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An Exploration of Health Care Delivery in Rural Areas of South Western Nigeria

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Abstract. There is a link between environment/eco-system and healthcare delivery in every society. The link often reveals difference between urban and rural areas healthcare provision, patronage, patterns and utilization of available health care resources. The nexus accentuates where one lives and the process of healthcare consumption available to individual or group of individuals. This pattern of inequality has brought about an unmitigated disparity and untold misery to the rural dwellers in all ramifications including health matters. Health infrastructure to be sure is understood in both qualitative and quantitative terms to mean the quality of care and accessibility to health care delivery within a country. It is judged by the quality of physical, technological and human resources available at a given period. It is therefore suggested that Transformation Approach and Improvement Approach may be adopted to bring rural and urban areas at par : Transformation Approach puts emphasis on the development of socio-economic factors available in order to experience a sustained growth and marked increase in the level of inputs that is complementary to labour and work done in the rural areas to increase income and financial independence. Whilst, Improvement approach emphasizes the continuity of existing social institutions and arrangement. To this approach, improvement upon all the existing institutions should be gradual and progressive. Emphasis is therefore placed on proper type of education to acquire skills. Education would also serve a veritable avenue to remove ignorance, increase level of income etc. All these put together form the structure upon which the healthcare delivery is anchored in any society and the determinants of its infrastructure and the extent of patronage. Therefore, for quality rural health, all these are to be in place with adequate budget allocation.

Keywords: Rural Health, healthcare delivery, infrastructure, Access, aetiology

1. Introduction

There is a link between environment/eco-system and healthcare delivery in every society. The nexus accentuates where one lives and the process of healthcare consumption available to individual or group of individuals. The link often reveals difference between urban and rural areas healthcare provision, patronage, patterns and utilization of available health care resources (Jegede, 2010; Nwokocha, 2004). There is a consensus that public health, health care consumption and delivery are skewed against rural settlements in Nigeria and elsewhere in sub-Sahara African countries (Tella, 2014; Ademiluyi & Aluko-Arowolo, 2009; Adebanjo & Oladeji,2006). To understand this division, particularly in Nigeria, is to situate rural settlements against urban areas by describing the difference or the gap between the 'have and have nots', poor and the rich (Erinosho, 1998; Jegede. 2010). This pattern of social structure of inequality has brought about an unmitigated disparity and untold misery to the rural dwellers in all ramifications including health matters. The National Programmes on Immunization (NPI) in 2005, for instance, shows that there was more success/advancement in healthcare patronage in the urban areas than the sub-urban and rural areas because there are more health infrastructures to sustain the programme in the former than the latter. The success rate was 25% for urban children and 7% for the rural areas (Owumi, 2002). The trend has not improved to any appreciably (Aluko-Arowolo & Ademiluyi, 2014) even, almost a decade after the programme. No wonder Nigeria has one of the world highest rates of deaths of under 5 children (0 to 5 years): that is 178 per 1,000 births (Owumi, 2002); with preponderance of these deaths from rural areas (Aluko-Arowolo & Ademiluyi, 2014).

The matter becomes worrisome because of neglect from the governments at both states and federal

levels (Tella, 2014). The neglect is apparent in budgetary allocation to health and other allied amenities such as potable water, good roads, electricity, well equipped and funded hospitals among other things which favour urban than rural areas (Jegede. 2010; Owumi, 2002). For instance, states with urban status like Lagos enjoy more patronage than those with rural status like Jigawa and other non- metropolitan states (Ademiluyi & Aluko-Arowolo, 2009). For example, 253 secondary health institutions/General Hospitals are located in Southwest and 209 in the North-Central Regions where there are more cities and towns than the remaining regions with predominantly rural settlements (Aluko, 2005). In addition professional healthcare workers like doctors and other highly skilled health workers would prefer to stay in the urban areas, especially where there are infrastructures, to practise their professions. Apart from this, life chance resources like water, energy (electricity) good roads, shelter, school for children, and employment for spouses which are likely to attract these personnel to rural areas are not generally provided in the rural areas (Mwatsika, 2015; Aluko-Arowolo, 2005). And where they are provided, they are grossly inadequate.

