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COLLABORATIVE IDENTIFICATION OF THE HEALTH NEEDS/ASSETS OF IKOT ISHIE COMMUNITY, CALABAR, NIGERIA

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ABSTRACT: Identification of health needs within Nigeria has often been done with a top-down approach where policy and funding determines what health needs to focus on for interventions. Communicable diseases such as malaria have been studied extensively however; lack of cohesiveness and continuity often derails the gains achieved. The objective is **to work** collaboratively with stakeholders in Ikot Ishie Community in identifying their health needs/assets. A community organizing exercise using Key Informant Interviews, observation and Focus Group Discussions (FGD) was implemented. The findings suggest that as a community embedded in a malaria endemic area, people are aware of malarial signs and symptoms and can easily identify *its management/preventive measures. Persistent self-diagnoses/treatment of malaria, lack of information about the causes, signs/symptoms of other conditions and poor patronage of the primary health centre for preventive and early diagnoses of diseases were the identified needs. Collaborative identification of needs/assets builds trust and ownership of interventions, encouraging continuity.*

KEYWORDS: Self-diagnoses, Malaria, Diabetes, Community ownership, Collaboration, Continuity

INTRODUCTION

Ikot Ishie community is a clan in Calabar Municipality Local Council. The community is believed to have been founded in 17th century and named after Ishie who was from Anambra

State of Nigeria, and a friend to the then Obong of Calabar. The community comprises eight villages with their various heads. These are: Idundu Ishie, Akai Ishie, Enem Ishie, Asiakobufa Ishie, Usung-Mbakara Ishie, Nsemo Ishie, Utibe Ishie and Akani Ebiet Ishie. Conducting a health needs assessment in Ikot Ishie Community of Calabar was deemed necessary in order to develop culturally appropriate health promotion programming. Engaging the community members and working with them as part of the research team was made a priority. The objective of this research is to work collaboratively with stakeholders in Ikot Ishie community in identifying their health needs as well as community assets that will help address some of the identified needs.

LITERATURE/THEORETICAL UNDERPINNING

Using community participatory methods was deemed necessary so as to encourage community ownership of the data, findings and also to encourage participatory planning of interventions. The PRECEDE-PROCEED model was used as a theoretical framework guiding the community assessments. Work involving the first half of the model is presented here. Precede – which is an acronym for predisposing, reinforcing and enabling constructs in educational/ecological diagnosis and evaluation (Green & Kreuter, 2005) involves a series of assessments which helped generate information needed to fully understand the health needs of Ikot Ishie community. According to Price, Dake and Ward (2010), collecting data on both the current health status and the ideal health status informs researchers on how a community's health status might be improved. Glanz and Rimer (2005), suggest that a community needs assessment must employ an ecological focus which includes the intrapersonal, interpersonal and population levels. In addition to assessing the needs of a community, capacity assessments are also necessary to identify the available resources to address the identified health needs (Wallerstein & Duran, 2006). In addition collaborative, informed data collection at the community level is essential in planning healthy communities and reducing most negative health indices including maternal mortality (Ndep, 2014).

METHODOLOGY

Following the cultural practices of Ikot Ishie, the research team accessed the community by visiting the Chief and his court. Other key stakeholders as identified by the Chief's court were also visited and interviewed. These key stakeholders formed an ad Hoc Advisory group working with the researchers. Using observations, document reviews, Key Informant Interviews and a Focus Group Discussion (FGD), the health status of the community was assessed. All participants of both the key informant interviews and focus group discussions were adults, aged 18 and older. They were informed that their participation was voluntary and they could withdraw at any time during the interview process, should they feel uncomfortable with answering the questions or talking in the presence of others (FGD participants). All the key informants live and work in Ikot Ishie and they are respected citizens of the community. A simple interview protocol comprising of questions that focused on indicators of physical, mental, social, environmental and spiritual health was used. Recurrent themes from the key informant interviews were collated to form the focus group protocol. Eight community members participated in the FGD.

RESULTS/FINDINGS

Both the key informants and the focus group participants identified the main health issues of the community as malaria and persistent self diagnoses and treatment of diseases by the lay public. Discussions about health were dominated by a recent death at the Ikot Ishie health centre resulting from complications due to undiagnosed diabetes mellitus. The main argument was how to accurately identify the signs and symptoms of malaria as well as being able to tell if something other than malaria was the problem.

