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CONSTRAINTS TO GOOD HEALTH CARE IN RURAL NIGERIA

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ABSTRACT

There has been a monolithic conception of health as being the result of only the availability of medical facilities. Such misconception has detracted attention from other equally vital factors of health. The ignorance of rural people in regards to the proper concept of health as being the consequence of composite factors has immensely contributed to the poor health condition of rural people.

The locational disadvantage of rural people to professional health services has been observed to be another debilitating condition to good health. In view of the importance of good health in the overall scheme of national development, other vital factors to good health (for instance, nutrition, environment, behaviour and recreation, and socio-economic factors) have been identified and the call made that both government and health agencies pay special and immediate attention to these aspects in regard to rural health

INTRODUCTION

Nothing is more important in the development of any nation than the health level of the people. It is in recognition of this that the developed nations constantly propose and, actually embark on, many strategies, often times experimental, to improve the health indices of their nations. Today, the developing countries are becoming increasingly conscious of this factor in the area of development and consequently engage in various ways and means to come closer to their developed counterparts, especially in the area of rural health.

Nigeria, for example, joined the race for nationwide health improvement when it proposed the "Health for all by the year 2000" about five years ago under the Babangida administration

In proposing the "Health for all by the year 2000" Nigeria was conscious of the lag in this area with regards to its rural sector in comparison to its metropolitan counterparts. The overwhelming concern of both government and citizens is that the magic year will soon

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come and until then, the noble objective appears yet a dream. What are the possible immediate and, even remote constraints to the realisation of this objective? Or, is it still true as the American rural sociologist, James Copp, observed in 1976 that the question, how healthy are rural people? has not been answered with precision without discrepancies in the literature.

Consistent with Copp's ambivalence is the contention that pre-induction physical examinations prior to World War II suggested that urban residents were more healthy than rural residents because rural people had a lower self-reported health status than their urban counterparts (Kleimann and Wilson, 1977), whereas the age/sex adjusted death rate for rural area suggested quite the contrary (Copp, 1976), an indication that rural people are no longer worse off than their urban counterparts.

While it may be true from the contention above that in the West, particularly the United States, urban habitat has not necessarily produced a healthier population than the country-side (or vice versa), contemporary literature is emphatic in its assessment of the situation in regard to the developing nations. Pearce (1984) observed a decade ago that there is no uncertainty about differing standards in health behaviour between the urban and rural residents. Although tracing the reason for lower utilization rate by rural residents to beliefs and attitudes, he noted that the ruralite is disadvantaged in relation to his urban counterpart. This article, therefore is an assessment of such rural constraints that led to the undesirable situation of a healthier urban habitat that the rural.

The argument will further be advanced to the effect that the rural health status should not be based only on the availability, or none, of medical health services but also (and particularly) on other factors or indicators such as food and nutrition, and, even recreation and the environment. For example, writing on food and nutrition as indicators of rural health, Purtle (in Dillman and Hobbs, 1982:224) stated with abundant clarity that inadequate nutrition has remained a major public health problem for reasons of under and over-consumption and questionable nutritive value of many of the foods consumed. Furthermore, she notes with dismay that the irony is that rural areas, the producer of the abundance, fare no better than urban areas in the nutritional status of their population.

Rural urban disparities in matters of health have for long been recognised although attempts at correcting the imbalance have yet to yield appreciable result. In Nigeria, for instance, Ekong (1988:399) observed that such disparities in the distribution of dispensaries ranged from 41 in Rivers State to 278 in Sokoto State in 1979. In the same year, maternity centres ranged from 8 in Niger State to 161 in Oyo State. Such disparities have led to the undesirable situation whereby a sick person in such rural areas as Gumel and Gwarzo in Tundun Wada Local government Areas would have to walk five times the distance that a Kano Municipal Local Government Area resident has to walk to get to a hospital.

THE CONCEPT OF HEALTH

According to Mckeown (1976) good health of both urban and rural people is a composite of nutritional, environmental, behavioural, socioeconomic and, to an unknown extent, professional health care contributions. This dismisses the mistaken conception that

good health is the result of any one single factor rather than a combination of the factors identified above. Of these factors, social scientists are becoming increasingly aware that the socio-economic status of people may very well be the most important determinant since good health is strongly influenced by an individual's social class. The United States of America is a case in point. It invests millions of dollars annually on health care (about $200 billion in 1980) because of the validity of what Wildavsky (1977) has termed the "Great Equation", that is, that professional health care equals health.

Dillman and Hobbs have concluded that many government sponsored programmes designed to improve the well-being of the rural populace have been based on this assumption. This has resulted in the preoccupation with the delivery of equitable quantities of professional health care resources to rural areas (Miller, 1978). In an obvious attempt to follow in this direction, Nigeria at all levels of government has attempted to provide rural areas with additional manpower and resources through the various health programmes initiated in the last decade (e.g. the EPI, ORT, Family Planning, etc). One only wonders if the other factors have received similar attention from the governments - Local, State and Federal.