In sum total, as a matter of fact there is such an extensive body of literature on rural and urban dichotomy, class differences, social stratification and paucity of infrastructures in rural areas that it would be unrealistic to attempt a detailed and critical review of all the regions in Nigeria in this write up; instead of a detailed and particular regional analysis of the subject matter a general overview explanations will be provided. The focus therefore, is on rural health, need for medical infrastructures, budgetary allocation and how disparity and negative health seeking behaviour can be assuaged. Rural areas are thus explained with plethora of social and income inadequacy

2. Rural Area as a Concept and Access to Health Care

There is no agreeable definition of what rural society is, its definition or conceptualization varies from one authority to other and from developed societies to developing ones. To some, the rural society connotes an aging population, dependent youth and/or an outmigration of young people and an in-migration of retired people ((Mwatsika, 2015; Aluko-Arowolo, 2014). However, for the purpose of this discourse, a rural society is a group of people who reside in a community, less than twenty thousand people in the developing countries and about five thousand in the developed climes and occupy a particular territorial area and feel themselves to constitute a unified and distinct entity with possibly a common culture (Home, 1983; Scott & Marshall, 2009). Otherwise, an aggregate network of social relationship of a group or groups of people who may have lived, worked together long enough to get themselves organized and to think of themselves as a social unit and live a common, simple and personalized life. The environment thus defined as a society may inhabit one-two or many groups with their distinct norms and values. A rural community may inhabit one group while a modern urban centre may inhabit many groups (Akpenpuun, 2014; Owumi, 1996).

In Nigeria, the neglect of rural areas is causing a lot of setback in the development of modern cities, health infrastructures and manpower (NHRFHSP, 2012) for sustainable growth. The rural areas, in a way are losing the services of able-bodied manpower to urban areas. The difference between rural and urban life is therefore, highlighted in the homogeneous social life of rural people as against heterogeneous social relationship as being amplified by urban people (Aluko-Arowolo, 2013). However, rural area is a complete detachment from urban area with its characteristics, norms and value quite unique and informal. Whereas, urbanization separates work and household and it is specifically based on formal relationship that invariably weakens social ties of the people, place of births and residences. Rural area consolidates and strengthens social ties with one's family serving as a reference point to whatever he or she becomes in life. Social mobility in the rural area is often based on ascriptive norms rather than achievement or expertise acquired in entrepreneurial skill or formal education.

In the urban area, there is a great dependence on government for security, health and welfare (Home, 1983). This is not the case in rural area where, security, welfare, health and other socio-economic functions are collectively undertaken together, as one is expected to be his brother's and /or sister's keeper. Sick role is not performed only by the significant others but almost everybody in the rural areas. This is to say on the other hand that urban settlements are more of a central-fugal-like contraption of fragmented individuals with governmental decisions left for centralized authority whereas rural area is central-petal-like with certain degree of devolution of power to several agencies including head of family, kinship head, quarter head and chiefs who possibly serves as the final arbiter in the kinship or family dispute in case of any. The difference between rural and urban areas is more pronounced in access

disparity to health care among Nigeria populace in that infrastructure and personnel that are very essential to efficient hospital system like food, roads, pipe-borne water and electricity for storage of drugs and surgical operation etc were not provided for in the rural areas (Aluko-Arowolo, 2005). The difference brought to the fore, the challenges in the healthcare system and other associated services; this has implication on the health policy of governments in Nigeria. Health-care reforms, as engrained in the 1999 Nigeria constitution focus on improvement of the quality of health-care, decrease the cost of health-care, improve the access to health-care specialists, expand the array of the health care providers for consumers to make their choices and broaden the population covered by private or public insurance(Owumi & Taiwo, 2012). From the above, a 'roadmap' was designed for health system and sundry services in Nigeria which placed health services specifically on three pedestals: the primary, secondary and tertiary institutions for rural, mixed population, and urban settlers respectively.

Most epidemiological studies clearly demonstrate the existence of associations between spatial distribution of residences (that is, where one lives) and socio-economic positions. Others are the incidence, prevalence of illness and access to healthcare (Jegede, 2002). It also dictates the prophylactic and therapeutic options to treatment. This fact explains the disparity in healthcare infrastructure, healthcare consumption and quality of healthcare between rural and urban areas.

