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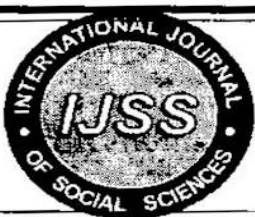
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Socio Cultural Practices and Health Care Delivery in Nigeria

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ABSTRACT: Maintaining good health for the people has always been the concern of the government at different times and levels in Nigeria. Health care delivery in the country has improved over the years. This is because better strategies for improving the people's health were explored year after year. That notwithstanding the health care delivery is still highly defective. A lot needed to be done to improve upon it. The paper therefore, examines the problems confronting health care delivery in Nigeria with a view to identifying the impact of socio-cultural factors on the people's health. It suggests that the government should embark on intensive health education and micro-credit programmes that will empower the people to take informed decisions about their health.

KEY WORDS: Cultural Practices, Capitalist, Disease, Health Care Delivery, Health Facilities.

INTRODUCTION

Health, according to the World Health Organization (Cited in Jegede, 1995) 'is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmities'. This definition provides an orientation to

non-biological process of well being favouring both preventive and promotive care services. Until recently, public health assumed little significance in care delivery in Nigeria. This is because the medical system, which the Nigerian government inherited from the colonial administration, had the hospital as apposed to rural health centers as cornerstone.

In post independence Nigeria, the Federal, State and Local governments as well as non-governmental organizations (NGOs) provide health services. According to the National Policy Declaration of the Federal Republic of Nigeria (1986), "The Federal, State and Local Government of Nigeria hereby commit themselves and all the people to intensive action to attain the goal of health for all citizens by the year 2000 and beyond, that is, a level of health that will permit them to lead socially and economically productive life at the highest possible level." Furthermore, "All governments of the federation are convinced that the health of the people not only contributes to a better quality of their lives but it is also essential for the sustained economic and social development of the country as a whole".

REVIEW OF HEALTH CARE DELIVERY IN NIGERIA

Trado-medicine as defined by Mume (1979) is a method and mechanism of treatment of human disease, which the African forefathers applied and which has been practiced by the succeeding generations over the years. Health care practice was based on this method until the advent of the British. By 1863, the colonial medical service was established in Lagos with the appointment of Dr. Hughes as the colonial Surgeon. The health care system at that time was essentially geared towards the health need of the white colonial officials. The coverage and scope of colonial health care services was later expanded in 1889 to cater for the needs of the local people.

The colonial officials felt that there was a great need to assess efficacy of the traditional medicine before it could be integrated into the colonial health system. Consequently, a variety of administrative mechanisms was instituted to ensure that traditional doctors neither gave "poisons" to their patients nor "used criminal medicine" that could in whatever manner disturb the objectives of the colonial administration.

A commission headed by Dr. Oguntala Sapara was constituted to examine the problems associated with traditional healers because many of them were accused of spreading small pox into the society through "sopona". This was the beginning of the interface between traditional and orthodox medicines. Many traditional healers were later banned from practicing.

From that period, the Western-medical service became dominant. There were series of reforms in the British health care service to ensure that the objectives of their administration were met from time-to-time. The various reforms were to

meet the health needs of the emerging Nigerian urban population. As a result of this, most health facilities and manpower were concentrated in the urban areas and in a few cases, the district headquarters where the whites resided.

By 1960, when Nigeria became an independent state, the emerging health care delivery followed strictly the British model. Nevertheless, the various changes in health service reviewed the practice of Medicare and attempted to ensure that health care service was provided at the grassroots. By 1970, shortly after the civil war, health care practice was embedded in the second National Development Plan, realizing the need for a comprehensive health policy for Nigeria. From this period, the clamour for a community-based approach to health care in Nigeria was intensified. There was renewed interest in public health; primary and secondary health cares became prominent. This was the situation until 1978 Alma-Ata (WHO) declaration. It is important to note that, the health care system was entirely controlled by the government. In other words, the government provided basic health care services. This began to change in the late 70s when people had to pay part of the cost of health services in the public hospitals.

Although, the agitation for a National Health Insurance Scheme (NHIS) had begun earlier in Nigeria in 1963, several factors prevented its actualization (Pearce, 1986). The rising cost of health care services, especially from 1982 accelerated the agitation. However, much of the agitation appeared to be political propaganda rather than an issue of National interest. From 1985 to 1992, more prominence was given to be National Health Insurance Scheme on the health agenda of the Federal republic of Nigeria. As a matter of fact, the NHIS is another stage in the development of health policy and programme in Nigeria.

