HOUSEHOLD ECONOMY AND HEALTH-SEEKING BEHAVIOUR IN RURAL COMMUNITIES OF AKOKO, ONDO STATE, NIGERIA

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CERTIFICATION

I certify that Raymond Kayode KUTEYI carried out this doctoral research under my supervision in the Department of Archaeology and Anthropology, University of Ibadan, Ibadan, Nigeria.

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DEDICATION

This work is dedicated to the glory of Almighty God for His favour and mercy on me at all time. It is also dedicated to late Mr. Omosehin, who supervised my undergraduate project work and also gave me the intellectual support during his lifetime.

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ABSTRACT

Household economy involves the production and consumption at micro level of human organisation and is characterised by cultural forces that influence actions taken to prevent and/or cure illnesses in rural communities. Existing studies on household economy in rural communities of Nigeria have focused on production and consumption patterns, without paying considerable attention to how local economic system influences health-seeking behaviour. This study, therefore examines the cultural strategies employed in household economy and their implication for choice and utilisation of healthcare services in rural Akoko communities of Ondo State.

The study adopted the political economy of health theory and exploratory design. The theory posits a relationship between economic structure and health care system. One rural community was randomly selected from each of the four local government areas populated by the Akoko, namely Akoko North-west, Akoko North-East, Akoko South-West, Akoko South-East. The sampled communities are Akunnu, Ese, Ikun and Ipe-Akoko respectively. Sixteen Focus Group Discussions were conducted with men and women in the sampled households. Key Informant Interviews were conducted with purposively selected 24 health care providers, and 68 economic groups. Unstructured Observation method is also adopted for data collection. Data were subjected to content analysis.

The cultural strategies adopted in household economy in rural Akoko are "*Abo"* (a system of organising services/labour) and "*Ajugba"* (a system of exchanging economic goods). Both strategies are anchored in the concept of *Moye* (a kinship ideology emphasising welfare creation), which demands mutual economic assistance to one's kinsmen. However, these are principles that make household economic activities more complex and tasking in rural Akoko. The strategies affect the choice and utilisation of healthcare services. *Abo* encourages the flow of labour but increases time and energy expended on economic activities. It therefore limits available time to seek quality orthodox healthcare, thus, making the people to rely more on traditional healthcare and home remedies. *Ajugba*, on the other hand, creates availability of goods more than attracting monetary rewards to finance healthcare, and makes the people to seek cheaper healthcare. Herbal concoctions are applied for injury and pains, while home remedies are applied for curing illnesses and for preventive measures. Rural Akoko people preferred traditional healthcare and home remedies which allow them have

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more time for economic activities. Orthodox healthcare providers indicate that rural Akoko people devoted more attention to work than healthcare and sought orthodox healthcare at advanced stages of illnesses, resulting in morbidity and mortality. The interface between cultural strategies and the utilisation of healthcare services in rural Akoko communities indicates their importance of healthcare intervention.

The cultural strategies adopted in the rural Akoko communities economic system has strong influence in determining the choice and utilisation of healthcare resources. The interface between the local economy and health-seeking behaviour in rural communities therefore deserves sustainable attention for aiding health interventions policy formulation.

Key words: Cultural strategies, Household economy, Health-seeking behaviour, Rural Akoko, communities

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Household economy describes the production and consumption at micro level of human organisation, while health-seeking behaviours refer to actions taken by individuals to prevent and/or cure illnesses in a given social setting. Household economy is characterised by cultural forces that influence actions taken to prevent and/or cure illnesses in rural communities. In rural communities of sub-Sahara Africa, there are household norms about production and consumption of household goods and services. The norms constitute standards through which one exercises appreciative behaviour towards one's kinsmen in the household (Awoyemi 2004; Odunbumi, 2012). All these behaviours are culturally undertoned, and individuals at the household are bound by socio-cultural and politico-economic structures, both of which have impact on their behaviours toward household economy. It is particularly manifested in the way they access and deploy labour and other economic inputs into the production and consumption of economic resources in the household. These transcend customs, values and beliefs that dictate and guide economic interactions, thus, making household economic activities more complex and complicated and in turn expose rural people to both health and healthcare challenges (Copper, 2006; Banti, 2013).

In rural communities, many health challenges have roots in the cultural arrangements of household economic systems, within which rural dwellers derive impetus to device, various means of healthcaring which constitute health care systems (Katung, 2001; Nwobuka, 2011). The structure of the household in rural communities facilitates expanded economic nexus through kingship connectivity, which makes many people interconnected. The interconnection forms the basis of socio-economic dynamics. This arrangement makes household economic interactions to remain complex. The complexity features inequalities, where certain categories of people in the household are denied access to some economic resources (Malucio, 1999; Dairu, 2012). The situations determine economic wellbeing and influence access to, and utilisation of healthcare resources (Ahmed 2000; Hopkins, 20004; Karen, 2006).

The political economy of health, as put forward by Parson (1972), is that health related actions are determined by the economic structure. The relationship between the economy and the healthcare system suggests that the way the economy is

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structured affects the healthcare system. In rural communities, access to economic resources also reinforces the capability of members to access and utilise healthcare resources. This is usually hindered in rural communities as health related actions are fraught with decision making arising from power relations that characterise household system (Sule 2008). This suggests that household economic system in rural communities depicts cultural attributes that affect healthcare systems. This makes it intricate for rural dwellers to effectively transform their socio-economic milieu for better healthcaring. Nonetheless, household members act together in social relations, involving both in objective and subjective interactions to transform their socio-economic milieu for better healthcaring (Ewhrudjakor, 2008). In spite of the publicly funded healthcare system in rural communities, morbidity and mortality rates have been on the increase. This scenario is applicable to rural Akoko communities.

It is in recognition of this state of health among the rural dwellers that this study was designed to examine the influence of household economy on decisions and actions on accessing health care resources among the rural communities of Akoko in Ondo State, Nigeria. An understanding of rural household economy tends to assist health interventionists in handling and evolving a proper and rational health policy formulation for rural dwellers in Nigeria. Through descriptive ethnography, the study specifically examines cultural strategies adopted in household economy (focusing on existing customs, values and beliefs subsumed in household economy) and how it influences choice and utilisation of healthcare resources in rural Akoko communities.

The thesis starts with the introductory aspect that highlights the background to the study. It shows the motivation behind the research. The aim and the objectives of the research were succinctly stated. The stated objectives provide the yardstick within which the project is conducted and evaluated, as they contain precise and measurable terms. Also in this chapter, research questions were used instead of research hypothesis since the study is mostly qualitative without complex statistical measurement. In order to ensure that the research investigation is directed and focused, the study scope was set. This was defined geographically and conceptually. In order to demonstrate that this study is worthwhile, its significance was also highlighted to justify the need for the study.

Chapter two consists of literature review and theoretical framework. The literature review deals with a descriptive and critical analysis of what other authors have written about the study theme. This helps to expand ideas about the research

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questions. In this aspect, the shortfalls of previous literatures are addressed in order to demonstrate awareness about the current state of knowledge in the topic, its limitation and how the research fits in its wider context. The following themes were reviewed: household and household structure; household economy; health and rural healthcare; health-seeking behaviour, household and the utilisation of healthcare resources. The theoretical discussion focuses on the application of political economy of health to the study. It evaluates the usefulness of the theory in solving the identified problem. The theory states that the way an economy is structured affects healthcare system. After the theoretical framework, the study assumptions were stated.

The ethnography of Akoko forms chapter three. Adequate description of the research area was highlighted to show the appropriateness of Akoko for the study. The basic characteristics of the study area, which justify its suitability for the study, were clearly stated.

Methodology forms the thrust of chapter four of the study. It explains the plan, structure and strategy of investigation, and how answers to the research questions were obtained. The major aspects of the research methodology section include: study methodology, study population, entering the field, sampling method; process and method of data collection and process and method of data analysis. Specifically, research methods included key-informant interview (KII), focus group discussion (FGD), and case study (CS). This is informed by the holistic and ethnographic nature of the study. Data analysis section was concerned with how the researcher processes the data and how he applies them in testing the research questions. Content analysis method in the form of ethnographic narratives was used to analyse the generated data.

Findings and interpretation section forms chapter five of the study. In this section, results were presented according to stated research objectives. This was done in such a way that appropriate titles used correspond to each objective. This section brings the findings together and achieves meaningful conclusion that creates the avenue for making the result generalisable. Discussions of the findings were done at the end of this chapter. Pictures and diagrams were appropriately used for illustrations.

Summary, conclusion and recommendation form chapter six of the study. In this section, the researcher relates findings together to make a reasonable summary and conclusion for the findings. The researcher also ties together the study findings in relation to postulations and established theories, as well as some of the past findings,

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especially those highlighted in the review of the literature. This section brings the findings together and achieve a meaningful conclusion that creates the avenue for making the result generalisable. The recommendation section contains practical suggestions for implementation of findings for further practice and research.

1.2 Statement of problem

In rural communities of sub-Saharan Africa, the role of culture is vital in the structuring of the economic system at the households. This transcends all economic endeavours and determines the efficiency of household economy. There is a high reliance on subsistence economy in rural communities and this determines and influences their mode of production. The mode of production in rural communities is peasantry because of the subsistence nature of their economy. Emphasis on subsistence production has impacted on their productive capacity leading to low income. This has made a large number of persons in rural communities to live below poverty line (Ogwumike 2010; Human Development Report 2012). This situation is also exposing a large section of rural dwellers to health risks and healthcare challenges. The low income created by subsistence production complicates out-of-pocket expenditures. The subsistence nature of household economy is incapable of funding the cost of household health. As the option of healthcare financing concentrates chiefly on out-of-pocket payment mechanism, individuals within the household that lack access to means of production equally lack access to quality healthcare.

In rural communities, how household unit is organised influences and determines the pattern of interaction between household members. This influences and determines the distribution of economic resources in the household. This made economic activities fraught with diverse challenges due to the system of organising household units. Some categories of people in the household are denied access to some economic resources due to some cultural forces (such as patriarchy and power relations). The effect of these cultural forces has been evident in the economic conditions of many rural dwellers that make them vulnerable to various incidences of poverty and healthcare challenges (Katung, 2001; Ajakaiye, 2010). In many rural households, patriarchy system influences and determines power relations. Power relations in the household influence gender relations and determine gender allocation

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of households' resources for health needs. This further determines household prioritisation of healthcare needs among members.

In addition, there are village taboos which affect the production and consumption of economic resources which have implications on healthcare system. All these cultural forces make rural dwellers economically insecure at the household and impact negatively on their healthcare. A variety of health conditions such as pregnancy related diseases, family health, water-borne diseases, fever and body pain are associated largely with household economic conditions. These undermine and determine the health status of rural dwellers (Adesiji, 2012). A large percentage of infants' morbidity and mortality in rural communities of developing societies are due to poor economy (Ogbimi, 2004; Walker, 2010). In 2009, the mortality rate for under-five years of age ranged between 284 and 180 per 1000 live birth in most of developing countries of the world (UNICEF 2009). UNICEF and WHO have reported different statistical records in 2006 and 2009 that mortality rates for mothers and children implacably increased in developing countries. In Nigeria, health indication revealed 120 per 1, 000 live birth as mortality rate in 2007 which increased to 145 per 1,000 live births between 2008 and 2009. The above conditions have adversely affected the well-being of rural communities by imposing low quality of life on them that made life expectancy at birth falling from 51.6 in 2008 to 43.4 in 2009 (UNDP, 2010).

Rural dwellers in Nigeria constitute over 70% of the country's population, yet these large numbers of people are unable to fully access and utilise qualitative healthcare resources that are essential for good living (Ajilowo, 2007). More than half of the Nigerians are in critical health problems and a good number of them live in rural communities (Demographic Health Survey, 2004). Over 75% of this population has no access to quality health care due to poor economy. Similarly, 85 percent of Nigerians could not afford proper healthcare and a larger number of them are also in rural areas (Federal Ministry of Health, 2009). About 70% of those living in rural areas do not have access to proper healthcare and even when they do, healthcare facilities are poorly utilised (Sule, 2008). These challenges have made the rural populace to seek healthcare in various forms, some of which have affected their health status. Some of these effects include, an increased rate in mortality of both children and adults, and impaired productivity of able men and women (Adejo, 2004).

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The attempt of both international and local organisations to address health problems of rural communities has been focused on the supply side of health market that is, how to improve health systems through increasing access to medical services (Alakija, 2000; Omoleke, 2005). In addition to this, the intervention also focuses on accident, health and health education, while the influences which socio-economic dynamics in the household have on healthcare have been given less attention.

A considerable number of detailed household studies have been carried out in rural communities focusing on welfare experiences, including time allocation and production efficiency. Nonetheless the impact of those studies has not been properly realisable on healthcare system. They have created awareness regarding the importance of household economy on welfare and development issues in rural communities. While there has been considerable research on household economy in rural communities of Nigeria, the focus has been on production and consumption patterns in the household. Little attention has been paid to how household economy influences health-seeking behaviour in rural communities. This might probably be because issues concerning economy and health are mostly looked upon and treated at macro-level while less attention is given to the micro-level of human organisation.