3. Healthcare Infrastructure and Quality of Healthcare

Health infrastructure to be sure is understood in both qualitative and quantitative terms to mean the quality of care and accessibility to health care delivery within a country. It is judged by the quality of physical, technological and human resources available at a given period. Physical structure entails laboratories, buildings and other fixed structures such as pipe borne water, good access roads, electricity and so on within the healthcare environments, whilst the technology is about the equipment meant specifically for hospital use including surgeries (Erinosho, 2006). This also includes computer/technology, laboratories equipment and consumables while human resource comprises the health professionals such as doctors, pharmacists, nurses, midwives, laboratory technologists, administrators, accountants and other sundry workers. All these put together form the structure upon which the healthcare delivery is anchored in any society and the determinants of its infrastructure and the extent of patronage. Therefore, for quality rural health, all these are to be in place with adequate budget allocation.

In 2014 budget allocation to health sector in Nigeria was six percent or N262 billion (or, 1.7billion USD), this is against N279billion allocated in 2013 (Aluko-Arowolo & Ademiluyi 2015). The urban areas benefitted to the detriment of rural areas and little effort was on primary health (including maternal health) which is very peculiar to the rural areas. The health sector in Nigeria, especially rural health is noted to be facing financial and human resources crisis (NHRHSP, 2012) as against urban areas. For instance, a break-down of provision of potable water shows that 67% was allocated to urban centres, especially state capitals, 60% of the remaining to other urban settlements, while 50% was to the semi-urban and the rest to rural areas (CBN, 2005). Although, this focus on disparity obfuscates the National Health objectives that seek to eliminate disparities that exist between urban and rural areas especially primary health matters between different population and/or subgroups on a wide range of health-related outcomes and behaviours, as well as conditions that affect health (Jegede,2010; Castro-Leal, Demery, & Mehra,.1999). Much success has not been recorded on this. In spite of this shortcomings, modernization, civilization and western education among other factors have helped to introduce change in a tremendously dimension in rural areas towards positive health seeking behaviour to embrace orthodox medicine and health practices (including in this behaviour is the encouragement of traditional health practitioners to upgrade their practices through trainings to conform to minimum health standard (Owumi & Taiwo, 2012; Erinosho, 2006; Erinosho, 1978).

4. Disparity in Access to Health Care among Rural and Urban Areas in Nigeria

There are disparities in health status and access to health care among different population groups in Nigeria. For instance, the under-five mortality rate in rural areas is estimated at 243 per 1,000 live births, compared to 153 per 1,000 in urban areas (UNICEF, 2006 in, Aluko-Arowolo, Ogundimu & Solarin, 2014). While 59 percent of women in urban areas deliver with a doctor, nurse, or midwife, only 26 percent of women in rural areas do so (NHRHSP, 2012). The Human Development Index (HDI) as a composite index that measures the achievement of countries in three basic dimensions of human development in the areas of: a long and healthy life,

knowledge, and a decent standard of living have poor rating for Nigeria (NHRHSP, 2012). There are also systemic deficiencies in the planning, management and administration of available personnel. The common outlooks are: shortage of professional staff in the north of the country as a whole and oversupply in the southern parts with more cities and towns. Distribution of health workers is also skewed toward urban centres with acute shortages in rural locations. Coupled with these are staff recruitment regulations in some states with shortages of critically needed health staff that discriminate against non-indigenes (NHRHSP, 2012). Attrition of health professionals is becoming excessive due to brain drains. Brain drain is whereby professionals from the country of origin are "pushed away" due to unfavourable conditions of service to the country of destination with alluring scenario that are "pull factors" (Ademiluyi & Aluko-Arowolo, 2009).