It is necessary to examine the evolution of Western Orthodox medicine in Nigeria because its emergence brought some remarkable changes to the country's health care delivery system. Orthodox medicine was introduced into West African by the Church Missionary Society (CMS) in the 19th century (Schram, 1971) although it is difficult to say specifically when Western Orthodox medicine started in Nigeria. The CMS is reputed to have built the first medical centres and brought into Nigeria the first Doctor and Catholic nuns as nurses.

The involvement of the colonial government in health services was a component of the Military expeditions to Nigeria, which later led to the establishment of the Army Medical Corp (AMC) at Lokoja. With the amalgamation of northern and southern Nigeria in 1914, medical services were centralized and hospitals built in major towns in the southern part of the country and Kaduna and Ilorin in the North. These colonial health facilities were initially planned for the European population and later extended to the Africans working directly for the colonial administration, that is, the civil servants. As a result, these services were predominantly located in the urban areas where the significantly small population resided.

With the attainment of limited self-government in 1952, health service was decentralized with each region handling its own health matters. There were plans for the establishment of hospitals in every geopolitical division. The emphasis on hospital development and medical schools, which gulped more than 80 percent of the health budget continued even after independence (Mojekwe, 1978). Generally, all efforts were primarily geared towards curative care, an approach in the health sector that has been severely criticized.

Studies (Alubo, 1986) have shown that the approach focused on curative as opposed to preventive health care and this has significant negative effects on the health status of the population. Available data revealed that most deaths in the society were preventable. Also, unlike public health service, hospital-based care is not accessible to majority of the population who reside in the rural areas. For instance, between 1985 and 1992 only 66 percent of Nigerians had access to health services of which 8 percent were urban dwellers and 62 percent were rural dwellers (UNICEF, 2000; Jegede, 2002). Beside curative services the hospital setting are too expensive to maintain like public health service. For instance, despite the rate at which medical personnel are being trained they do not meet the needs of the increasing population. In fact, the number of physicians to the population is much less than desirable and the distribution is lopsided (NPHCDA, 1997). However, these criticisms spurred the nation to reconsider its steps and shift to preventive health care.

Although the health care system of the country has witnessed tremendous growth since independence yet a number of problems persist which hinder corresponding improvement and progress in the health of the people. The major problem is that there is no adequate information about the sick due to poor disease surveillance system and low patronage of hospitals. It has been argued that the future depends, to a large extent, on being adequately informed because "reliable health information is needed not only by health professionals, politicians and business people who need it to meet the various responsibilities of their jobs but by the individual and families in every walk of life" (Nakajima, 1995).

SOCIO-CULTURAL PRACTICES THAT INFLUENCE HEALTH

Studies (Verbugge, 1976; Lewis and Lewis, 1977, Mechanic, 1978; Igun, 1982; Buckley, 1985 Jegede, 1991, 1995, 1998, Caplan, 1993; Owumi and Jegede 1996) have shown that there is relationship between socio-cultural factors and causes of disease and utilization of health care services. Culture has been found to play important role in health and illness behaviours especially in the underdeveloped nations of the world where majority of the people live in the rural areas and are still traditionally oriented. Hence, a number of socio-cultural factors affect health care delivery in Nigeria. The factors include, age, education, patriarchy,

inheritance practice, widowhood practice, son-preference practice, socialization, residential pattern, economic factor, belief system, child and gift marriage, nutritional practices, occupation and political factors which influence accessibility and decision making about health needs.

Generally, gender is a socio-cultural factor that influences health in Nigeria, but it is less emphasized in most patrilineal societies. Although reproduction is a function of male and female coming together in sexual encounter, decisions, about its outcomes remain largely that of the male gender. Studies have shown that the husband or father is most prominent in decision-making in the household (Jegede, 1995, 1998, Orubuloye et al, 1991). Majority of the fathers decide where their wives should go for antenatal and post natal cares. Aside from this, knowledge and attitude toward reproductive health service vary along gender line as more females are more knowledgeable about and disposed to family planning services than males (NDHS, 2003).