Despite all these, the researchers' attentions on the social aspect of health care in rural communities were directed to macro-economic concerns with unrecognised attention to micro-economic factors that could influence health-seeking behaviours of the people (Omoridion, 2010).In addition, the publications that have appeared on health-seeking behaviour in Nigeria have addressed the issue in other areas but almost to the exclusion of the present study area. The question is: why is there an increasing rate of health insecurities in rural communities of Akoko despite all the intervention programmes to improve health status? This question therefore constitutes a subject for this anthropological investigation. Specifically, attention is given to cultural strategies such as customs, norms, beliefs and values embedded in household economy and how they influence health-seeking behaviour including choice and utilisation of healthcare resources in rural Akoko communities. Relevant to the research problem are the following questions: what are the cultural strategies employed in household economy? To what extent have these cultural strategies impacted on the choice and utilisation of healthcare resources? What are the patterns of healthcare in rural Akoko communities?

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1.3 Aim and Objectives

The broad aim of this study is to examine the cultural strategies adopted in household economy and explain their implications for the choice and utilisation of healthcare resources in rural Akoko communities of Ondo State, Nigeria, with the view to establishing their importance to health care intervention. In doing this, the study specifically pursues the following objectives:

1 Examine management of household units in rural Akoko communities;

2 Identify cultural strategies in household economy in rural Akoko communities;

3 Explore how household economy informs health-seeking behaviours;

4 Describe how cultural strategies in household economy influence choice and utilisation of health care resources;

5. Identify patterns of healthcare in rural Akoko communities.

1.4 Scope of the study

Considering the fact that studies are yet to be popular on how household economic system influences health-seeking behavior, especially in rural communities of sub-Saharan Africa, this study examines cultural strategies employed in household economy and their implication for the choice and utilisation of healthcare resources in rural Akoko communities. Specifically, the study focuses on economic activities that are popular in rural Akoko households. This is because in rural communities of sub-Saharan Africa, more economic activities are engaged within the household than family, because family has a restricted membership as it directly limited to blood related kin (Bryson, 1998).

This study does relatively exclude economic activities which are formally conducted outside the household and which are not culturally inclined (such as civil service). The study focuses more on the prevailing economic activities that directly and indirectly impact on rural Akoko healthcare. It highlights the interdependence and connectivity in production and consumption within the household unit and the various customs, values, norms and beliefs associated with them. It similarly identifies patterns of healthcare and kinds of illnesses that are prevalent in the communities studied. The study makes reference to cultural forces in household economic practices, working in line with scholars' assertion that kinship ideology, patriarchy, and power relations contribute to determining the nature of relationship within the

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household in Nigeria (Olawoye, 1988; Aina, 1998). Specifically, it is how these cultural forces dictate household economic relationship and its influence on health-seeking behaviour that forms the central argument of this study.

The study is qualitative with emphasis on ethnography. This is in an attempt to describe the study variables in a holistic perspective. The study adopts multilateral perspective in the sense that it does not consider only people who fall within the same age groups, levels of education, marital status, occupational background and religious affiliation. This is necessitated by the need to collect a reliable and detailed empirical data. Considering the fact that household economy and health-seeking behaviour are cultural phenomena that affect all categories of people, the study makes a choice of its study population among rural people of Akoko. The target populations for the study are economic groups within the household that engage in farming, hunting, *gari* and palm-oil production which form the central economic activities in rural Akoko communities. The rationale behind this is that these activities are those that are mostly common in the study areas. The age of study elements is between 18 and 80 years. This is to ensure that people who participated have attained maturity. Rather than conceptualise healthcare processing from a conventional belief of pure bio-medical etiology, this study examines the customs, values and beliefs that characterised socio-economic dynamics in the household in order to explain the etiology of ill-health and patterns of seeking healthcare.

In conceptualising the relationship between household economy and health-seeking behaviour, the theory of political economy of health strengthens the study. The theory, which posits that the way an economy is structured affects the healthcare system, was integrated to have the broad-based explanation of the research objective. This has made the explanation of the interface between household economy and health-seeking behaviour to extend beyond disciplinary perspective to a more holistic perspective.

1.5 Significance of study

Since the study borders on ethnography which occupies a central position in anthropological studies, the study provides first-hand opportunities for people in the rural communities of Akoko to express their feelings, attitude and behaviour on the study themes. This opportunity widens the horizon of rural dwellers, especially in their health and healthcare problems. It therefore leads to the verification and

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refinement of existing theories concerned with an interface between health and economy. The extensive cultural data it turns out enhances a proper documentation of both the indigenous and contemporary values and attitudes of people in the study area. The data would contribute to documented history in Akoko.

Considering the magnitude of healthcare challenges facing rural dwellers in Nigeria, and the global concern on the effects of socioeconomic dynamics on rural healthcare, this research is significant in the sense that, it identifies cultural forces in economic relationship that influence action taken to prevent and or cure illnesses in rural Akoko communities. It would inform the government and agencies involved in healthcare in formulating policy for health intervention and at the same time assist in providing insights capable of creating a pathway to rural healthcare in Akoko land. In this case, it would assist in curbing the increasing morbidity and mortality rate in the rural communities.

Most studies on interaction between economy and health have been limited to small survey with high statistical analyses that are often devoid of detail description of study variables. In this regard, this study provides holistic information on knowledge, attitudinal practices and beliefs related to household economy through a detailed description of customs, norms, beliefs subsumed in household economic practices and their implication for choice and utilisation of health care resources. Hence, through this methodological rigour, the study reveals the underlying health problems associated with the lives of rural dwellers that are most significant to the agricultural sector in the Nigerian economy.

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1.6 Operationalisation of concepts

Community: A group of any size whose members reside in a specific locality, share government, and often has a common cultural and historical heritage. A locality inhabited by such a group.

Culture: Culture, according to Edward Tylor, is the complex whole which includes knowledge, beliefs, arts, morals, law, customs and other capabilities acquired by man as a member of a society. It is a fundamental way of doing things common to people.

Cultural strategy: This refers to a process of planning something or carrying out a plan in a skillful way that is anchored on culture.

Health: Many definitions of health abound, but the World Health Organisation's definition of health in 1948 is seen as the ideal definition. It sees health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Health behaviour: This is any activity undertaken by a person who believes he is healthy for the purpose of preventing disease or detecting an asymptomatic state.

Health-seeking behaviour: Health-seeking behaviour refers to the action taken by an individual to prevent and/or cure illnesses in a given social setting.

Household economy: This refers to production and consumption at the micro-level of human organisations.

Patriarchy: This is a social system in which males hold primary power, predominating in roles of political leadership, moral authority, social privilege and control of property, and, in the domain of the family, assume authority over women and children.

Rural: This is a sparsely populated area outside the limits of a city or town or a designated commercial, industrial, or residential centre. Rural areas are characterised by farms, vegetation and open spaces.

Socialisation: This is a term used to refer to the long life process of inheriting and disseminating norms, customs and ideologies providing an individual with the skills and habits necessary for participating within his or her own society. Socialisation is thus the means by which social and cultural continuity is attained.

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CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Household and household structure

The household is a primary unit of organisation where humans interact to enhance livelihood (Yanagisko, 1979). Several descriptions and definitions of household exist as scholars defined the concept according to their disciplines, languages and perception (Deaton, 1987; Mullins, 2000). Brydon and Chart (1989) define household as a residential unit, where members share domestic functions and activities while Goody (1958) defines household as a network of individuals that relate together based on economic cooperation. In addition, Nigerian National Population Commission (NPC, 2006) defines household as a group of persons living together under the same roof in the same building/compound and recognises themselves as a social unit with a head. Attempts to establish a valid cross-cultural definition of household have been difficult due to different orientations and perspectives. The various definitions that are available create confusions, which make it difficult to properly conceptualise and understand the concept of household (Guyer, 1987; Chadeau, 2005). The definition of household poses an intractable theoretical problem, given the varied and complex nature of human society (Burch, 1979).

Household is one of the human organisations that have caught the prime interests in applied anthropological study because of its significance to livelihood (Yanagisko, 1979). It is characterised by features, which make it difficult to separate it from family. As pointed out by Moore (1988), household and family are two terms which are particularly difficult to clearly separate and have been documented as becoming burgeoning areas of interdisciplinary research that deserve sustainable attention. Household has more members than family and more economic activities are engaged within the household than the family. A family has restricted membership and it is directly limited to blood related kin (Bryson, 1998). In recent times, due to economic pressure, family, as the basic unit of society, is facing contraction that continues to reduce its membership. On the other hand household embraces more members that go beyond the family's direct blood related kin. The conceptual distinction between household and family is still problematic, and interventions toward any of the two terms in rural communities do not yield optimal result as most studies continue to employ the two terms interchangeably (Deaton, 1997). Within the

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last three decades, a lot of international scholarships have been invested in the notion of household, but generalisation seems as elusive as ever (Ashley, 2004).

Household is a joint social and economic unit at micro-level of human organisation characterised with cultural affinities which act as its underlying structure. Nonetheless, the most basic demographic characteristic of household is the number of people it contains; and this constitutes one of its basic structures for economic relationship (Martins and Beittel, 1987). The various dimensions of household structures have been identified to reflect adaptation to economic challenges and, to secure individual welfare. However, this structure is often fraught with complexities due to unequal relationship (Goody, 1958; Duncan, 1990). The household structure in most rural communities has been one of the major challenges which make micro-level development intervention more problematic due to cultural forces that are very crucial in all their interactions. Moreover, circumstances surrounding individuals in household settings are not static as the people constituting a household constantly undergo changes due to the dynamic nature of households (Wilk and Netting, 1984).

Wilk and Netting (1984) also argue that as household dissolves and resolves to meet certain challenges, it encounters changes in regard to its structure and the welfare of its members. Mullins (2000) observe that the composition of household could change drastically when chronic illness and death happen as in the case of the Zulu society in South Africa when the HIV/AIDS pandemic struck, and in Rwanda during the genocide that decimated the country. He further noted that such changes could affect the activities of the household.

Wittenberg and Collinson (2007) investigate the changes in household structure in rural South Africa over a period of seven years, a period that was marked with changes in household structure due to an escalating HIV/AIDS epidemic. Results from this national survey show dramatic changes in the social structure of rural areas. This national change was ascribed to changes in household structure due to complex socio-dynamic relationships. Wittenberg and Collinson (2007) did not highlight the cultural significance of household structure on relationship in their analysis. Kooreman and Wunderink (1997) indicate that the number of people in the household is highly significant in regard to how incomes are earned and spent; money is saved and borrowed; time and money are invested on health and education; and meals are prepared. They also assert that the number of people is also significant to how household members enjoy leisure activities, and whether or not to change jobs and so

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on. This is also in line with Mcilviaina-newsad et al (2003) assertion that household composition is an important factor governing household behaviour. Nonetheless, the assertion of Kooreman and Wunderrick (1997) as discussed earlier does not highlight cultural forces that are significant to the formation of household structure and their impact on livelihood and survival.

David (2003) illustrates the importance of household structure in terms of composition, in the production and decision making in agrarian households. His work shows how household composition affects decision making. His work demonstrates how household decisions are influenced by the availability of resources, activities and members' needs. However, David's illustration (2003) fails to highlight the power relations that subsume or predispose people to such action; and also does not analyse the customs that dictate them. Deaton (1997) highlights how households change overtime due to several circumstances. He states that household formation and composition are internally determined which affect the economic structure of the household. Deaton (1997) also argues that, one could not be certain about the nature of the correlation between household composition and household resources. His argument does not indicate how household composition affects the allocations of resources and its implication for welfare.

While noting the confusions in researches on household structure, Russell (2002) opines that data generated through a single informant has been a source of problems for social scientists in the area of interpretations of facts and figures to correctly highlight and analyse how household composition determines welfare. A panel study in which the same panel of informants are interviewed and later re-interviewed over a period of time was recommended to determine changes in welfare due to household composition (Seeking, 2003).

To resolve these complexities, some studies (e.g. Strauss and Thomas 1995) have indicated how household structure can be a useful approach in analysing the effects of household decisions on the production of utility such as nutrition, health and human capital formation. However, the approach has not been applied to determine how culture is sensitive to household productive activities generally (Behrman, 1997; Thomas, 1990). Different theoretical perspectives have also constituted problems in the measurement of household structure on economic activities. This further has implication for measurement of household welfare due to the dynamic nature of the household. Household theorists and researchers have therefore gained considerable

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insights by viewing various household behaviours in terms of symbolic interactions, social exchange, and system framework, even though these theoretical perspectives diverge from each other and none is universally accepted as valid for measuring household economic behaviour (David 2003).

Household and household structure research enable one to capture the extent to which altruism or egoism prevails, that is, whether household decision making is dominated by a single person or made jointly to perfect or disaffect the household welfare (Strauss 1995). In order to compare levels of income across households, economists commonly resort to equivalence scales which summarise such demographic profiles as the size and composition of household. Since scales are used to deflate household income to render it comparable to the income benchmark of a household, in practice, equivalence scale adopts household demand data as economic behaviour. However, household demand is driven by preferences and the estimation of equivalence scales may thus be severely biased if preferences systematically differ across gender. Therefore, the approach to household should go beyond being one-sided in a quantitative manner through scaling to embrace an encompassing approach in a qualitative manner that would yield comprehensive knowledge and understanding (Ferrer, 2004).The importance of understanding or having an in-depth knowledge about household and its structure is relatively obscure. This is as a result of inadequate and non-comprehensive empirical investigation on household processes. Household is a basic unit where the welfare of the populace is best analysed and measured, and such knowledge could be made feasible through an in-depth search for household socio-cultural dynamics (Hammermesh, 2000).