MAJOR CONTRIBUTING FACTORS TO RURAL HEALTH

1. Nutrition

There is more to the sociological aspects of food and nutrition than whether rural people get their minimum daily requirements of the necessary vitamins and minerals. Food must be produced, distributed, selected, paid for and served. Each of these steps has its own contribution toward the health and well-being of rural people. A poorly fed population does not respond positively to medical treatment when sickness strikes, for it lacks even the most basic immune mechanisms for warding off common human enemies like bacteria.

Nutritional status of a population is important because people without adequate nutrition "are likely to become chronically ill, unable to work and buy the food they need" (Purtle 1982).

Food and nutrition have long been of interest to sociologists. In 1975 Sorokin described hunger as a determinant of social organisation, including food production, trade, migration, collective behaviour and social change (Sorokin, 1975). Some sociological literature have also dealt with family structure and interaction as related to the nutritional level of the family (Schafer and Bohlen, 1977; Coughenour, 1972), and even attitudes and values as they relate to food habits (Steelman, 1976). Poor nutrition, therefore, in many ways can lead to poverty which in turn is a constraint to obtaining professional health care services.

Another important factor is examining the basis of food taboos and food faddisms among rural population. Food taboos, of course, exist among the educated as well as the uneducated. There is, for instance, the unhealthy belief among some segments of the rural as well as the urban population that to eat fish and milk at the same time makes people sick. Others wrongly believe that cornstarch consumption is important in the diet of pregnant women. It has been documented (Purtle, 1982) that among the educated there are people

who refuse to eat meat as well as those who go on high protein diets for weight loss. Both practices, they observe, have inherent health dis-advantages. These practices rather than promote the health status of the population produce an adverse effect. The basis of those taboos and faddisms has to be discovered and proper nutritional combinations made available to the rural people, especially the uneducated.

In Nigeria, this aspect of the nutritional determinant of good health has so much been neglected that Pearce (1984) noted that as of 1977 there were only an embarrassing 35 dieticians nationwide to serve the then estimated 78,000,000 people.

2. Environment

In this context, environment is defined as the field of adjustment of any responsive organism. As such, it blends with the ecological idea of habitat.

Civilization and economic growth are strongly correlated with the availability of natural resources. The traditional idea of viewing the environment as replete with natural resources is gradually disappearing. Natural resources, unlike the sky, have their limits. This recognition, painful as it may be, is nevertheless true. Resource depletion (the degradation of the renewable natural resources, e.g. soil erosion) and environmental pollution are closely linked and their combined effect on health is rarely recognised. Rapid depletion of a renewable resource such as timber can lead to leaching of nutrients and water pollution, while salinization of an agro-ecosystem from irrigation will render it less productive. In areas where these go unchecked as in most rural areas in Nigeria, the effects are clearly visible in the deteriorating health status of the people. This area also needs immediate attention.

BEHAVIOUR/RECREATION

Civilization has shown that the relationship between recreation and health is no longer an inconsequential union. We can no longer afford to think of outdoor recreations as frivolous activities that command our attention only after other needs are met. Outdoor recreation must be seen as an integral part of the life of every citizen. Modern man is becoming increasingly conscious of the need of such recreational activities as picnic, swimming, camping, bicycling, jogging, tennis playing, walking for pleasure and, even sight-seeing for the sake of health.

Government and health officials in particular have to encourage the use of these activities by making adequate provision for them both in quantity and quality. Gordan Bultena (1982) has made the proposal that given the swiftness of societal changes today, it is important that public decision makers be sensitive to changes in the public's use and demand for outdoor recreation. With this in mind, it should be ensured that the public's recreational demands remain competitive with other growing pressures on the nation's resources

SOCIO ECONOMIC FACTORS:

Topmost in the list of social indicators of well being enumerated by Bauer in 1966 was health. Then followed poverty, housing and unemployment. Among the factors that contribute to good health of both rural and urban residents, McKeown (1976) noted that the socio-economic status is the most important determinant; further he adds that the other factors like nutrition, behaviour and to some extent, one's environment, are strongly influenced by an individual's social class position.

One might wonder how the social class position of a social group impacts on its health status.

Surely medical care claims a large proportion of our income. Studies have shown that low income people have far more illness than the upper class, yet they receive less medical care than the affluent due to financial constraints. A study by Horton and Leslie (1970:536) revealed that in the late 1960's the poorer families in the United States received only three fourths as many physician visits, although they had nearly twice as much chronic illness and two and a half times as many disability days per year. An obvious example is with the aged who generally have low incomes, yet have more illness than other age groups. Horton and Leslie have enumerated a number of reasons why the poor or those who are socio-economically disadvantaged, received less adequate medical care than the prosperous people. There is the scarcity of medical services in the regions and local neighbourhoods where the poor live; a complicated red-tapism and bureaucratic procedures which the poor must surmount in order to get medical care; an organisation of medical services which are ill adapted to the life styles of the poor; finally our provision of health services for the poor is spotty and categoric, i.e. only certain categories of poor people are eligible to have certain kinds and amount of medical services provided. In consideration of those factors it is little surprising why many of the deadly diseases kill proportionately twice as many poor people as the rich.