The direct intervention of education in people's life course becomes necessary for social mobility. Formal education plays a significant role in the knowledge base and use of most reproductive health services. In fact, studies have shown how schooling reflects, rather than challenges class stratification, and racial and sexual discrimination. Findings from several studies on infant and child mortality conducted in developing countries over the last decade showed a nearly universal and positive association between maternal education and child survival (Cochran, Ottara and Lasley 1980). The education of women alters the traditional resources because of increase in family size, leading to changes in decision-making and allocation of resources in the household. Education modifies beliefs about disease, causation and cure and thus influences receptivity to modern health care services. However, schooling enhances peoples' knowledge of modern health care provided, increase the value they place on good health results in heightened demand for modern reproductive health care services.

Economically, most Nigerians are poor because more than 40 percent of the people live below poverty line (Soyibo, 1998). This has implication for health care consumption. UNICEF (2001) has shown that Nigeria has very low daily per capital hence, the people may not be able to afford good meals on regular basis. Stawart and Esterline (1961), have shown that, among low-income groups, reduction in the monetary costs is usually associated with increase use of health services. But for middle and upper income groups, time tends to be more important, and rates of physician visits often decreases in response to lowering monetary price. In Nigeria the cost of health services is enormous, sometimes out of reach of the common man. Having patterned Nigeria health system after the American's health system it becomes fee-for-service approach. As a result it is a matter of 'money for hand back for ground' syndrome. Therefore, it is a commodity,

which is being rationalized by price mechanism. In this situation health service in Nigeria is primarily for those who can afford it, an indication of capitalist mode of production.

The perception of care of diseases and illnesses in African societies are influenced by the belief system. Traditionally, there are cults or movements which focus on sickness and health (Bourdillion, 1991). According to Oke (1993), most people all over Nigeria respond to illness in accordance with the culture. Among the predominantly rural populace, illness is commonly believed to be due to the evil machination of witches, sorcerers, deities and ancestors. This perception thus influences the health seeking behaviour of the people. Christianity has merely turned away people's attention from idols to the mystical power of God while orthodox medicine aberrates the influence of traditional care systems. However, studies have shown that people shuttle between the two (traditional and orthodox) medical systems. Definition of health and illness is a function of the belief system. Generally, three main causations of disease have been identified in Africa namely; natural, supernatural and mystical or preternatural forces. These determine the health and illness behaviours of the people and their therapeutic choice.

Patriarchy is also a socio-cultural practice that influences health. It literally means "rule of the father". The term was originally used to describe social system based on the authority of male heads of household. It has now acquired a more general usage, especially in some feminist theories, where it has come to mean male domination in general. Sociological and feminist researches have documented a huge variety of instances of male domination. According to Kandiyoti (Cited in Jegede, 1998), patriarchy often evokes an overly monolithic conception of male dominance. Women control under patriarchy is woven around norms and values of the society and this, most of the time, makes women perpetually submissive to men. This, however, affects social relationship as men appropriate it to occupy apex of decision making and surplus from women and children. This brings hardship to women as they cannot take informed decisions about themselves and their sexuality thus, promoting such practices as Polygamy, widowhood, discrimination and violence against women.

Women's status vis-à-vis men's may affect reproductive health in several ways. Patriarchy simply evokes the principle of male domination not necessarily by coercion but through institutional arrangement of the society. Hence, women lack access, to economic opportunities and have to depend on men for survival. Although modern economic system encourages women participation in labour force but studies have shown that most women still turn their income to their husbands (Jegede, 1998). Patriarchy encourages that women should remain silent and should not be heard independent of their husbands. This has implication for reproductive health service utilization as women cannot take decision on the best

ante and post natal services to use or when to have sex. All these impact negatively on the women folk.

Inheritance is another socio-cultural factor influencing health. This is derivative of patriarchy, as women have no inheritance rights, which put them at the least rung of the ladder. Studies (Jegede, 1999) have shown that inheritance practices play a significant role in male/female relationship in the patriarchy society. Since this is a cultural issue, women are socialized to the culture of submissiveness, which brings about inequality between children who are born of the same parents. As a result women spend most of their time to negotiate survival with their male counterparts. Inheritance practice favours male folk at the expense of females (Jegede, 1999). In patriarchal society while males inherit immovable properties like land and building, females in some cases can only inherit moveable properties such as their mother's mortals and cloths. Studies have shown that females have no say in property sharing, they only inherited through their brothers who inherit for their mother's side of the polygamous family known as "idi'gi" in Yoruba culture (Jegede, 1999). Since women are denied access to inheritance they may not have economic means of coping with life challenges since the proceed of their labour belongs to their fathers or husbands. Hence, they may not have enough resources to care for themselves and their children in case of medical emergencies.