In spite of the structural arrangement for economic security in the household, its significance in macro-economy has not been perfectly acknowledged especially in rural reform programmes (Short, 1996). Governments often rely on analysis of people's age, sex and spatial arrangements of people in homesteads only to determine household variables to aid policy formulation for intervention. Furthermore, other studies that border on household welfare give less attention to internal process within the household; the customs, values and beliefs that dictate and guide relationships and interactions are given little attention. Household research, drawing from the above, should involve a higher level of integration as indices to be studied are many and to determine an overall result is intricate. If not appropriately addressed, such complexity may lead to biased results and wrong conclusions

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(Edward, 2008). Wittenberg and Collison (2007) assert that more concern should be shown towards micro-level dynamics of cultural representation surrounding the everyday life of people within their domain.

Recently, anthropological discussions on rural development have been more concerned with the household especially in regard to the micro-impact of economic relationship in the rural economic system. Researches on household and its structure have not really highlighted the underlying structure that shape household and its formation. An exception, however, is Davidson (1998) who in his research on internal power system of the household in rural Kenya shows that structural arrangement determines privileges and opportunities. These opportunities and privileges are so unequal as to make some people to be more economically viable than others in the household. However, Davidson does not highlight in detail the underlying structures that inform or reinforce the inequality in the household. Anthropologists have been able to attach more importance to socio-economic connectivity in physical environment rather than the figurative structure of household as emphasised by demographers. Most of the studies that were designed to determine the influence of household structure on economic relationship are highly quantitatively couched with statistical analysis, focusing on demographic variables and devoid of thick description in holistic approach. Cultural affinities that dictate the internal relations within the household are given less attention. Even where they are emphasised, the customs, values and beliefs that anchor relationship are mostly ignored (Edger, 2007).

Dojoh (2005) suggests that studies on household should not focus on things that will not give a clue to the covert behaviour that dictates the structure of the household. He further argues that it is through this avenue that the complexity subsumed in household could be understood. Studies that focus on the demographic nature of household alone are incapable of generating a comprehensive understanding of household process. The methods often used for studying household and its structure are often quantitative. These methods are usually geared towards computing index numbers from demographic profile of households so that it (the index numbers) can be used for comparing households of different sizes. Little or no concern is shown to cultural strategies adopted in household structural arrangements (Ashley, 2004).

In conclusion, judging from the foregoing review of literature, some gaps were noticed. Most of the studies are more concerned with the demographic variables (sex, age and population) as the basic underlying structure of the household. These

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studies centered their arguments on the dynamic nature of household created by the demographic variables. Also their arguments did highlight the cultural structure of household and the importance of cultural strategies on the management of household unit as done in this study. Moreover, these studies adopted quantitative method that is devoid of thick description of customs, values and beliefs that dictate and guide household management. Based on these contestations, the review of household and household structure is inevitable. This would facilitate the background knowledge of household and its structure to this study. It would also go a long way in formulating policies on household welfare in rural communities.

2.2 Household Economy

Household economy refers to the production and consumption at the micro level of human organisation. It explains relationships within the context of access, distribution and utilisation of primary economic resources at micro level of human organisation. Household economy has been a concept that cuts across every human society and its importance for enhancing livelihood is immense (Becker, 2007). Harris (1992) asserts that household economy is significant to development as it forms the mechanism for linking an individual with both micro and macro economy. Hence, household economy is referred to as a substructure of the larger economy that forms the basis for the measurement and evaluation of economic growth of a nation. In view of this, Harris suggests that economic activities in the household should be given much attention in order to reduce poverty and to improve the welfare of the citizenry. Christensen (1976) also state that household is at the centre of every social interaction at micro-level and concluded that no interaction embedded in social institutions is completely devoid of an element of household economy. Christensen (1976) highlights the process of interaction entrenched in household economy but does not indicate the impact of the processes of interaction on other variables such as health.

Some scholars (Collins, 2004; Becker, 2007; Edward, 2008) have highlighted the problems associated with household economy and these problems range from structural to emotional factors in the household. Folbre (1998), while highlighting the problems, asserts that there are some cultural arrangements that are responsible for diverse temperaments and personality that make economic activities complicated and complex in a household. He argues that individual members of the household has a separate (if not competing) preferences, interests and resources which in turn gives

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rise to separate (if not competing) decisions and actions which make economic interactions intricate. The intricacies in household economic interaction make it difficult to effectively analyse and generalise. Its empirical application to all cultures might be problematic and may have to be studied and explained according to the context in which it takes place. This is because structural arrangement in the household varies from one culture to another (Harris, 1992).

Klassen's (2000) observation is also in line with the above. He argues that how household is constituted in terms of age, sex and position of individuals brings about diverse temperaments and personalities that reflect in the economic activities in the household and this is what makes it complex and intricate. He also argues that household composition influences and determines individual economic roles and responsibilities in the household. This argument is also in line with that of Empey (2004), who notes that the degree of a member of a household's engagement, participation and contribution to household economic activities varies, and that the variation may be attributed to power relations that dictate or influence role performance. He also argues that the variation usually generates contention with unpalatable consequences for the household. The argument of Empey (2004) has not provided a detailed explanation of the cultural antecedents of role differentials in terms of customs and beliefs associated with such interactions and their implication for the well-being of the individual members of household. Edger's (2007) submission on the several implications of role differential for household members also fails to explain the cultural antecedent of role differentials. Though he argues that role differentials could be associated with positions of individuals in the household, along with poor socio-economic status, he does not explain how it weakens the financial and material resource provision of some members in the household. He does not explain the customs, values and beliefs that could be responsible or associated with these.

Other scholars (Guyers, 1987; Folbre, 1988) have shown that there are certain odds embedded in household economy. One of the odds is disparity in time allocation as well as inequalities in allocating economic resources. Folbre (1988), in her explanation of time allocation and consumption of economic goods and services in Laguna Philippine, presents an alternative and more compelling explanation for reported inequalities in household economy. She found that male members of households have significantly more leisure time than women and they consume 101

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percent and 116 percent of the household production respectively of their required daily allowance of calories and protein. Women diets were markedly deficient, providing 87 percent of their calories and 79 percent of the protein. The findings do not highlight in detail the cultural basis of disparities in both nutrition and time allocation.

How household units are organised determines the nature of interaction as power and privileges are not equally distributed. This has influenced the distribution of economic resources in the household. This made economic activities fraught with diverse challenges due to the system of organising household units. Some categories of people in the household are denied access to some economic resources due to some cultural forces (such as patriarchy and power relations). The effects of these cultural forces have been evident in the economic conditions of many rural dwellers that make them vulnerable to various incidences of poverty (Katung, 2001; Ajakaiye, 2010). In many households, patriarchy determines power relations. Power relation in the household influences gender relations and gender allocation of household resources for household needs.

The high reliance on subsistence economy rather than market economy in many communities affects their mode of production. Emphasis on subsistence production has impacted on their productivity capacity which further attracted low income. This makes large number rural dwellers to live below poverty line (Ogwumike, 2010; Human Development Report, 2012). In view of this, decisions about expenditure, savings and deployment of labour for income become complex. The complexity feature unbalanced relationship that breeds conflicts, chaos and upheavals which impact negatively on the welfare of household members (Aslaken, 2006). Aslaken views the complexities purely through an economic lens, which fail to reflect the various interactive rules and regulations which bring about negative implications. Doornick (2006) also supports the idea of complexities while arguing that complexities are highly embedded in household economy thereby making members of household to have differentiated effects on their welfare. Doornick (2006) does not explain or highlight the pathways of varied effects, but argues that the more a particular person is at an advantage, the more adverse effects it would have on other persons or groups. Unfortunately, he does not go further to specify the processes involved and the nature of the adverse effects it has on others.

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Deaton (1989) notes that the composition of a household unit determines its structures and further defines the extent to which individuals are either burdened or relieved from economic responsibilities. In his study of the influence of household composition on household expenditure pattern, Deaton establishes that in many households, the activities of a particular group tend to increase geometrically, while some arithmetically, considering the gender relationship. Deaton (1989) employs quantitative techniques that are devoid of descriptive explanation of the nuances that could aid an in-depth understanding of the various cultural forces dictating diverse forms of economic relationship.

Collins (2004) studied household economy among the Philippines living in the outskirts of Kokondos. He found that various activities subsumed in household economy are spread across members and are not restricted to a particular set of people, as they are amenable to changes, but depend on the circumstances prevailing in the household. In his work, the circumstances are not clearly defined and this is probably because the method adopted in the study is quantitative. Likewise, he found that many household members are saddled with so much responsibility that undermines their ability to realise their potentials. However, he did not show the various cultural processes involved in terms of customs and beliefs that ordered the ascribed economic responsibilities which make it difficult for them to realise their economic potentials.

Hoddinott (1992) argues that the mode of economic activities that determine the level of equilibrium in the household is significant to welfare and overall well-being. He also argues that where there are deficiencies in terms of production and consumption, there is tendency for disequilibrium, a situation that has implication for individual welfare. The importance of household economy lies in its potential to enhance livelihood as well as improve the welfare of members in the household. The irony is that household economy is often at disequilibrium as a result of the complexities embedded in it as it does not benefit members of household in the same proportion (Ironmonger, 2007). The assertion of Ironmonger (2007) is not detailed enough; he is unable to highlight how and why some people derive more benefit than others. The effect of complexity in the household is evident in the assertion of Empey (2004) that the level of a member of a household's engagement, participation and contribution to household economy varies, and the variation usually generates contentions that accommodate unpalatable characters within the household. However,

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Empey (2004) fails to provide a detailed and full explanation of the process of role differentiation in terms of interaction and its implication for the welfare of members of household.

Scholars (Folbre, 1988; Fapounda, 1988; Sen, 1987) have put forward a model of analysis of household based on assumptions that household members bargain and negotiate. In these models, the question of power and ideology became prominent. The focus on power is a response to the recognition that the outcome of bargaining and negotiation between household members is a question of relative power. Focus on ideology is a response to the recognition that the bargaining power cannot be defined simply with reference to economic factors. Moreover, these scholars make a related equally significant point, namely that principles that guide decision making are not equivalent to the principle of economic rationality (Folbre, 1984; Fapounda, 1988; Sen, 1987). As pointed out earlier, they describe social mechanisms for resource allocation which are based on reciprocity or redistribution and therefore are quite distinct from market mechanism based on principles of economic rationality. In analysing the wider social system, anthropologists point out that social and cultural, not just economic principles, govern the social system as a whole and its constituent units. In response to the economic focus on rationality, anthropologists have highlighted the importance of non-market processes and non-economic principles on social system (Martian and Bethel, 1997).

Certain aspects of the literature (Ferrer, 2004; Doornick, 2006) on household economy fall within pure economic studies which place emphasis on production and consumption pattern, showing different risk management and coping strategies. In these studies, the cultural situated nature of people's engagements within the household economic realm has not been emphasised. This problem is probably, as a result of the dominance of quantitative research methods through the social sciences that is almost devoid of basic descriptive analysis. Hoddinott (1992) argues that it is often difficult to comprehend the contents and implications of complexities in the household if quantitatively studied. Unless the interactions among parties were qualitatively studied, the various nuances could not be easily expressed. Economic texts and research efforts have remained silent on cultural strategies adopted in household economy. In developing countries, the policies for economic development usually focus on household economy in urban areas with little attention to household economy in rural communities. When reference is made to rural and urban contexts,

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the problem is usually looked upon and tackled within the ambit of purely economic lens, while the socio-cultural dynamics involved are largely ignored (Doornik, 2006). Development projects, which are meant to improve the condition of the rural populace, are usually not yielding the desired result because the basic knowledge of economic interactions within the household seems to be almost obscured (Collins, 2004). There is the need to investigate the household culture and its relevance to various discourse associated with the political economy of everyday life within the household (Machlachlan, 1987).

The incidence of poverty in rural households is increasing daily, thus suggesting that there is a need to examine household economic activities in order to determine the effects of poverty on members' welfare (Kooremanm, 1997). Collins (2004) in this regard, asserts that the nature of macro-economy in the rural communities affects economic activities in the household and exacerbates poverty. Consequently, a large percentage of people in rural communities are living below poverty line (Human Development Report, 2012).The well-being of rural people has declined by as much as 8% between 2008 and 2009, with life expectancy at birth falling from 51.6% in 2008 to 43.1% in 2009 (UNDP, 2010). This has further impacted on the productivity of rural dwellers, making them economically insecure in the household.

In conclusion, judging from the above review of literatures on household economy, they all highlight the effects of various economic relationships in the household but do not show the cultural antecedents of such relationship and the effects on household members. Also, these studies do not highlight in detail the kind of cultural relationship subsumed in household economy as most of the studies are quantitatively analysed. How these relationships lead to increasing morbidity and mortality has not been given proper attention. Most of the studies pay little or no attention to cultural strategies adopted in household economy in rural communities. The studies have not indicated in detail the cultural forces that dictate and guide economic interactions and how they create insecurities that can increase morbidity and mortality in the household. These studies have not given adequate attention to the distinction between household economy in rural and urban areas, as most of their findings are narrowed. A lot of researches in this context adopt different approaches and methodological perspectives that lead to the generation of different findings.

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Existing studies in this area are yet to agree on the appropriate ways of modelling household economy in rural communities.