> *"It (malaria) is very common. Everybody complains about it"* (Focus group participant)

Participants identified the persistent habit of self-diagnoses and/or treatment of malaria based on previous experience as a problem. They insisted that if community members formed the habit of using the services of the health centre, confusion and mis-diagnoses of diseases and conditions will be reduced. Participants also cited the long history of living in a malaria endemic region and having developed a certain level of complacency when it comes to malaria diagnosis and treatment, especially among adults. Most adults think that they are immune to malaria and that they do not need health services to treat or manage their symptoms. Diabetes however, is an emergent disease in this region and many people are not aware of it signs, symptoms and management options. Unfortunately, according to our focus group participants, the few community members who had been diagnosed with diabetes were diagnosed after a life threatening event such as a diabetic coma or by accident when patients reported to the hospital with wounds that refuse to heal. Each of these cases had mistaken his/her illness to be malaria.

> *"Out of ignorance we were treating malaria instead of diabetes and the patient ended up losing his leg"* (Focus group participant)

> *"After a youth died due to diabetic complications, we now know that other diseases like diabetes and hypertension may be the cause of deaths in our community and not only malaria"* (Focus group participant)

On the poor use of the health centre's services, the adult men argued that the programmes often advertized by the health centre are geared towards women and children; hence the misconception that the community health center is for women and children only. The older women on the other hand described the center as place for pregnant women and young mothers to get healthcare. When asked where they received care, some of the key informants and focus group participants reported self care using nearby medicine stores and pharmacies. They argued that the closest health facilities to them are private hospitals which are usually more expensive that the public hospitals and that the public hospitals are used as a last resort, when they can no longer manage their pain or symptoms at home. When they were asked to offer suggestions for improving the health status of Ikot Ishie, the respondents were interested in having health information sessions and interventions by both government and non governmental agencies.

> *"Routine health interventions will be helpful"* (Focus group participant)

> *"We have a Town Hall that can be used for such interventions"* (Key informant)

The social diagnoses revealed that Ikot Ishie has historically been a social hub in this region. According to the 2006 census, the population of Ikot Ishie was estimated at about 70,000 people and bounded by many villages such as Ikot Eyo, Ikot Uduak, Ikot Amanso, Ikot Ansa, Akai Efa, Ikot Abasi Osai, Obutung Clan, Big Quo, Ikot Effanga Mkpa, Kasuquo Clan among others. The community embraces the Ekpe, Obon and other socio-cultural societies which portrays their social heritage and as a symbol of authority to distinguish members from others in the community. The community has Ishie Primary/Nursery School, a town hall located quite close to Ishie Market, Church of Scotland Mission (CSM) now known as the Presbyterian Church of Nigeria, the Sanctified Mount Zion Church and the Ishie Shopping Mall. The people of Ikot Ishie are mainly Christians, some pagan worshipers and some a combination of the two. The main occupation of Ikot Ishie people is subsistence farming and petty trading.

The environmental diagnosis revealed a changing community. The main streets are swept every morning by staff of the Calabar Urban Development Agency (CUDA). Therefore on face value, the community looks clean. The gutters, however still harbor stagnant water and debris. The waste bins are usually filled and overflowing due to inconsistent emptying by the waste management agencies. Some participants however fault the community members who dump refuse on the ground near the bins as opposed to inside the bins and also using the gutters as refuse dumps thereby clogging the drains. These unsanitary conditions were identified by key informants as unhealthy and probable breeding grounds for mosquitoes and rodents.

> "*Because we know that dirty environment bring disease, we have been trying hard to monitor and keep our environment clean, better than we used to do before"* (Key informant)

DISCUSSION

Malaria has proved to be an unconquerable disease with the definitive host, the mosquito thriving in most parts of Nigeria, including Calabar. According to the National Malaria Control Programme, malaria is responsible for 60% outpatient visits to health facilities, 30% childhood deaths, 25% deaths in children under one year and 11% maternal deaths in Nigeria as a country. According to the World Malaria Report 2011, there were about 216 million cases of malaria and an estimated 655,000 deaths in 2010. Most malarial deaths occur among children living in Africa where a child dies every minute from malaria. It is a major cause of low birth weight in newborns, anemia and infant mortality (WHO, 2012).