Widowhood practice is another socio-cultural factor. Women are more or less property owned by their husbands as they are shared along with other properties at the demise of their husbands. This is a development from property acquisition embedded in a Yoruba adage "eni to ni eru lo ni eru" meaning "who owns the slave owns the property". Widowhood practices are prevalent in Nigeria. Studies have shown that widowhood practice impact negatively on reproductive health as it may increase STIs (Sexual Transmitted Infections) including HIV transmission, hard labour, resulting from late pregnancy, haemorrhage and death due to labour complications.

Son preference is another cultural practice that inhibits the health of the population. It is a common practice for people to want to have male child at all cost, since family stock is usually replenished through the male (son) who occupies a unique position in the family structure. It is a measure of women's legitimacy in their matrimonial homes as this attracts the attention of husbands and their family members to their wives. Studies (Isiugo-Abanihe 1994; Jegede, 1999) have shown that women will want to bear children until a male child is born. The dangers in this are hard labour and high maternal mortality due to too late pregnancies as indicated by Nakajima (1995). Apart from this, it usually leads to large family size, which has a resultant effect on family budget and nutrition.

There are harmful traditional practices that affect health. Reproductive health is associated with a series of harmful traditional practices such as genital

mutilation, which can cause such problems as Vesico Vaginal Fistula (VVF). Many of such practices may lead to labour complications and STIs including HIV infections. Harmful traditional practices such as female genital cutting (female circumcision) and child marriage are found to be widely practiced in parts of Nigeria. For instance, in Niger State majority (73%) married below the age of 20 years while more than one tenth (13%) married between 12 and 15 years representing 0.1% males and 15.8% females. Also nutrition wise gender differential exists, because of the value for male gender, male child gets preferential treatment in terms of food rationaing in the household. As a result, female children are likely to experience malnutrition than male children.

Health is also influenced by accessibility to health facilities. Residence and proximity to health facilities tend to influence therapeutic choice. It has been argued that location of health facilities too far away from the population affects the level of utilization (Okafor, 1984). Eugenia et al (1989) in a study in, Togo for instance, found that access to health clinic was a barrier to accessibility, especially for mothers who lived in villages along a road that was impassable during rainy season. All villages included in the study were not more than ten kilometers away from the nearest health clinic providing immunization services. In location theory, emphasis is placed on minimizing travel distance by patients in the use of health care services. Okafor (1984) has argued that the cost of travel has serious implications for the location and use of health care services, as most people want to spend less on travel costs apart from the transportation problems facing developing countries, which affects women mostly as indicated in the data.

DISCUSSION AND CONCLUSION

Examining the socio-cultural factors affecting health status of the Nigerian populace it is obvious that the current care policy in Nigeria is based on multi-sectoral approach. This means that sectors other than health are expected to contribute meaningfully to health care development. Generally, modern health care practice as it were continues to maintain status quo of rational basis for prevention and cure. Hence, the primary health care programme could not make appreciable impact on the population. Although the government is diverting into preventive care but the largest proportion of the health budget still favour curative. The health care provision still favours the upper class a clear reflection of patriarchy in its true practice in modern form. For instance, the National Hospital at Abuja was recently sold to a British organization. Not too long ago the hospital management, announced that the hospital will no more entertain unreferenced accident cases. This means that its care is no more at the reach of the average man on the street neither is it preventive. The issue of traditional practices such as the widowhood practice has not received adequate national preventive policy

statements. This may be due to the fact that victims are mostly women while majority of the policy makers are men. Since most of the traditional practices are aimed at controlling female reproductive and economic capacities modern social structure fails to deal decisively with these practices. This is an indication that the society is still having one foot in the new and the other in the old harmful cultural practices.

Public health is yet to be fully appreciated in this country due to the present capitalist mode of production influencing health care policy. Although evidence abounds that Western societies like Sweden and Britain with similar programs have achieved success, the situation is compounded in Nigeria in particular, and Africa in general by the influence of patriarchy and poverty, it is a system producing more poor than rich.

This paper has critically discussed the socio-cultural factors affecting health of the Nigerian populace. It is therefore, suggested that there is need for intensive health education and micro-credit programmes that will empower the women especially to be able to take informed decisions about their health and that of their children. This should be pursued since women are care givers at the household level. Also gender sensitive health policies should be put in place in order to provide guide for women friendly health programmes. Hence, the capacity of NGOs, and individuals should be built so that the adopted interventions can be sustained.

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