Migration of health care personnel to other countries is a current, critical and serious issue in the health care system of the country, from a supply push factor, a resulting rise in exodus of health care personnel may be due to the unbearable working condition among other things. Furthermore, there are low level and discrepancies in salaries and other conditions of service for health professionals working at different levels and between urban and rural states. The health worker force available was unevenly distributed (Aluko-Arowolo, 2005) with urban areas of 30 percent inhabitants having the larger concentration of health workers more than rural areas with preponderance percentage of 70 percent having to do with lesser health workers (NHRHSP, 2012; Aluko-Arowolo, 2005). In Nigeria of more than 160 million people, there are about 39,210 doctors and 124,629 nurses (This would translate to a doctor's ratio of 1: 4103; or, about 30 doctors per 100,000 populations and 1: 1284 or about 100 nurses per 100,000 populations respectively) registered in the country, currently working (or not working or practicing at all - NHRHSP, 2012). Though, it is taken for granted that we cannot all be sick at the same time, but this figure is in gross contradiction of WHO standard ratio, which specifies ratios of doctors, Nurses and environmental officer of 1: 600 patients,1: 4 patients and 1: 8,000 people respectively (Erinosho, 2006). Paradoxically, as noted elsewhere in this paper, the insufficiency in the numbers of health personnel does not prevent the available ones from seeking for better pay and conditions of service elsewhere, where it is assumed that there are favourable conditions of service. Furthermore, there are wide variations in health status and access to care among the six geo-political regions of the country, with indicators generally worse in the North than in the South (MDG Report 2004 in, NHRHSP, 2012). One prominent characteristic of poverty in Sub-Saharan African is inadequate access to social services. Access to care is a directly proportion to prevailing socio-cultural variables and poverty.

5. Poverty and Health Inequality in Rural Area

At present, more than one billion people in the developing world continue to live in absolute poverty with majority in Sub Saharan Africa (Tella, 2014). In Nigeria today, there is rising incidence of poverty in all ramification. Poverty is highly visible in most African Countries with rural communities having larger concentrations of poor people without basic social services including health services. World Bank (1996 in, Tella, 2014) reported an estimate 40 percent of the people in sub-Saharan African (SSA- including Nigeria) lived on less than one dollar a day. Almost all SSA countries performed poorly in the Millennium Development Goals – MDGs assessment - on health (Aluko-Arowolo, 2014). The incidence and prevalence of poverty varies greatly, depending on what definition of concept that is used. If one accepts a relative measure of poverty such as the below 50 percent of the median income, then quantum of those living in poverty in Nigeria has been held steady for more than 30years, with majority in rural areas. If we adopt an inequality or disparity in the share of income measuring indices, then poverty is widespread and has made no progress in the last 25 years to halt its spread as attested by a study carried out in Nigeria by Bureau of Statistics which indicates that proportion of the population in poverty in Nigeria fell from 43 percent in 1985 to 34 percent in 1992 from 36 million people (out of a population of 84 million) to 34.7million people (out of population of 102 million) of those in poverty, 10million people were extremely poor and of these 8.4 million lived in rural areas (see Tella, 2014 for an update – which indeed has worsen now). The numbers of poor in rural areas are noted to be rising now in spite of initial gains of reduction 1980s when rural poverty fell sharply from 26.3 million to 22.8 million, while those experiencing urban poverty rose from 9.7 million to 11.9 million. The reason for this is not farfetched, non-food requirements, i.e. social services including safe water, healthcare facilities, and shelter and education facilities are inadequate in rural areas. Sixty percent of poor families lived in urban areas but the pervasive incidence of poverty was 50 percent greater in rural areas than urban areas.