PROFESSIONAL HEALTH CARE

It is in order at this stage to make an observation on professional health care status in relation to the rural population. An earlier observation indicated that the greater metropolitan centres have nearly four times as many physicians per 1,000 people as the isolated rural areas (Leslie, 1970:534). Added to this is the problem of excess older, less well qualified and less active physicians in rural centres in relation to the cities. Furthermore, government aften makes the mistake in its distribution exercise in assigning physicians to localities, not according to medical needs, but in consideration of the economic opportunity in order to earn a large income.

A number of reasons could be adduced for the inadequate presence of professional health care services in rural areas. The most common among these include:

1. Physician's dislike for practice in isolation from fellow practitioners;
2. Physician's dislike for practice in localities where hospital laboratory and specialist services are limited or inferior;
3. Medical graduate's tendency to establish practice either in their home towns or in the areas where they attended medical school. Such motives contribute heavily to the inadequate supply of medical services in the rural areas where the poor are most prevalent.

This is probably why Dillman and Hobbs (1980:217) come to the conclusion that virtually all rural people (especially in the West) are at a locational disadvantage with regard to access to professional health care services, and Cordes (1977), Hessinger and Whiting (1976) also agree that, almost globally, the absolute quantity of services is not the issue but maldistribution.

This issue in the Nigerian situation has been sufficiently addressed (Ekong, 1988). What is left is to give sufficient attention to the fact that rural people are heavily dependent on transportation as a means of gaining access to professional health care, this factor contributes significantly to the cost of obtaining health care for those who have transportation and a much more desperate situation for those who have not. In recognition of this imbalance, Pearce warned that "modern" medicine is associated with urban/rural imbalances in the distribution of personnel and facilities, pointing out that as of 1972 the Nigerian Doctor/Population ration of 1:22000 conceals the urban/rural and regional inequalities of 1:2000 in Lagos and 1:100,000 for other more rural northern zones (Afonja and Pearce, 1984:165). The fear is that little has changed ever since this revelation twenty years ago.

CONCLUSION

The Nigerian declaration of the year 2000 as the magic year in which there will be health for all its citizens has been the spin-off for this article. Particularly doubtful is the possibility of the achievement of this noble objective in regard to rural Nigeria. The major point of focus has been to identify those factors that are responsible for the lag in medical provisions in relation to rural Nigeria. To this end, it has been observed that good health is the result of not only the provision of medical services but a combination of other factors such as nutrition, environment, recreational behaviour, and even the people's socio-economic levels. In so far as these factors are concerned, the Federal, State, and Local Governments have been most negligent. If the health of the rural people is to catch up with that of its urban counterparts for the purpose of a balanced national development, these areas must be given immediate attention at all levels.

REFERENCES

Bauer, Raymond, A. (ed) (1966) *Social Indicators.* Cambridge, Massachusetts Institute of Technology Press.

Copp, J. H. (1976) *Diversity of Rural Society and Health Needs.* Iowa State University.

Cordes, S. M. (1977) *Social Science Research on Rural Health Care Delivery. A compilation of Recent and Ongoing Studies.* University Park, Pennsylvania State University Pres..

Coughenour, C. Milton (1972): Functional Aspects of Food Consumption Activity and Family Life Stages. *Journal of Marriage and the Family.* 34:636-664.

Don. A Dillman and Daryle J. Hobbs (eds.) (1980): *Rural Society in the U.S.: Issues for the 1980's.* Westview Press, Colorado.

Ekong E. Ekong (1988) *An Introduction to Rural Sociology.* Jumak Publishers Limited, Ibadan.

Gordon L. Bultena (1980): (In Dillman and Hobbs) *Rural Society in the U.S. Issues for the 1980's.* Westview Press, Colorado.

Hassinger, E. W. and Larry R. Whitting (eds). (1976) *Rural Health Services: Organisation, Delivery and Use.* Ames, Iowa State University Press.

Kleinman, J. C. and R. W. Wilson (1977): "Are Medically Undeserved Areas Medically Undeserved?" *Health Services Research.* 12:147-162.

McKeown, Thomas (1976) *The Role of Medicine.* London, England, Muffield Hospital Trust.

Miller, Michael K, and C. S. Stokes (1978): "Health Resources and Consolidated Structural Parameters: Implications for Public Health Care Policy". *Journal of Health and Social Behaviour.* 19 (September) 263-279.

Paul B. Horton and Gerald R,. Leslie (1977)., *The Sociology of Social Problems.* 4th ed. Appleton-Century-Crofts, New York.

Schefer, Robert B. and Joe M. Bohlan "Exchange of Conjugal Power in the control of Family Food Consumption." *Home Economics Research Journal.* 6 (September): 131-140.

Semi Afonja and Tola Pearce (1984): *Social change in Nigeria.* Intec. Printers Limited, Ibadan.

Sorokin, P. A. (1975) *Hunger as a Factor in Human Affairs.* Gainsville, Florida, University Press.

Steelman, Virginia P. (1976) :"Attitudes towards Food as Indicators of Sub-Culture value system" *Home Economics research Journal.* 5 (September) 21 - 32.

Virginia S. Purtle (1980: *Food and Nutrition* (in Dillman and Hobbs) P. 224 - 33.