2.3 Health and Rural Healthcare

The issue of health has been a concern to individuals, governments and other institutions because of its importance to development. Scholars have defined health based on their orientations and disciplines. Health, according to World Health Organisation (WHO, 1978), is a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity. The explanation of WHO indicates that health is more than the absence of diseases; and that it also includes the psychosocial dimensions which necessitates that man must be in a state of homeostasis. The cultural understating of the concept varies across human societies and has both influenced and shaped health-seeking behaviours (Sharma, 2009). Scholars have described health as a relative term and they see it as culture bound (Annandale, 2000).Macintyre (1997) opines that cultural relativity of health have widened its scope, making it multifaceted. He argues that due to its multifaceted nature, conceptualising health has been very problematic and has influenced and affected various activities towards health care seeking. The understanding of health by individual, communities and governments has affected rural health care programmes (Orubuloye, 2003; Abduhameed and Ibraheem, 2012).

Rural healthcare system is one of the mechanisms designed to ensure and ascertain the health security of rural dwellers. The cultural sensitivity of individuals and government policy determines the healthcare system in rural communities (Abduhameed and Ibraheem, 2012). Individual pursuits of good health have further generated both objective and subjective actions that have implication for health security in a particular social setting. Similarly, the cultural forces in rural areas have affected individual orientations towards healthcare, as it influences and shapes health related actions (Iyalome, 2012). The influence of culture on health is indispensable, as great value is placed on the health of individuals in a socio-cultural milieu (Inyang, 1994; Humbley, 2004). In rural communities, the opportunities for expanded economic system are limited; and this makes them vulnerable to poverty correlates with implication for health security (Murphy, 1981). Though Murphy's (1981) assertion is factual, it does not highlight the cultural precedents to their vulnerability.

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In the review of the health of the rural populace, Berneji (1994) reveals a dichotomy between rural healthcare and urban healthcare. He highlights the inequalities in terms of welfare and notes that there are situations that expose the rural population to health inaccuracies, such as lack of adequate health facilities and inability to sustain western medical care. This assertion is also consistent with Omotosho's (2010) observation that, one of the major factors that compound the health of the rural people is lack of adequate access to qualitative healthcare. Omotosho's (2010) assertion is in tandem with Ajilowo's (2007) opinion that rural communities are marginalised in terms of healthcare systems-a condition that makes it difficult for them to have adequate and equitable access to healthcare. Less than a third of rural dwellers requiring medical attention actually receive treatment. Most rural dwellers have the tendency to delay or even avoid seeking health treatment altogether until their condition is very serious, mostly after all other resources have been tried (Omotosho, 2010; Lawton, 2013). The under-utilisation of healthcare services has negative impact on the health status of rural dwellers as morbidity and mortality rate increase daily in rural communities. The World Health Report (2008) highlights the fact that the performances of health system affect peoples' lives in terms of means of enhancing livelihood. Demographic Health Survey (2004) indicates that more than half of Nigerian populations are in critical health problems and a large number of them are in the rural communities. Similarly, the Federal Ministry of Health (2009) shows that 85 percent of Nigerians cannot afford proper healthcare and a good many of them are also in rural areas.

Poverty has been the main factor constraining rural dwellers' from the utilisation of healthcare facilities (Ajala, 2005; Olujimi, 2006), with 75% of Nigerians falling below poverty level (Obadan, 2001; Oni, 2006), a situation that has exposed a large population to health risks (Ajala, 2009). Magree (2002) also argues along the same line, stating that rural communities are most affected due to the nature of their local economy. This observation is in agreement with Ataguba's (2008) assertion to the effect that rural communities are significantly poorer than their urban counterparts. He argues further that the rural Nigeria is characterised by lack of irrigation facilities, shortage of farmland, early marriages and low education, all of which is seen as causes and consequences of poverty and with further implication for the health status of the rural populace. Also significant in this regard is Nwaiwu's (2004) expressed opinion that people in urban areas enjoy more healthcare facilities

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than their rural counterparts, and affordability constitutes a major challenge in the utilisation of these healthcare facilities.

Some scholars (Robert 2005; Fajemilehin 2006) have argued on the contrary by stating that the affordability and marginalisation of healthcare facilities in rural areas are not important among the factors affecting the accessibility and utilisation of healthcare facilities. They argue that though those factors are important, they do not wholly constitute hindrances to the utilisation of healthcare facilities and health insecurities in rural communities. They contend that even where few facilities exist, many people in rural communities find it difficult to utilise them. They opine that there are factors that interact with others to influence affordability and determine utilisation. They also argue that even where few facilities exist, some people could afford to use them but may be constrained due to some circumstances.

Iyalome (2012) notes the factors affecting the health of rural people feature as an interface between the rural people and the healthcare system. He contends that the problem of health insecurity in rural communities would continue to aggravate daily if appreciable measures are not taken to iron out those challenges. Rural healthcare has been a concern to government and non-governmental agencies, as health challenges confronting the rural people continue to be on the upswing despite several interventions.

Primary healthcare which constitutes the first level of contact between individuals, households and the community is linked to the national health system designed to bring healthcare as close as possible to where people live and work. This has been fraught with various logistic problems especially in rural communities, and most times, it defeats the purpose of constituting the first element in a continuing healthcare process (Adeyemo, 2005; Abiodun, 2010). Rural healthcare has not achieved an appreciable result in many rural communities due to the imbalance in the relationship among members of rural household, health related actions and the nature of government interventions (Mallenbaum, 2006).

Malenbaum (2006) in his study of healthcare in a rural community in Mexico opines that the government focused more on preventive and curative elements associated with biomedical and environmental correlates, and made the presence of government less visible in that community because little attention was given to cultural forces. This finding is also consistent with Nemet's (2009) assertion that healthcare intervention in rural communities focuses on prevention and control of

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locally endemic diseases, immunisation of children against major communicable diseases, family planning and health education, treatment for common diseases and injuries and the provision of drugs. Peter and Ayotunde (2007) also reveal that rural healthcare is focused more on the disease aspect of care which often yields lesser result. A health issue like disease is of vital importance, but it no longer defines the totality of health needs on the approach to health care, rather, it goes beyond the description of biological and environmental, and requires a more holistic understanding of health correlates (Odebiyi, 1977; Ogunmodede, 2004).

Marmot and Wilson (1999) and other scholars have provided extensive documents which involve a more comprehensive approach that covers other areas of health components beyond biomedical nosology. Many health problems have roots in institutions not currently amenable to medical solutions. Some of these root problems include unhappy homes, unemployment, poverty, child abuse and social alienation and many other complexes in rural societies (Jegede, 2002). This supports the argument that rural healthcare should be comprehensive and should go beyond biomedical and environmental concerns. Today, many individuals with those kinds of challenges are asking for help. This is probably what is responsible for the shift in the healthcare needs of the people with these ailments to local and public healthcare institutions. The non-biological nature of many of these problems and their roots in socioeconomic situations outside the classic concepts of diseases means that they cannot be solved within biomedical contexts (Katung, 2001; Jegede, 2002).

Prakash (1987) asserts that there are many factors in the household that predispose many to healthcare insecurity and the negligence of these probably affect success in health intervention. Scholars (Omoridion, 1993; Okafor, 1994) have suggested ways by which rural healthcare can be improved to yield desirable results. For instance, some of them have opined that holistic intervention should be integrated, and focus should be extended to socio-cultural dynamics within the household. The National Council on Internal Health (NCIH) held a path setting conference on health in 1991 with representatives from 74 countries. The conference provided a frame for the articulation for new agenda on a holistic view of health as a lifelong phenomenon affected by a variety of mediating factors (Vlassof, 1996). Vlassof opines that a holistic approach to health has not been adequately adopted and suggests that to better understand the various dimensions of health, it is necessary to use life span approach in holistic perspective, informed by many factors beyond the physical health.

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In spite of the various health interventions to improve the health status of the rural populace, there is still a high rate of morbidity and mortality, reflecting that much ground is yet to be covered on health. Interventionist programmes have not been effective or are misdirected in addressing the issue of health insecurity. Though considerable efforts have been made by government and non-governmental organisations to solve health problems, emphasis is on the biomedical aspects (Macintyre, 1997) with little attention to micro-economic forces. Odebiyi (1977) has called for a re-examination of the place of socio-cultural practices in health in Nigeria. Similarly, Scholars (Otite, 1994; Owumi, 1993; and Aregbeyen, 1992) have made persistent call for researchers in various areas of human health to invest their skills in the socio-cultural aspects of health. Despite the emphasis on the social aspect of health, there has been remarkably little attention paid to the role of social-economic factors at micro-level. Ewhrudjakor (2008) has argued that this is important in drawing out health implications through factors driving macro-economy by focusing “upstream” on what causes illnesses in the first place, instead of simply focusing on the grassroots in the households. Such a focus opens up the possibility of more surveillance of social factors contributing to poor health, so that those upstream interventions can be better monitored or targeted.

Most of these studies on health intervention in rural areas gave little or no attention to the socioeconomic dynamics within household. The failure to integrate the socioeconomic dynamics at the micro-level of the household in formulating policy in health intervention is a costly policy error that has contributed to the misfortunes in health intervention (Omoridion, 1993; Nwobuka, 2011), hence there is the need for the situation to be adequately studied empirically. In view of these, the review of health and rural healthcare becomes imperative in an attempt to provide an explanation for the gaps in health and rural healthcare. This would aid policy formulation on intervention in rural communities.

In conclusion, judging from the above review on health and rural healthcare, the following gaps were noticed. Most of these studies attributed the healthcare problem in rural communities to marginalisation and accessibility. There are other factors apart from marginalisation and accessibility affecting healthcare in rural communities as indicated in this study. The interface between household members and healthcare providers that form the basis of rural health were not explicitly highlighted. Most of these studies create awareness to the place of sociocultural

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dynamics, but they do not lay much emphasis on socioeconomic dynamics as a factor determining the patterns of the utilisation of healthcare resources in rural communities. Moreover, these studies that are quantitatively analysed are devoid of detailed descriptions of customs, values, and beliefs that dictate and guide the economic interaction which have strong influence in determining healthcare as shown in this study.

2.4 Health-Seeking Behaviour

Health-seeking behaviour refers to actions taken by an individual to prevent and/or cure an illness in a given social setting. Tipping and Sengall (1995) look at health-seeking behaviours generally, drawing out the factors which enable or prevent people from making health choices in either lifestyle behaviour or their use of medical care and treatment. They conclude that health-seeking behaviour varies for some individuals or communities when faced with the same illness. Health-seeking behaviour has been a topic of interest to both social and medical researchers who have been long interested in what facilitates the use of health services, and what makes people to behave differently in relation to their health. There has been a plethora of studies addressing particular aspects of this debate carried out in many different countries. Ting (2009) emphasises the fact that health-seeking behaviour is not evenly mentioned in widely used textbooks, a situation that perhaps reflects that many health-seeking behaviour studies are presented in a manner which delivers no effective route forward. This results in an unfortunate loss for medical practice and health system development programmes as proper understanding of health-seeking behaviour could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in different contexts (Ting, 2009).

A large number of factors determining health-seeking behaviour have been mentioned in the literature (Goldman, 2000; Franckel, 2008; Spheri, 2008). These factors include the following: the nature of illness, influence of relatives, socio-economic status and availability of healthcare facilities. The approaches of individuals to health-seeking determine the overall state of their health. In sub-Saharan Africa, 70% of those that are seeking health are often faced with one challenge or the other due to one of the above mentioned factors. Health-seeking behaviour is more problematic in rural areas compared to the urban counterparts due to some structural and economic deficiencies featured in most rural communities. In rural households,

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evidence shows that 65 percent are usually faced with health insecurity as a result of their inability to access and afford healthcare due to their socioeconomic positions (Burkey, 2011).

Health promotion programmes worldwide have long been premised on the idea that providing knowledge about causes of ill-health and health choices available will go a long way towards promoting change in individual behaviour, and will lead to better health-seeking behaviour. However, there is a growing recognition in both developed and developing countries about the need to provide education and knowledge at the individual level which are seen as not sufficient in themselves to promote a change in behaviour towards healthcare (Goldman, 2000). A plethora of studies on health-seeking behaviour have highlighted similar and unique factors that demonstrate the impact of complexity on an individual's behaviour at a given time and place. However, the studies focus almost exclusively on the individual as a purposive and decisive agent and there is a growing concern that factors promoting good health-seeking behaviours are not rooted solely in the individual, but also require a more dynamic and collective interaction among people in the household (Peter and Ayotunde, 2007).

Health-seeking behaviour is not just a one-off isolated event, it is part and parcel of a person's, a family's or community's identity, which is the result of an evolving mix of social, personal and experiential factors. There has so far been little synthesis of knowledge and understanding around the structural influence on health-seeking behaviour and conceptualising it as a social structure phenomenon rather than one that solely resides in an individual. Thus, what seems to be missing in much of the literature on health-seeking behaviour is a sense of how the process of seeking extends overtime, space and the health system in complex ways. This cannot be associated with something only intrinsic to the individual considering the social, economic or cultural circumstance (Uzochuwkwu, 2004). Williamson (2000) suggests that while health promotion places emphasis on individual behaviour, the lens needs to be broadened to other determinants of health, including policy directives, to enhance population health, reduce inequality and improve social justice.

There is now a growing attempt to foster community in local health system and to encourage better health-seeking behaviour and develop management structures. However, there are ideological and theoretical differences about the nature of participation abound, and there remains a lack of clarity over mechanisms for

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inclusion. There is the lack of a detailed comparative analysis of what form a civic organisation might take to have the greatest benefits for both the health of the system and the health of the individual. This results in various challenges in health intervention, especially in rural areas (Abduraheem and Oladipupo, 2012). The trend towards mobilising existing community resources in health promotion strategies makes the theoretical and the political sense and the reality of translating it into practice fraught with difficulties. This happens especially where existing community networks are structured around unequal and exploitative relations (Campbell and Mzaidume, 2001).