Each year, more than 30 million African women in malaria endemic areas become pregnant and are at risk of infection with Plasmodium falciparum; this result in high prevalence of parasitemia and clinical malaria in pregnancy (Okwa, 2012). Many in malaria endemic regions are said to have developed some level of complacency and familiarity with the signs and symptoms reducing their perceived susceptibility to the disease. As our results clearly show, community members have become so familiar with malarial symptoms that self diagnosis and treatment is very common. Easy access to pharmaceutical products including anti-malarial drugs seems to aid this behaviour. This is true for most African countries where there is a proliferation of patent medical stores and a doctor's prescription is not required for the purchase of these medicines. In a study on the occurrence and treatment of common health problems in Jos, Nigeria, it was found that anti malarial drugs were the second highest consumed after analgesics(Auta, Banwat, Dayom, Shalkur, & Avu, 2012). Level of education was identified as the main factor influencing self medication and the use of patent medicine stores in a

research carried out in Ifako-Ijaiye, Lagos. The same research also identified patent medicine dealers as main source of information on medications (Afolabi, 2008). Similarly, Auta and colleagues found self medication as a major treatment of common ailments among adults in Jos, Nigeria and that patent medicine stores were the most common source of medications (Auta et al., 2012).

According to Fuente and Villa (2008), family and friends as well as re-use of previous prescription influence an individual's self medication practice. In addition, most consumers use medication without proper knowledge of how to use it and the dosage (Fuentes & Villa, 2008). In order to curb this self-medicating trend, pharmacist organizations are urged to implement long term multifactorial campaigns. One such campaign carried out in Spain was found to be successful in reducing the non-prescription dispensing of antibiotics (Gastelurrutia, Larrañaga, Garay, Echeveste, & Fernandez-Llimos, 2013). In Nigeria, it has been recommended that license renewal for patent medicine vendors be tied to a training session on managing simple complains and over-the-counter (OTC) dispensing of medication (Afolabi, 2008). This could potentially be beneficial in helping community members understand the intricacies involved in managing chronic health conditions like diabetes mellitus.

According to the International Diabetes Federation (IDF), Nigeria has the highest number of people with glucose intolerance and the highest number of people with diabetes (IDF, 2011). Diabetes mellitus is one of the basic non-communicable diseases that cause severe complications and death worldwide. DM is characterized by the body's inability to breakdown glucose for energy; instead the body uses up its fat deposits. The breakdown of fat to produce energy in diabetic patients can lead to high ketone content in the blood known as ketoacidosis which is characterized by a fruity alcoholic smell. As a result Ketoacidosis is often mistaken for drunkenness. It is easy to understand how symptoms of diabetes mellitus can be mistaken for malaria. Some of the signs of ketoacidosis include staggering, dizziness, stomach ache, fevers, excessive thirst and urination, confusion and coma (IDF, 2011; Nwafor & Owhoji, 2001). And drunkenness is a social vice that may not be an acceptable behaviour among our Christian Ikot Ishie Community. In addition, instead of encouraging a community member with a fruity alcoholic breath to seek the help of a health professional, they may be blamed for drunkenness. This socio-religious view may be implicated in the poor rates of diagnoses and management of Diabetes in Nigeria despite having the largest diabetic population in Sub-Saharan Africa(Chinenye & Ogbera, 2013). The increasing prevalence of diabetes mellitus in the community is a cause for concern not only because of its debilitating effects but also because it has been shown to increase the risk of malaria infection in communities where malaria is endemic (Danquah et al, 2010). There is a strong relationship between higher socioeconomic status and diagnoses of diabetes or glucose intolerance (Nwafor & Owhoji, 2001). With a low life expectancy in Nigeria which is currently approximately 48years, it is recommended that people above 30 years of age should engage in routine health checks including blood glucose tests (Oputa & Chinenye, 2012).

The involvement of the Chief and his court, the church leaders, the school principal and the health centre coordinator in this needs and assets assessment process shows the level of commitment to the improvement of the health status of the Ikot Ishie community. According to Shulz and Israel (1998), a community participatory process ensures that the community's needs are identified by the community members themselves and not outsiders. In addition, the identified remedies to the community's needs are more likely to be embraced by the community members since their voices and inputs are part of the community intervention planning process.