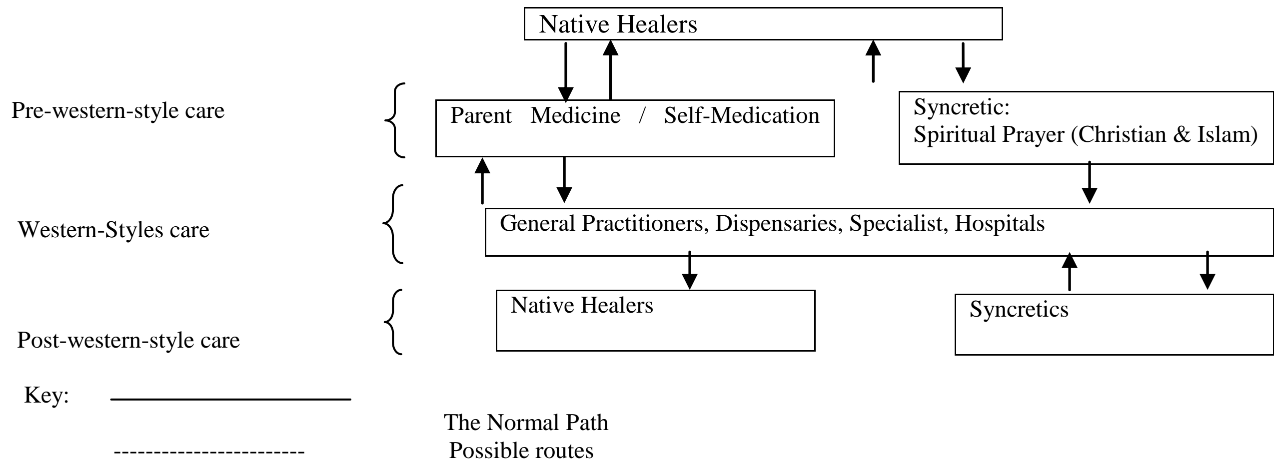
Furthermore, most Nigerians are still living subsistence lifestyle, an indication of extreme deprivation and poverty occasioned by the persistent devaluation of the Naira, for several decades under the IMF - imposed Structural Adjustment Programme (SAP). This has adversely affected the quality of life of the average Nigerian. The ever-increasing hardship has become so entrenched that the three basic necessities of life: food, clothing and shelter are no longer taken as basic. The effects of this biting poverty are certainly more pronounced on the children and their mothers who are compelled by the circumstance of culture to eat less, thus exposing themselves to serious health hazards. However, the pervasive poverty in Nigeria do not appear to be abating as a result of spiraling inflation, massive layoffs of workers, rising food price, unaffordable health care and a deteriorating standard of education which have all contributed to worsening living conditions and the low income of households. Due to this fact, traditional medicines, some without proof of quality assurance are now being patronised to take care of common and not so common diseases, both communicable and non-communicable ones.

Many poor people move frequently in and out of jobs and the number affected by employment instability is far greater than the number of unemployed at any given moment. This to a large extent reflects the incidence and prevalence of poverty in the Nigerian Society. While recognising the relative vulnerability of the above groups to poverty, it must be stressed that they do share one crucial common feature – their social class position. This characteristic therefore, is what causes the social conditions for the inhabitants of rural areas and marginalized urban poor to be exposed to poor healthcare. It is sufficing to mention the fact that among the groups most affected by extreme poverty throughout the world are those who do not have the capacity to organize themselves nor to exercise the right to protest their situation. Of course, this circumstance is also strong determinant of pathways to healthcare consumption.

6. Pathways to Health care delivery in Rural Areas

Pathway studies are increasingly becoming important aspect of health services, in terms of planning, provision of appropriate training and human resource for service delivery, including implementation of efficient referral system from lower levels of health care and other care providers to specialist institution (Jack-Ide, Makoro, Bip-Bari & Azibiri, 2013). Pathway to healthcare is used therefore, to explain health-seeking behaviour. This describes the steps and process from the recognition of symptoms to the use of particular health facilities. This method specifically attempts to identify a sequence of steps and looks at social and cultural factors of disease causation, which affect the sequence. In rural Nigeria, care providers include the native healers, faith-based organisations and sundry unorthodox methods which are not included in the referral process. This makes referral system clumsy or not attainable in most cases. It also gives room for all sorts of medical/treatment options that vitiate proper referral process from primary to secondary and tertiary care levels. Not very few also believe in the efficacy of herbs. These practices in one way or the other helps to keep the morbidity and mortality rates high and harbingers low life expectancy in rural areas. However, in developed countries, general practitioners and health professionals are central in the pathway of care with the majority of persons receiving services in health facilities are being referred from primary care/general hospital (Gater et al., 2005 in, Jack-Ide, Makoro, Bip-Bari & Azibiri, 2013). Health-seeking behaviour in this respect can be perceived as a function of a set of determinant factors which are associated with the choice of different kinds of health services. Dominant among these factors are where people reside, the roles of family, significant others, social networks and culture.