Campbell and Mzaidume (2001) believe that a developed country's research work has a better track record of exploring this broader context picture, while researches in developing countries failed to acknowledge the poor relationship between knowledge and health-seeking behaviours. These suggest we need to develop a more critical approach to our conceptualisation of health-seeking behaviour in developing countries where there are many socio-cultural traits embedded in their social structure that shape health-seeking behavior. Campbell and Mzaidume (2001) explore the neglected societal, normative and cultural contexts in which individual level phenomena such as knowledge, attitude and behaviours are negotiated or constructed. In their work on risk taking behaviour and sexuality among young South Africans, they criticise much previous works which focus on the individual level, utilising A KABP (knowledge-attitude-belief-practice) that assumes an individual behaviour is built upon rational decision making based on knowledge. This is as a result of different contextual nature of individual health related actions which have not acknowledged group influence on the individual.

Rahaman (2000) demonstrates that a woman's decision to attend a particular health care facility is the composite result of a personal need, social forces, the actions of healthcare providers, the location of services, the unofficial practice of doctors, and in some contexts, has very little to do with physical facilities at a particular service point. The complexity of such findings is rarely traced in detail, and is usually disaggregated, losing all sense of the actual reality and need to be subjected to empirical investigation for clarity.

There has been much description of the contextual nature of an individual's health-seeking behaviour in the literature. This wider perception of the importance of social context has not been explicitly acknowledged because of the dynamic nature of

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the society. Furthermore, while much emphasis is placed on cultural norms, social conventions and expectations, little has been done to translate this into a contextual picture of how the structural preconditions of the healthcare system reinforce or contribute to the related set of healthcare problems (Ahmed et al, 2000). Thus there is a growing acknowledgement that healthcare seeking behaviours and local knowledge need to be taken seriously in programmes and interventions to promote health in a variety of contexts (Price, 2001; Runganga, and Aggleton 2001). Thus, the provision of medical services alone in attempt to reduce health inequalities is inadequate (Ahmed et al, 2000). Clearly, any research interest in healthcare seeking behaviour focusing on end point utilisation, needs to address the complex nature of the process involved and take cognizance of the fact that the particular 'end point' uncovered may be multifaceted and not correspond to the proffered end points of service providers. It should, however, also extend to both individual and group interactional influence within a social context, in order to understand the interactional process involved in health-seeking (Manzor, 2009).

The interactional processes involved in health-seeking behaviours are not usually emphasised; only the factors involved are usually highlighted. The problems which health interventionists face were probably as a result of the above point stated. Nemet (2009) looks at various ways in which government attempts to seek better health for its citizenry, noting that circumstances surrounding individuals economically contribute a cog to the efficiency of overall healthcare. The issues of economic constraints were seen to be crucial but need to be linked with socio-dynamics that influence the individual and group healthcare seeking behaviours.

The literature reviewed demonstrates that many HSB studies provide quite mundane solutions for complex health problems and care seeking. Mundane solutions mostly presented in the form of reinforcement, for what is discovered to be unhealthy or inappropriate practice or beliefs. This is partly the result of using narrow research methods that provide little or no information about causation. There is usually the need to adopt broader perspectives which involve a holistic view of interactional factors that predispose an individual to a particular health action (Price, 2001).

In analysing health-seeking behaviour from the standpoint of the capability of individuals, households and community health system, it is essential to understand that expectations about the behaviour of others combine to shape the health behaviours of households and individuals (and vice-versa). This broader perspective

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on examining health-seeking behaviours, together with the use of multiple methods for data collection and analysis is more likely to capture the social and institutional dynamics. This includes the causation of health-seeking behaviour in various circumstances: will it be to design and implement effective programme that provides patients and their communities with the capability to appropriately access referred health services (Machiam, 2003).

It is evident that few health-seeking behaviour studies have been conducted in Nigeria, especially since 2005. Researches that were conducted focused largely on disease-specific conditions with narrow research questions. In the international literature as well, there is not a great deal of information on health-seeking behaviour in relation to the expectations and pressures of society on decision making. Large household surveys have been undertaken on the pattern of utilisation, but apart from identifying the exposures related to socioeconomic variables, such large household surveys do not demonstrate an understanding of the determinants of health-seeking behaviours (Shaikh, 2008).

By contrast, qualitative and mixed method approaches are more likely to capture both the prevalence of behaviours according to specific health conditions and the rationales for specific health-seeking behaviour pathways. With this understanding, it becomes not simply a mechanism for testing the validity of findings but, more importantly, it is a way to build a multidimensional understanding of reality that corresponds to the interacting influences of care seeking. Qualitative methods can then map out socio-cultural determinants of behavioural patterns and of provider choices to uncover perceptions of quality and provide an understanding of the impact of the values, beliefs and social conditions that shape patterns of decision making in communities (Victor, 2013).

In conclusion, judging from the above review of health-seeking behaviours, studies on health-seeking behaviour focus on the category of individuals with specific diseases and/or illnesses rather than generalising it. Also there is much emphasis on the individual, while the household interactional process was given less attention. Some of these studies that highlight the influence of household structures on health-seeking behaviours focus on the influence of relatives, socio-economic status, but fail to highlight the customs, values and beliefs that inform group influence on an individual. Also various strategies adopted in health-seeking were subjected to quantitative analysis that was devoid of ethnographic characteristics. In the

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consideration of these, this study extends its explanation of health-seeking beyond the individual, and extends it to both household and community levels in order to understand how community and household influence individual health-seeking behaviour.

2.5 Household and utilisation of healthcare resources

Studies on utilisation of healthcare resources generally use individual as the unit of analysis. Much of these works have taken their points of departure from Grossman's (1972) seminal work, in which he argues that the individual produces the commodity, "good health". This commodity is part of the individual's human capital and affects the total amount of time the individual can spend on productive activities. Even if Grossman's work provide the field of health economics with great input, it does not emphasise the fact that individuals are household members, and take much influence (willingly or not willingly) from other household members. However, it is very crucial to use household as the unit of analysis for healthcare studies.

Income is among the most significant factors in utilising healthcare resources. However, other factors such as age also influence utilisation since age reflects perceived benefit and income (Olujimi, 2006). Considering the above discussions on household economics, it is likely that the household composition may affect utilisation in terms of the number of adult females, males and children within the household. Moreover, not only the composition in itself but individual characteristics of household members, such as the head of household, may influence healthcare consumption. Since income is a strong determinant for healthcare utilisation, it is likely that the income of the head of household affects utilisation. The same applies to the education and the sex of the head of household, which also have significant impact on the utilisation of healthcare resource (Odunbunmi, 2012).

There have been a number of studies (Rashba, 2006; Walker, 2010) showing the relationship between household income and the utilisation of healthcare resources. However, all these have shown a relatively weak relationship, with studies on developing countries showing that the income elasticity is rather high ((Babatunde, 2008). Data from northern Nigeria shows that fees at clinics affected the poorer individuals' healthcare utilisation to a greater extent than it affected the richer individuals' (Nwobuka, 2011). Similar results were found in Kenya, where the utilisation of primary healthcare services by very poor individuals in Kenyanese

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communities was proved to be deterred by user fees to a greater extent than for the moderately poor individuals (Banti, 2013). These results correspond very well with a study undertaken in a rural area of Bangladesh, which shows a decline of 24.2 percent in attendance when user fees were introduced at government facilities (Lawton, 2013).

The way a household is structured places individuals at different strata, and this affects how resources are allocated among members. The system of resource allocation forms another part of an economic system within the household that puts risks on one's health security through the inability to adequately utilise healthcare resources (Edger, 2007). In the same vein, Pfeifer (2003) recognises that intra-household resource allocation pattern could be a critical determinant of health in the developing world. It also has links with cultural forces. In his argument, he asserts that some people, by virtue of their position, as well as patriarchal tradition, receive less household resources, compared with others. This makes them consequently prone to certain deficiencies that affect their healthcare seeking.

Utilisation of healthcare facilities is in practice very much influenced by the decisions of the provider, and physicians' advice. However, the first contact with a health system is taken by the individual and the expected access cost is probably the largest determinant of seeking care. Access cost is a combination of several factors such as, distance to health facilities, waiting time at the facility, out of pocket payments (that is, monetary costs) as well as time costs (Adesiji, 2012). Time costs include the time it takes to reach the facility, the waiting time and the time for consultation. Monetary costs include fees for services and travelling costs. In a health system with low fees or where no fees exists, that is before the healthcare reform in Nigeria, costs other than the directly financial ones were very important to take account of. Travel to the health facility can be measured either as time or distance and can be used to analyse accessibility to healthcare. In Nigeria, where a large number of households live in rural areas, distance to healthcare facilities must be expected to be a decisive factor for seeking healthcare or not. Costs of access are usually an important explanatory factor of differences in healthcare utilisation between different social groups in developing countries (Ibraheem and Oladipupo, 2012).

Studies based on developed countries commonly focus on annual income as a proxy for a household's economic situation. However, household consumption could be a better approximation of economic circumstances, including a household's long

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term and short-term ability to pay for healthcare (Katung, 2001; Burkey, 2011). This fact is even more important to consider in a developing country context, where annual income is often an inappropriate measure of economic circumstances due to, for example, subsistence farming. Nwobuka (2011) also finds household consumption to be the natural approximation of the household's economic circumstances in their analysis of decisions, which act as proximate determinants of individual health status. Bhattia (2001) uses household expenditure instead of income in their analysis of rural dwellers healthcare expenditure. In this study, they also use household expenditure as a proxy for economic circumstances. They also seek to determine if this has any significant effect on healthcare utilisation. However, they include income in the model, that is, cash income, and test whether cash income has any significant effect on healthcare expenditure.

Jacobson (1998) extends Grossman's model into a model in which the family is viewed as the producer of health. In this model, families have common preferences and her main conclusion is that not only the individual's own income, but the family's combined resources are used in the production of health. The family will not try to equalise health capital of different family members, but allocate the investments in health capital so that marginal benefits equals marginal net cost of health capital. It has long been recognised that individual members of a household affect the resource allocations within a household. The most obvious example would be that households with children allocate a larger share of the budget to food compared to households without children. A natural parallel to this would be that households with children also would allocate a larger share of the budget to health expenditure.

Harkness (1994), in his theoretical framework for analysing household production of health, highlights the relationship between household production and women's utilisation of healthcare facilities. He finds that women are, most times, more engaged in production activities within the household, a situation that makes them to have little or no time to properly utilise healthcare facilities. The study also shows that there is a significant relationship between women's productive endeavours and their health-seeking behaviour. Harkness (1994) also relies on quantitative methods which prevented him from explaining in detail how household production hampers women's utilisation of healthcare facilities but only justifies the significant level, devoid of full description of the relationship.

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Becker (2007), whose argument centres on a neutral level, asserts that division of labour constitutes one of the components of household economy through production. He also argues that the mode of exercising it within the household presents unequal relationship among members. Some members are saddled with much economic activities that are more stressful and time consuming which limit their time from seeking healthcare. Harmermesh (2007) reports that divorced women experience more labour stress in household economic events than other members of household, particularly negative events involving loss. When children are involved, additional strains might be associated with divorce. The custodial parent, usually the mother, assume many household financial and emotional responsibilities previously shared by two parents which would make it difficult to utilise health care resources. Harmermesh (2007) does not indicate in detail the cultural process involved and the extent to which it would impact on the health and utilisation of healthcare resources by the custodial parents.

Frankel and Lalou (2008) equally show in a study in the region of Fatick in Senegal, among 202 women with malaria-related fever that the uptake of healthcare is fundamentally a collective process which depends on the availability of resources at hand. The involvement of members of household in the healthcare of women followed different logics. Each caregiver had a specific and complimentary function depending on resources, gender norms, intergenerational relations and characteristics of family unit. Family management of illnesses aims at optimising financial and human resources, given the economic, logistical and several constraints on healthcare. Nevertheless, collective management also favours home-based care, prevents good treatments compliance and delays the resort to healthcare facilities.

Another study by Sepehri et al (2008) seeks the influence of family and community on the individual use of healthcare services in low income countries. Using Vietnam's latest national household survey data, Spheris et al. (2008) assesses the influence of individual-and- household-level factors on the use of healthcare services, while controlling for the unobserved household level effects. The estimates obtained from a multilevel logistical regression models suggest that the individual's likelihood of seeking treatment is jointly determined by the observed individual-and-household-level characteristics as well as the unobserved household-level effects. The chance of seeking medical treatment when ill varies strongly with the observed individual-and household-level covariates: health insurance status, income, the

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severity of an illness, the number of other household members with an ailment and the presence of young children in the household. The points mentioned by Sepheri et al. (2008) indicate that they focus more on structural variables with little or no consideration for cultural forces in terms of power relations and patriarchal consciousness involved in seeking healthcare.