It is anticipated that whenever the community intervention is implemented, it will have community buy-in and activities may continue long after the researchers have left the community. Working with an already motivated group of community members towards identifying and solving their health issues creates a good atmosphere for more long term interventions in the community. The geographical location of this community makes it easier for the dissemination of health information that may influence a wider area, including the neighbouring communities of Ikot Ansa, Essien Town and Big Qua.

The belief that the health centre services are for women and children negates the purpose and intent for which it was established. The health centre is the smallest health care unit in the Primary Health Care model proposed by the World Health Organization and signed on by member nations including Nigeria. Each local government ward has at least a health centre or health post in order to increase access to healthcare even in remote rural areas (WHO, 1978, 1981, 2008, 2012). Therefore a participatory community-wide organizing to re-orient members and encourage the use of local community health centres is recommended.

IMPLICATION TO RESEARCH AND PRACTICE

Because participatory approaches tend to create conducive environment for the growth of highly informed citizens, yet could be time consuming, further research on any health issue should build into the research timeline a period for trust building and information sessions using the town hall meeting format.

CONCLUSION & FUTURE RESEARCH

The Proceed part of the model which stands for policy, regulatory and organizational constructs in educational and environmental development (Green & Kreuter, 2005), basically deals with the evaluation of the intervention. The intervention is currently on-going and the evaluation and recommendation will be presented elsewhere. Future research on diabetes and other chronic conditions in communities similar to Ikot Ishie is recommended.

REFERENCES

Afolabi, A. O. (2008). Factors affecting the pattern of self-medication in an adult Nigerian population. *Ann Afri Med, 7*, 120-127.

Auta, A., Banwat, S. B., Dayom, D. W., Shalkur, D., & Avu, M. O. (2012). Occurrence and Treatment of Common Health Problems in a Nigerian Community. *J Young Pharm, 4*(1), 49-53.

Chinenye, S., & Ogbera, A. O. (2013). Socio-cultural aspects of diabetes mellitus in Nigeria. *J Soc Health Diabetes, 1*, 15-21.

Fuentes, Albarran K., & Villa, Zapata L. (2008). Analysis and quantification of self-medication patterns of customers in community pharmacies in southern Chile. *Pharm World Sci. , 30*(6), 863-868.

Gastelurrutia, M. A., Larrañaga, B., Garay, A., Echeveste, Fde A., & Fernandez-Llimos, F. (2013). Impact of a program to reduce the dispensing of antibiotics without a prescription in Spain. *Pharm Pract (Granada), 11*(4), 185-190.

Green, L. W., & Kreuter, M. W. (2005). *Health program planning: An educational and ecological approach* (4th ed.). Boston, MA: McGraw-Hill.

IDF. (2011). Diabetes Atlas *International Working Group on the Diabetic Foot*: International Diabetes Federation.

Ndep, A.O. (2014). Informed Community Patricipation is Essential to Reducing Maternal Mortality in Nigeria. *International Journal of Health and Psychology Research, 2*(1), 26-33.

Nwafor, A., & Owhoji, A. (2001). Prevalence Of Diabetes Mellitus Among Nigerians In Port Harcourt Correlates With Socio-Economic Status. *J. Appl. Sci. Environ. Mgt. , 5*(1), 75-77.

Okwa, O. O. . (2012). Malaria a Pending Problem in sub-Saharan Africa. *Tropical Medicine and Parasitology, 20*, 17-30.

Oputa, R. N., & Chinenye, S. (2012). Diabetes mellitus: a global epidemic with potential solutions. *African Journal of Diabetes Medicine 20*(2), 33-35.

Wallerstein, N. B., & Duran, B. . (2006). Using Community-Based Participatory Research to Address Health Disparities. *Health Promotion Practice (July)*, 312-323.

WHO. (1978). Alma-Ata 1978: Primary Health Care. Geneva, Switzerland: World Health Organisation.

WHO. (1981). Global Strategy for Health for All by the Year 2000. Geneva, Switzerland: World Health Organisation.

WHO. (2008). Primary Health Care: Now More than Ever. Geneva, Switzerland: World Health Organisation.

WHO. (2012). Malaria fact sheet. Geneva: World Health Organization.