Primary health care will then go beyond prevention of death to reduction of amount of disease, and improvement of quality of life, so that there will really be health for all by the year 2000.

### REFERENCES

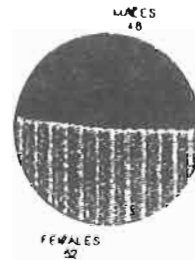
1. Ogbalu M. M., 1987. Keynote address to the UNICEF formulated Primary health care programme review workshop. Calabar.
2. Dada, B.A.A., 1988. National health profile; an overview. Paper presented at the First National Workshop on Health problems of rural dwellers - strategy for prevention and control. Kuru.
3. Nwabara, C.I., 1985 Women in Nigeria: The way I see it. In women and the family, Edited by Women in Nigeria (WIN) Editorial Committee. Codesria book Series.
4. Braide, E. I., Akpabio, S. Arikpo, B. U., Udo, I. Okeke, N., and de Rooy C. 1989. Knowledge, attitude and practices of the people of North Ukelle, South Ukelle, Western Yala and Mbembe clans of Cross River State with regards to water use habits and Sanitation. UNICEF. Lagos.
6. Giorgis, B.W. 1985, The health needs of rural women. In women and rural development in Africa. Edited by AAWORD/AFARD (Association of African Women for Research and Development). Dakar, Senegal.
7. In straw (International Research and Training Institute for the advancement of women) 1988. Proceedings of a national training seminar on Women, Water supply and sanitation. Kadugli, Sudan, Addis Ababa, Ethiopia, Nairobi, Kenya, Mogadisco, Somalia.
8. Arikpo, B.U. 1988. Population migration and rural development in Cross River State. In Mobilization of Resources for Rural Development. M. O. Ebong (ed.). Wusen Press Calabar. Chapter 19.
9. Hermione Lovel 1989. Targeted interventions and infant mortality. Transactions of the Royal Society of Tropical medicine and hygiene.
10. Preston S. H. 1978. Mortality, morbidity and development in UNICEF 1983.
11. Newland K. 1981. Infant mortality and the health of societies. World watch papers No. 47. Worldwatch Institute, N 76 Massachusetts Avenue N.W. Washington D.C. 20036. U. S. A.
12. ICDDR B. 1984. Annual Report 1983. Dhaka: International centre for Diarrhoeal Disease research, Bangladesh.
13. UNICEF 1983 State of the World's Children. Oxford University Press.
14. Caldwell J.C. 1981 Maternal Education as a factor in child mortality. WHF 2 75-78.

15. Chen L.C. 1986. Primary Health care in developing countries: overcoming operational technical and social barriers Lancet ii 1260 - 1265.
16. Mortality in developing countries. Document ST/ESA/SER,A/97. New York.
17. Chidan Baram V.C., McDonald J.W., Brachor M.D. 1985. Infant and child mortality in the developing world: information from the world fertility survey. International Family Planning Perspectives. 11 17-25.

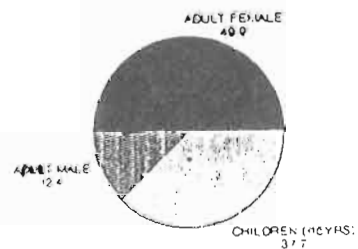
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