Gjerdinger and Charloner (1994) investigate the changes in the division of household labour and in the emotional and practical support received by new mothers during the first postpartum year. Results show that the more women assumed primary responsibility of the majority of household tasks. Women perceived a decline in their husbands' participation in household chores. Their husbands' expression of caring, and in the frequency with which friends and relatives "helped out" during the year is relatively low. Results also indicate that it has a significant effect on the time they have to utilise healthcare facilities. Women who had caesarean sections (versus those with vaginal deliveries) and who returned to work (versus those who stayed at home) believed that their husbands participated more in traditionally feminine household chores. Results also show that women's satisfaction with their husbands' contribution to household activities was significantly related to their own mental health and subsequent efforts to seek healthcare. The work of Gjerdinger and Charloner (1994) was subjected to quantitative study, which only shows the significant relationship between household activities and health effects, but it is devoid of an in-depth description of the process involved in the relationship.

In conclusion, judging from the foregoing, a concise and well-coordinated link between the economy and healthcare has not been well established. Most of the studies reviewed emphasise on income as the main determinant of the utilisation of healthcare resources and pay little attention to the group influence as a determinant. It is also evident from the above discussions that cultural processes involved in the utilisation of healthcare resources in the household are given less attention. Most of these studies are gender-blind, focusing more on women and have primarily utilised quantitative approaches to posit the links between an economy and the utilisation of healthcare resources. The quantitative approach is devoid of ethnographic characteristics that could unravel the customs, values and beliefs associated with the utilisation of healthcare resources. Similarly, the social-cultural context in which a household economy affects the utilisation of healthcare resources has not been extensively highlighted. Thus, these studies do not tap the detail socioeconomics

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dynamics within the household and how it impacts on the utilisation of healthcare resources. All these form the gap which this study intends to highlight. It is imperative to determine the role of socio-economic dynamics and especially to understand the complex interactions among multiple factors involved in health insecurity and the channel of health-seeking. To explore these links, an in-depth ethnographic research employing qualitative methodologies is needed to explain the various customs, values and beliefs embedded in a household economy that affect the utilisation of healthcare resources. It is hoped that the essential data required for the advancement of knowledge, policy formulation and execution, would probably emerge. This is with a view to projecting the report as aiding policy that will assist the intervention programme on health promotion.

2.6 Theoretical Framework: the theory of political economy of health

The thesis is premised on the theory of political economy of health. The political economy of health states that the way an economy is structured affects health care. It is a theoretical framework used to study health inequalities. It also proposes that health disparities are determined by social structures and institutions that create, enforce, and perpetuate poverty and privilege. Rooted in (but not restricted to) classical Marxist historical materialism, political economists of health takes a critical historical approach to analysing the social production, distribution, and treatment of health and diseases (Parson, 1972; Kelman, 1975).They analyse the relationship between health status and political-economic institutions throughout the global economic trends, with particular emphasis on detrimental health effects created by the capitalist relations of production and sustained by specific political-economic arrangements. The political-economic approach focuses on the social determinants of disease etiology and health inequality rather than on individualistic, biological, geographical, cultural, or psychological explanations of ill-health. The political economy of health refers to a body of analysis and a perspective on health policy which seeks to understand the conditions which shape population health and health service development within the wider macro-economic and political context. However, the relationships between economic development and health development are complex and can be analysed in terms of a range of different linkages (assumptions) as follows:

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1. Economic growth leads to increased resources for health (improved living conditions and better health services).
2. Health contributes to economic growth (in particular, through improved labour productivity).
3. People's health is exchanged for economic growth (mining 'accidents', unhealthy environments) and the ‘disease burden' associated with these is the price of economic growth.
4. Stagnation and austerity damage health (for example, where unemployment, perhaps through the 'productivity overhang', leads to negative health outcomes).

The political economy of health is an interdisciplinary framework used by anthropologists, economists, geographers, political scientists, sociologists, and experts in medicine and public health. Political economy of health is a relatively new endeavour in medical social sciences. Research undertaken in the field is conceptual and theoretical, as well as empirical and applied. Political economists use a variety of methodologies, including epidemiological, ethnographic, and historical research. They are committed to community-based, participatory methodologies and to *praxis*, defined as putting theory into action. Political economists of health often put their skills at the service of labour organisations, libratory social justice movements, and community activists to develop strategies for health-enhancing social change. Despite the fact that the political economy of health may appear to be a new endeavour in the medical social sciences, its roots can be traced back to the publication of Engel's (1968) *The Condition of the Working Class in England* in 1844. In this classic account, Engels relates the features of the workplace and the environment that caused disability and early death among the British working class during the Industrial Revolution. He argues that high morbidity and mortality patterns in the working class ultimately resulted from the organisation of the productive relations of British capitalism and its accompanying social environment, which included poor housing, crowding, insufficient ventilation, chronic food shortage, excessive drinking, and the uneven distribution of medical practitioners.

Political economists of health traditionally begin their analyses with a focus on social class. Following the nineteenth-century, political theorists Karl Marx and Friedrich Engels, and other political economists argue that ill-health is often

determined by one's relationship to the means of production, with a fundamental division between workers and owners. They point out that the logic of capitalist accumulation provides little incentive for owners to invest in healthy environments, safe workplaces, supportive social services, affordable housing, or high-quality medical care for workers, if such investments will be subtracted from potential profits. Capitalism fosters disease by exploiting workers, minimising health-promoting investments, maximising short-term profits, and ignoring the long-term consequences on health and the environment. By promoting political institutions that support and enforce capitalist accumulation, the medical-industrial complex that grew up in the twentieth century has been able to shift the costs of disease to states and workers through mechanisms such as health financing, industry subsidies, and private medical care and insurance schemes. The discourses of biomedicine, meanwhile, obscure the origins of suffering and prevent people from understanding the sources of poverty and disease. The economic structures of capitalism, as well as the political and medical institutions that support and enforce them, are thus implicated in the social production and unequal distribution of diseases and medical care.

Kelman (1975) proposes a materialist view of health. This is based on the axiom "that human beings are the basis of both the forces of production (physical ingredients of production, such as labor, resources, and equipment) and the relations of production (division of labour, legal, property, and social institutions and practices) in any society. Therefore 'appropriate human organismic condition' (i.e., 'health') can only be understood in the concrete context of the particular mode of organisation of production and the dialectical relationship between the productive forces and relations." In this approach, a distinction is made between "functional health" and "experiential health." Following Parsons (1972), the former refers to the "state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialised." Conversely, the latter refers to the "freedom from illness, the capacity for human development and self-discovery, and the transcendence of alienating social circumstances" (Kelman, 1975). Under capitalism, functional health is a necessary ingredient at least, during periods of prosperity and expansion for the maintenance of an efficient labour force, whereas experiential health is subordinated to the productive process rather than an end in itself. Underlining the political economic perspective is the premise that the only authentic form of health is experiential health which can only be fully achieved under socialism, “a social system

in which the production system (capital accumulation) is subordinated to, though not independent on, the democratically determined process and direction of social development" (Kelman, 1975).

Ironically, the working classes in various developed nations benefitted, although not to nearly the same degree as the ruling classes, from imperialism, which in turn contributed to the underdevelopment of health in many Third World countries. Furthermore, the process of commodity production results in health hazards and stresses in the workplace, as well as damage to the surrounding natural environment and those who live in it. Also, many of the products that people are enculturated to consume may be dangerous to their health. While in a sense everyone in an industrial society is endangered by the production process, patterns of morbidity, mortality, and health services closely follow along class lines. Whereas the affluent may often choose to retreat physically from the more harmful effects of environmental deterioration or seek expensive healthcare to treat those complications that they contract, members of the working class generally have much less choice in such matters. Just as access to health care reflects the class structure of capitalist societies, the same can be said of the ownership, control, and operation of health institutions.

Political economists of health retain their attention to social class, for example, by criticising epidemiological surveillance systems that do not collect information about social class. But in response to these theoretical debates, political economists have broadened their investigations to include the health effects of stratification due to gender, race and ethnicity, national origin, religion, and sexual orientation. An overemphasis on the deleterious effects of capitalism, they acknowledge, has sometimes prevented them from appreciating the steps people take to protest, oppose, and overthrow harmful policies. This realisation has inspired many political economists of health to study health activism, resistance strategies, and emancipatory social movements.

The political economy of health is a subject which has been dropped and rediscovered several times since the mid-19th century. The most recent revival of interest in this area began in western Europe but was soon diffused to the United States (Waitzkin, 1978). Undoubtedly, one of the principal reasons that the political economic perspective struck a responsive chord among certain medical social scientists was related to a growing dissatisfaction with functionalism and the failure of

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many studies to place an analysis of health problems and the organisation of medical care in a larger societal context.

The theory of political economy of health is applied to this study because it captures the themes of the study. In application, the structure of household economy (norms, values and customs that guide household economic relationship) influences decision making and access to healthcare, and the utilisation of healthcare resources. There is high reliance on subsistence economy in rural Akoko communities that determine their mode of production. The mode of production in rural communities is peasantry because of the kinship connectivity. The kinship ideology in rural Akoko communities emphasises welfare creations which make economic responsibilities towards one's kinsmen obligatory, thus, placing the burden on one's time and finances which further has implication for one's capability to effectively utilise modern healthcare facilities.

Moreover, emphasis on subsistence production has resulted into poor economy in rural Akoko communities that affect their productivity, which makes their income low and subsequently influence the choice and utilisation of healthcare resources. Similarly, the low income has put a larger number of rural Akoko people live below poverty line. This situation further exposes large number of rural dwellers to health risk and healthcare challenges. The low income created by subsistence production complicates out-of-pocket expenditures. As the option of financial healthcare concentrates chiefly on out-of-pocket payment mechanism, many rural dwellers in Akoko households that lack access to the means of production equally lack access to quality healthcare.

Household economy in rural Akoko communities is a political and economic institution. It involves an arrangement which is similar to what Karl Marx called 'capitalist system', where there is an unequal economic relationship within a particular setting. The unequal economic relationship is exacerbated by the patriarchal system coupled with power relations, and creates economic disparities that have implication for health-related actions. This scenario is also applicable to rural Akoko communities, as the way household units are organised determines the nature of interaction. This is because power and privileges are not equally allocated. This has influenced the distribution of economic resources in the household. This made economic activities fraught with diverse challenges due to the system of organising household units. Some categories of people in the rural Akoko households are denied

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access to some economic resources due to some cultural forces such as patriarchy, power relations and a host of others. The effects of these cultural forces have been evident in the economic conditions of many rural Akoko dwellers that make them vulnerable to various incidences of poverty and healthcare challenges.

More than half of the rural Akoko people are in critical health problems and a good number of them cannot afford proper healthcare because they have no access to quality healthcare due to poor economy. Similarly, rural Akoko communities are relatively marginalised in terms of quality orthodox healthcare facilities. Few healthcare facilities available in rural Akoko communities are poorly utilised to promote the sustenance of healthcare services. These challenges have made the rural populace to seek healthcare in various forms, some of which have affected their health status. Some of these effects include increased rates of mortality of both children and adults and impaired productivity of able men and women in rural Akoko communities.

In many rural households, the patriarchal system determines power relations. Power relations in the household influence gender relations and determine decision making on gender allocation of resources to health needs. This further determines household prioritisation of healthcare needs among members. In addition to this, there are village taboos which affect the production and the consumption of economic resources which have implications on healthcare system. All these cultural forces make rural dwellers economically insecure in the households and impact on their capability to seek quality healthcare. Emanating from the above are the following assumptions.

2.7 Study Assumptions

(1) Household economy is characterised by cultural forces that shape and influence health-seeking behaviours in rural Akoko communities.

(11) Some customs, values and beliefs militate against economic relationship in the households and impact on health-seeking behaviours.

(111) Choice and utilisation of healthcare resources are most determined by the combination of both subjective and objective economic actions.

(1V) Empirical data on health-seeking behaviours in rural Akoko communities would aid policy formulation for health intervention.

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CHAPTER THREE

ETHNOGRAPHY AND GEOGRAPHY OF AKOKO COMMUNITY

3.1 Location, geography and vegetation

Akoko is situated in the northeastern part of Ondo State, Nigeria. Nigeria has 36 states, with the federal capital territory in Abuja. Ondo State is one of the 36 states. Figure 3.1.1 below is a map of Nigeria showing the location of Ondo State. Akoko is on located on upland elevation with a hilly settlement, shares its northern and eastern boundaries with Kogi and Edo states respectively and western boundaries with Ekiti State. Akoko is the largest community in Ondo state with 17km wide and 35km long. Akoko lies on the latitudinal range of between $7^{0}46^{n}$ and $7^{0}52^{n}$ and on the longitudinal range between $3^{0}85^{n}$ and $3^{0}89^{n}$ to the north of Kogi. Akoko as a whole, because of its latitudinal location, enjoys the characteristics of West African Monsoonal climate, marked by a distinct seasonal shift. Akoko is under the influence of the moist maritime south west monsoon winds which blow inland from the Atlantic Ocean. There is a lengthy rainy season. The dry season occurs from November to February when the dry dust laden winds blow from the Sahara Desert. The annual temperature in this area ranges from an average minimum of 21.3^{0}C to an average maximum of 31.2^{0}C. The average monthly relative humidity reaches its minimum in February and its maximum in August.

Akoko community is made up of a collection of towns. The population is estimated to be approximately 509,113 but this number is continually being adjusted due to the high levels of in and out migration for work abroad. Two-thirds of the populations live in the rural areas of Akoko community. The largest town is Ikare-Akoko. Akoko takes a large percentage of the local governments in Ondo State. Out of the present 18 Local Government Councils, it takes four local government areas (LGAs), namely Akoko North-west, Akoko North-East, Akoko South-West, Akoko South-East. Akoko comprises about 40 towns, predominantly situated in the rocky areas of Ondo State. Nevertheless, the rocky terrain may have helped the region to become a melting pot of sorts with different cultures coming from the northern, eastern and southern Yoruba towns and beyond. Akoko became one of the few Yoruba clans with no distinctive local dialect of their own. Figure 3.1.2 below shows the map of Ondo State indicating the location of Akoko.