The determinant factors may also be seen in various contexts such as political – government provision of healthcare with medical and technological infrastructures, or not; physical - distance to care centre(s), social and economic (Erinosho, 1978). Other is culture which defines aetiology and epidemiology of illness/disease. Situating illness/disease in the context of culture Jegede (2002) traces occurrence and/or prevalence to enemies (ota), which include witchcraft (aje), sorcery (oso); gods (orisa) or ancestors (ebora); natural illness (aare) and hereditary diseases (aisan idile). Therefore, the utilization of healthcare systems, public or private, formal or non-formal, faith-based and/or native healing methods may depend on socio-cultural-demographic factors in terms of level of education, cultural beliefs and practices. The decision to engage or consult with a particular medical outfit among other issues is also a factor of culture and the source(s) of decision making. Sometimes, pathways to healthcare may be a factor of where one resides – may be rural or urban - Pathways to healthcare consumption in most rural Nigeria is showing below graphically:



Adapted from Erinosho, 2005

In explaining the diagram, an average rural Nigerian, whenever he/she is taken ill, would rather start treatment with self-medication, consult with pre-western/unorthodox practitioner(s) including the syncretic healers (the aladura, exorcists and diviners). This is before going to orthodox care centre(s). In most cases orthodox option is often the last resort. Even after consultation with the orthodox, the tendency is to go back to the pre-western method, believing that orthodox medication only works fast but very ephemeral. Only the traditional methods work with intensity and very deep rooted. From whichever direction one is looking at rural health in Nigeria, with appropriate intervention(s) however, healthcare system in the rural areas can still be made to conform to the dictate of sustainable development.

7. Recommendations

From the foregoing, sustainable rural healthcare delivery can be interpreted to mean a state of health devoid of neglect, poverty, poor access, ignorance and inadequate education. But one notices that all these indices are still prevalent with devastating consequences. Therefore, healthcare delivery in the rural areas at present is abysmally poor. To improve on this, the perspectives of transformation and improvement as propounded by Long (1982) are suggested below:

Transformation Approach: This approach puts emphasis on the development of socio-economic factors available in order to experience a sustained growth and marked increase in the level of inputs that is complementary to labour and work done in the rural areas to increase income and financial independence. In these regards, all thing being equal, poverty would be reduced and there would be upsurge for improvement on wealth gained. It was also suggested that substantial part of the labour supply would have to migrate to urban-industrial employment so they can repatriate their incomes/resources gained as a result of migration back home for necessary improvement. Interpreting this in relation to healthcare delivery, therefore, is to maximize health care delivery and consumption in the rural areas, especially for those who are left in the areas.

Improvement approach however, emphasized the continuity of existing social institutions and arrangement. To this approach, improvement upon all the existing institutions should be gradual and progressive. Emphasis is therefore placed on proper type of education to acquire skills in order not to contribute to legion of unemployed in the urban centres. Education would also serve a veritable avenue to remove ignorance, increase level of income etc. Other areas of concentration are provision of physical/ social infrastructures including hospital facilities, good roads, etc.

Improvement approach is akin to Health-Care Policy and Reform of 2005 as elucidated by Owumi & Taiwo (2012). The policy is thus stated:
The Principle of Social Justice and Equity and the Ideals of Freedom and Opportunity that have been affirmed in the 1999 constitution of the Federal Republic of Nigeria.

Another principle is that of access to quality and affordable health care which is considered as a human right.
A third principle is the fact that good health care shall be assured through cost effective interventions that are targeted at priority health problems.

There is the need to recognise the contribution of traditional/alternative medicine: An understanding of this fact is inevitable for the proper appreciation of traditional medicine to enable everyone to appreciate and understand the need to promote and develop traditional medicine.

These approaches appear very crucial and suitable for a developing society like Nigeria where division between rural and urban areas looks like it was cut in granite and the forms of available healthcare are also sharply divided between poor and the rich.

8. Concluding Remark

The present lopsided distribution of health facilities between urban and rural areas in Nigeria is a carry-over from colonial era. The urban areas where the educated, the rich and the powerful live, receive the lion share of the infrastructure. The irony of it is that majority of Nigerians live in rural areas. This therefore suggests that there is the need to redistribute the infrastructure in such a way that all Nigerians have a chance of benefiting maximally.

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