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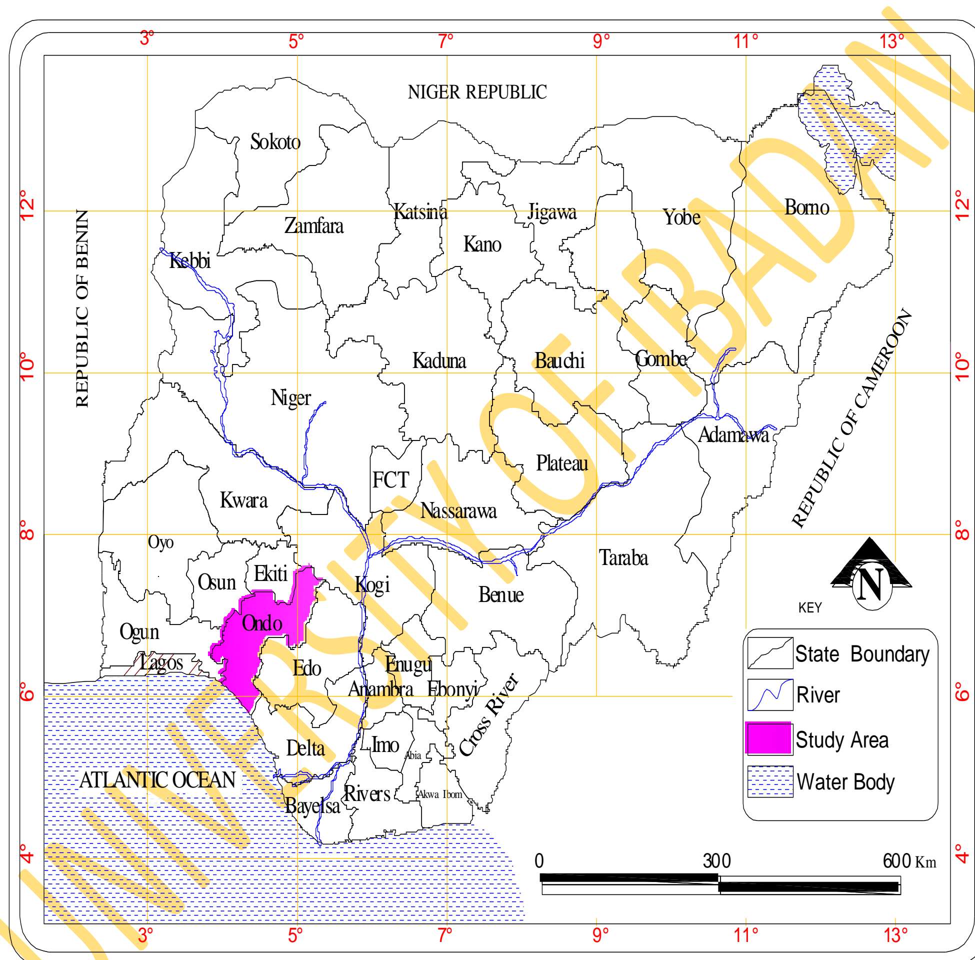
Figure 3.1.1 Map of Nigeria showing the location of Ondo State



Source: Ondo State Ministry of Works and Environment

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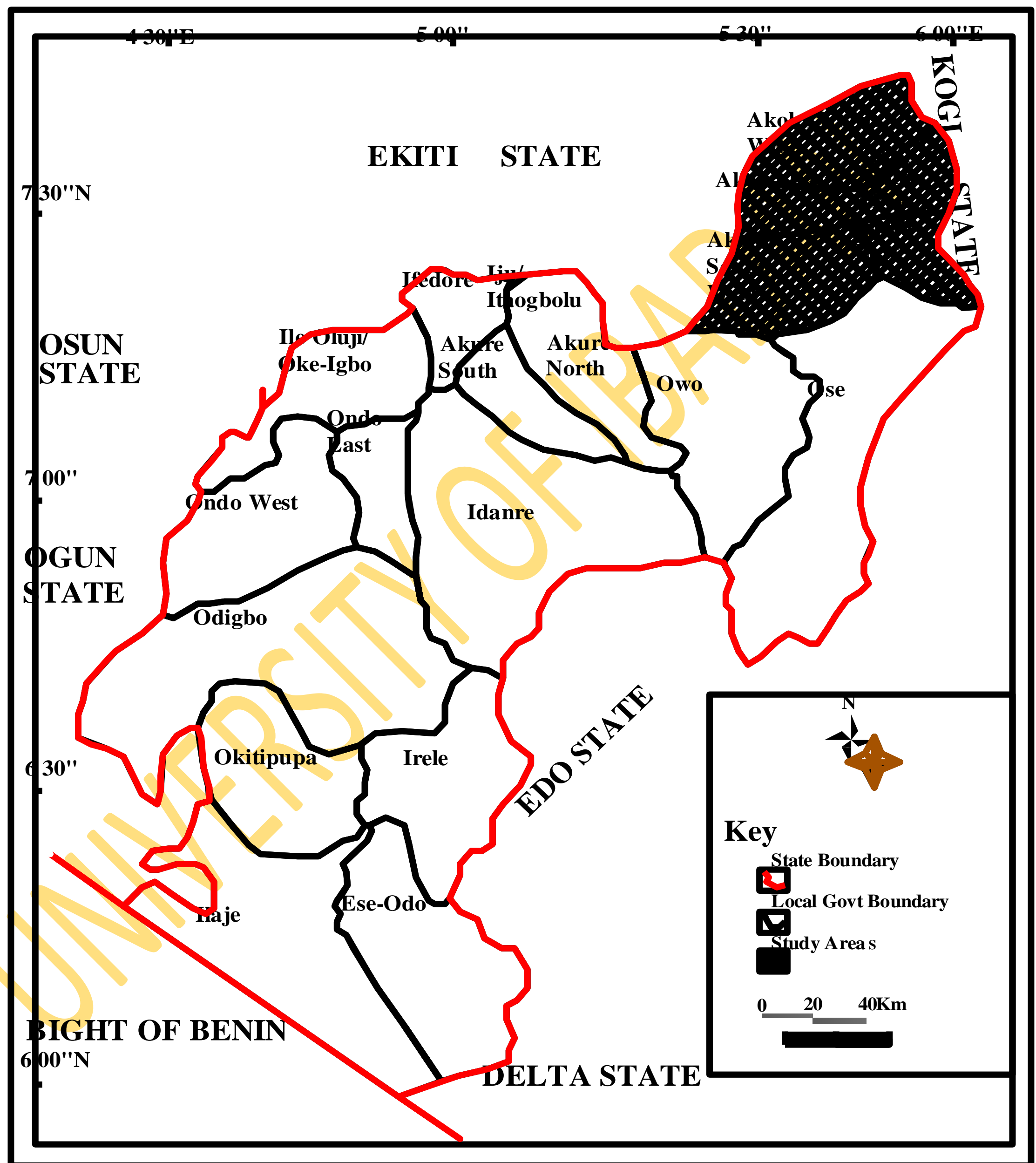
Figure 3.1.2 Map of Ondo State showing Akoko (study area)



Source: Ondo State Ministry of Works and Environment

Being a frontier zone, Akoko is a meeting place for all the ethnic groups across the borders. The word "Akoko" is derived from the phrase "Akoko-tun-ko" meaning "a gathering together of the various groups, which eventually becomes a whole". Those who came through Ekiti settled at Irun, Ogbagi, Ese, Afin, Ikare, Ugbe, Iboropa, Akungba, Oka, and Supare. Those who came through Owo settled at Oba, Ikun, Ifira, and Ipesi. The Bini Group settled at Isua, Ipe, Epinmi, Sosan, Ikakumo and Ise. The Kabba group settled in the northern areas of Akoko land closest to Kabba area. The people's affinities, language and legends, suggest that the inhabitants who make up the components of Akoko belong to five main groups. Each group bears similarities with its neighbours. Thus, the Akoko groups are identified as Bini-Akokos, Owo-Akokos, Ekiti-Akokos, Akoko-Kukurukus and Kabba-Akokos. The inhabitants migrated through different routes where they contacted different cultures and languages, and finally settled in their present location, which is topographically hilly, with attractive sceneries.

Akoko community is situated within the vegetational zone of the highland tropical rainforest which has recently been turned to a secondary rainforest due to human activities such as farming and construction of houses which involve felling of trees. The vegetation is now more open with few rainforests, which scatter around the community. The flora in this area is predominantly *Chromoleana oderatum*, which is commonly used as medicinal herb. Scattered among these weeds are trees such as *Milicia excels*, *Elaeis guineensis* and *New bouldia laevis*.

The fauna in this ecological zone include insects such as termites, butterflies and grasshoppers; invertebrates such as millipedes, earthworms and snails; amphibians such as toads; reptiles such as snakes and lizards; birds, and rodents such as rats and grasscutters. The hills in Akoko are thickly wooded, and the plains are of savannah and pasturable vegetations. The area is also blessed with numerous springs. The hilly areas in Akoko served as places of refuge in the ancient days of inter-tribal wars and slavery, as well as a colonial district, which was most suitable for agriculture and animal husbandry. All these were of great advantage to Akoko's local economy and population growth. Unfortunately, as the population keeps increasing, there are limited available lands for both individuals and the household for agricultural activities. Akoko people build houses on the hilltops when there is shortage of low lands. They cultivate and plant crops on the hilly environment. Similarly, pasturing activities are also taking place in the hilltops. The figure 3.1.3 below shows a hilly

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environment, with thickly wooded area for pasturable activities and where some houses were also built for residential purposes.

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Figure 3.1.3 showing hilly and thick wooded area

Source: fieldwork in Akoko

3.2 Akoko in Yoruba society

Between 1700 and 1900, the entire Yoruba land was embroiled in revolutionary wars. There were large-scale disorders and population displacements. The Egbas, Owus, Ijebus, Ibadans were involved in a series of fratricidal wars. The situation was further compounded by the Fulani invasion in the southern part of the Yoruba land. The Fulani overran most of the principal towns and a large number of those displaced took refuge in Ife area, particularly in Moro, Edunabo, Yakoyo, Ipetumodu, and Modakeke. It was a period of anarchy when might was right. The revolution was spreading to the northern part of the Yoruba land. It was such a situation that sent jitters throughout Ijesha and Ekiti land. There was a sense of insecurity among the inhabitants of the ancient of Akoko settlement as a result of which, they relocated to the hilltop. However, rather than desiring the abundant land below the hills, they opted for the landless of the hills.

Oral tradition claims that early settlers in this area migrated from Ile-Ife. They were mostly hunters, though some of them had superior knowledge of farming and blacksmithing. The date of their arrival in Akoko is not yet certain. They most likely left Ile-Ife, their original and legendary home at different times and migrated by different routes where they imbibed different cultures and languages, and finally settled in this area which is topographically hilly and of attractive sceneries. It was suggested to be hundreds of years ago, though not all of them came to settle at the same time or by the same route. Akoko migrated from different routes to their present site; they cooperated to form a united community. Like many other Yoruba communities claim, Akoko people (though migrated from different routes to present site) also trace their descendants to the Yoruba progenitor, *Oduduwa*, who was credited with the establishment of Ile-Ife as the cradle of Yoruba civilisation. Nevertheless rightly speaking, this is likely responsible for their multi-lingual peculiarities. Akoko land appears to be a meeting place of different Nigerian tribes who peacefully fused together in brotherhood.

However, it is significant to note that despite the differential and confederate nature of their composition and set-up, Akoko people never waged war among themselves, but they lived together peacefully on their hill-tops which were natural places of refuge and base for common purposes of self-defence in the days of intertribal wars. In fact, the nature of Akoko topography confirms the history that Akoko hills apparently cluster together and are blessed with springs which were

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peculiarly covered with forests in the ancient days. The area thus served as a convenient district for refuge, victuals and relaxation where eminent clans vied to settle in their emigrations from their original homes in Ile-Ife and elsewhere. Meanwhile, all the quarters and sub-quarters situated on the top of the hills had moved down and those hidden in the bush had come to the open. This happened throughout Akokoland at the end of the inter-tribal wars. When the white men came, *Ikare* had just moved down from *Oke Eporo* (Ebisa Hills) unto the central area. Ikare became the obvious choice of the site for the colonial administrative office. A dispensary was built at Ikare, where a travelling doctor from Owo attended to patients once or twice a month.

3.3 The people of Akoko

Akoko people lived a communal life and are intensely religious. Religion features prominently in almost all the spheres of their activities. The religion in Akoko before Nupe domination was purely heathenism. It was through the influence of the Nupe rule that Islam spread to some places, especially Arigidi which was virtually influenced and dominated by a mixture of Ilorin and Nupe people who exercised government administration over Akoko area at that time. However nowadays, Islam, African Traditional Religion, and Christianity dominate Akoko religion. Akoko people are very resourceful, hardworking, sociable and accommodating. They accommodate other ethnic groups, and the other ethnic groups include Ibos, Hausas, Ghanians and Fulani. Fulani settlements were found in different locations in the community. These settlements usually have between 10 and 25 people in each of the bands. The bands have close contact and relate with one another. Tribal mark is not common among the Akoko people, but some families do give facial tribal marks to indicate awareness of certain conditions of life. The practice is however fast diminishing among the younger generation.

Their dressing is a typical Yoruba traditional attire of flowing garment, *Agbada* with an underwear called *Danski* or *Buba* worn over *Sokoto* (the local pairs of trousers) with *Fila* (cap) to match. Occasionally, common among the elders is the use of walking-stick called *Opa*. The local chiefs (males and females) wear necklaces made of beads as regalia of the office- *Akun*. Women on the other hand, dress in wrapper called *Iro* with headgear- *Gele* to match, and a broad cloth usually placed around the shoulder. This is referred to as *Iborun*. Although many young people tend

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to wear different types of dressing that of the Yoruba pattern is still acknowledged. However, traditional dresses still remain the most valuable in the society, especially for important occasions like marriage, naming and funeral ceremonies. Children use similar attires which are tailored to their sizes.

The houses were constructed with mud and concrete blocks. Other materials such as ropes, woods, bamboos and palm fronds were used for the construction of houses, and are obtained from the surrounding bushes. The houses were constructed according to the size of the family as well as the status of the owner. Akoko land occupies the western forestry region of Nigeria. This provides opportunity for the growth of arable crops and cash crops as previously indicated. The people convert arable crops such as yams, maize, cassava, plantain, cocoa-yam, beans e.t.c. to various staple foods such as pounded yam (*iyan*), pap (*eko*), yam or cassava flour (*elubo*) for *amala*, and beans for beans cake (*moinmoin*) or (*akara*). The environment similarly provides opportunity for the growth of vegetables such as okro, pepper, tomatoes, *ewedu*, and many species of leafy vegetables. From all these staple foods, *iyan, eba, amala, fufu*, *eko* (both in solid and liquid forms) are common foods especially in the traditional family setting. These common foods are taken with any type of desired soup. Sometimes among the farmers, their protein is derived from the bush meat occasionally trapped or hunted for. To meet regular supply of the bush meat, they usually engage in-group hunting.

Food allocation does not exist in a vacuum. The ways that food is prepared, served and consumed are culturally patterned. There is a predictable tempo and form that characterises the "culture of eating" in Akoko and it cuts across time, households, and individual personalities. This shared structure does not mean that eating is static or rigid, however. Each meal has its own dynamic and mood depending on, for example, the number and relations of those present, the disposition and the appetite of the cook, diners, the degree of fatigue, weather conditions and time of the day. Meals are cooked and consumed at times near the kitchen; although young children may eat outside if the weather is pleasant. Women do most of the cooking but are helped by their children who prepare the food items, wash dishes, and run errands. The women head-of-households always serves the meal, unless she is absent or confined to bed.

Their ways of life in terms of what they use and their health behaviours have significant influence on their health. For example, accessibility to food in terms of requirements for labour in the farm influences the family size, which in turn

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influences fertility and the number of people a family setting caters for. Similarly, the mode of dressing protects them against excessive cold. The abundant fauna and flora in their location also provides sufficient herbs for therapy, with arable crops making for balanced diet.

Nature is very unfair to Akoko. Apart from the inadequacy of land, half of Akoko land mass is rock. For many generations that Akoko people were confined to the hilltop, their economy was hundred percent dependent on agriculture, having to be content with the little arable parts of the rocky hilltop and the immediate surroundings of the hills. The main occupation of the Akoko people is farming; more than 80 percent of them are farmers. Land is the most important requirement for farming, and the total land area of Akoko is less than 50 percent of what farmers require. Half of Akoko land areas are made up of rocks and mountains. The valleys, chasms and the arable part of the land can hardly suffice for 30 percent of the population. Hence, there is the popular saying "Akoko a yeye ma ri le ko" meaning, Akoko is well populated with insufficient land to cultivate. The most important cash crop, which is the mainstay of the economy, is cocoa. Unfortunately, cocoa cannot grow on Akoko land, because it requires rich soil, extensive and intensive cultivation. For these reasons, Akoko farmers have gone far and wide to cultivate cocoa plantations. They often suffer untold hardships from some shylocks and the ruthless landowners who usually dispossess them of their farms. A relatively large number of Akoko people are teachers and government workers who work on full-time bases. However, artisans such as carpenters, masons, mechanics, traders, transporters work as part-time farmers.

3.4 Languages in Akoko

The essential function language plays in Akoko community is that of communication. Although human communication in Akoko is not limited to spoken language, such language is of overriding importance, because, it is the primary vehicle through which culture is shared and transmitted. Language is a unifying factor in Akoko community and it is a means in which they communicate and order their experience. Without language, the transmission of complex traditions would be virtually impossible, and each person would be trapped within his or her own world of private sensations. The language of Akoko people plays a greater role in explaining their identity. The most striking feature of Akoko community is the existence of large

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number of towns, all of which are autonomous and independent of one another. Akoko is unique for its diversity of language. Each of these groups speaks different sub-dialect of Akoko language. Nevertheless, a unifying factor amid this multiplicity of dialects is the use of Yoruba-Oyo as the standard Yoruba language which remains the lingua franca of Yoruba in Nigeria. It is this complex traditional background that informed the outsiders' assertion that Akoko land is a meeting place of different intrepid original Yoruba clans.

As stated above, each town speaks a unique dialect. Within the towns in Akoko area, there are different towns that understand the dialects of one another. The people of Oyin, Arigidi, Erushu, Afa and Igashi towns speak the same dialect; the people of Oka, Ishua, Ifira, Shosan and most villages in the present Akoko south speak the same dialect and the people of Eriti, Afin, Irun, Iro, and Eshe speak the same dialect with Ekiti. Akoko people claim to have come from Ife in the 19th century but they are probably influenced by their closest neighbours (such as Ekiti, Owo, and Edo) as seen from similarities in their dialects or languages and cultural affinity.

3.5 Family system and kinship structure

In Akoko, a family consists of, mainly parents and children forming a social and economic unit. A family in Akoko is made up of the husband, wife and children. Two or more families form a kin group and trace their descent through known links in the male line from a common ancestor. This makes Akoko a patrilineal society which features male dominance and leadership. In a patrilineal society such as Akoko, women lack right to inheritance. The husband is usually regarded as the head of the family. He takes care of his wife and the children. He is the decision maker for the family with little or no objection from the wife.

As a patriarchal society, Akoko communities are stratified and this influences how a household is structured and how resources are distributed among members of families, as well as households. They are organised in households to form socioeconomic unit in order to provide economic support for each other. They organise themselves into a community characterised by extended family arranged in households. The extended family members form the basis of social support. Like other Yoruba groups, whose descent is traced mainly through the male line, priorities

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are given to males when allocating economic resources in the family. This is indeed, the cornerstone of the Akoko kinship structure.

The residential units are in compounds, as members of a patrilineage live in a compound completely demarcated into discrete areas. Each compound could accommodate between one and ten families. Housing within the areas varies but it is typically constructed of mud and bricks, and roofed with corrugated iron sheets as earlier indicated. It is obvious therefore, that the founder of every lineage was a male member of the society. In each patrilineage compound, every newly married male brings his wife or wives to join the lineage. Usually in every patrilineage, male members play prominent roles. Women's status in such settings is generally lower than that of men who adjudicate cases, and decide on issues relating to the lineage. To some extent, gender inequality is inherent in Akoko social organisation but to a larger extent it is characterised by bias against women. Allocations of economic resources are genderised in Akoko, and are backed up by customs, beliefs and values. This practice is very prominent in rural communities of Akoko. Even within the rural communities of Akoko, there is the evidence that food allocation is related to local gender stratification.

Polygamous marriage is commonly practiced among the people. Until recently, polygamy was the system of marriage. The Christians introduced monogamy according to the biblical injunction. Among the Yorubas, polygamy was regarded as a desideratum for the following reason: it regulates the number of women per men and ensures that there are no surplus women in the society. Since women are numerically more than men, polygamy absorbs surplus women that will result if monogamy was practiced by men. Creation expects every man and woman to marry. Polygamy enables a man to satisfy his nature provided he is capable of maintaining them. He is forbidden from committing adultery with other women not his own. Traditionally, a man's social status is determined by the number of wives he possesses. The responsibility of the family is borne by the husband who provides not only shelter and food but also all the needs of the wives and children.

Upon marriage, the right of ownership is absolutely transferred to the husband who might have fulfilled all marital regulations. It legitimises the husband's access to sleep with his wife without any objection, and as such, the husband should claim the fatherhood of the children raised from such intercourse. Usually, a wife does not own

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any property outside the husband. The wife is completely dependent on her husband. It is unusual for a man to live in a wife's family home. Polygamy enables a man to have many children. Barrenness also leads a man to marry other wives in Akoko. The inadequacy of a woman at times often leads her husband to take another wife.

Family size in terms of the number of women married to and the children is an indication of social status for the husbands. However, as a result of the spread of western education, Christianity and the poor state of the economy, monogamous marriage is also on the increase. Marriage is usually inter-ethnic especially among the traditional people who marry within their towns or villages. There are modern cases of inter-ethnic marriages, which feature marriages contracted from other ethnic groups. A couple may be joined together in wedlock when the parents of both the bride and groom have given their consent. This will involve a period of betrothal and courtship during which gifts and dowries are being presented to the bride's parents. When a man has gained the consent of the girl he wants to marry, he makes a token presentation to the girl. He then informs his own parents who may make investigations. If the match is considered favorable, representative of the groom's family will pay a goodwill visit to the parents of the bride. The customary gifts at these visits are kolanuts and palm-wine. If these were accepted, it signifies the consent of the bride's parents. From thenceforth, the groom and his parents are expected to show deep interest in the affairs of the bride and her family.

Long ago, it was the duty of parents to find wives for their children. The father would select a family of his choice. If he noticed any girl in the family, he would begin to pay attention to the girl and show kindness to the girl and her mother. He would give unsolicited assistance to the father on his farm and supply firewood and food items to the mother. The acceptance of such favours signified that the girl's parents were well-disposed to a future proposal (if the girl could be persuaded to marry the boy on whose behalf the parents were showing interest). If the girl was well under-age, the courtship would go on for many years. Throughout the years of courtship, the parents would not accept any other proposal. They would prevail on their daughter not to show interest in other people. Thus there is the saying in Yoruba: 'A ki mo oko omo ka tun mo ale re' meaning, it is not proper to know the husband of our daughter and at the same time know her concubine.

During courtship, a day would be fixed for the wedding. The groom would have completed the payment of the bride price, and kola nut, wine, and orogbo e.t.c.

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would be presented before the day was fixed. On the day of the wedding, the bride would be escorted by the wives of the family member accompanied with music and dancing. This usually took place between 7p.m and 8p.m. The wives of the groom's family would be waiting at the entrance of the family compound to perform the ceremonial washing of the feet of the new wife. The bride (*iyawo*) would be carried in to the bedroom of the senior wife (*Iyale*). This act of carrying the bride was the 'igbeyawo'.

In the olden days, chastity was not taken for granted. It was a tragedy for a bride who had lost her virginity. She was always open to disgrace. If a bride was found to be a virgin on the night of marriage, a keg of wine and a white fowl would be sent to her parents on the second day. It was a great rejoicing for the bride's family. The father would invite friends and relatives to share his joy. The bride would become a priceless treasure. She would remain indoor for weeks being attended to by maidens (*Olubajoko*) chosen to serve her. This was the period of *obotun*. In the case of a bride who had lost her virginity nothing, or a keg of wine, half full, would be sent to the parents. The following morning, she would be expected to fetch water and cook just like the other wives.

Maids who had intended to serve her would be sent home the following morning. If before marriage, a girl was suspected to have lost her virginity, she would be sent to her husband without the usual fanfare. Today, this virtue no longer exists. Teenage pregnancies and abortions have rendered virginity test irrelevant. The pride of the chaste bride and the inestimable joy and lasting satisfaction of her groom are irretrievably lost. When a bride has lost her virtue, if the groom was the cause, he will have to present the keg of wine in order to remove the stigma of the bride. The wife does not call the husband by name. She chooses pet names for other members of the family. She is forever dedicated to her husband who is invariable a polygamist. Among these people, marriage is relatively stable. Although in some cases, divorce is allowed. In this case, either of the couples could initiate divorce suit on the grounds of infertility, maltreatment, loss of adequate care and so on. Customary courts are vested with the determination of marriage suits. The courts can award damages against the husband in most cases. In an exceptional case, a woman can inherit her father's property with conditions. She cannot inherit her husband's property but she can be inherited by the husband's relative who is bound to care for her and her children. When a woman divorces her husband, she is required to return her bride price. When

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a man divorces his wife neither party is expected to pay any compensation, unless any claim is ordered by the court. A woman forfeits any property jointly acquired with the husband after divorce. If a woman survives her husband, she is expected to observe a mandatory period of mourning. A widower is also expected to observe a reasonable period before taking another wife. An impropriety in either case is condemned.

3.6 Economic system

The economic system in Akoko is mainly based on subsistence economy than market economy. The mode of production in Akoko community is peasantry because of the kinship connectivity. Emphasis on subsistence production has implicated on their productivity capacity which further attracts low income. This makes a large number of people in Akoko community to live below poverty line. Akoko people are largely farmers. Their major crops include cash crops like cocoa, kolanut, and plantain, while their food crops include cassava, yam, cocoyam, maize and vegetables. All these are still very common in dissident forestry portions of Akoko community. Farmers are found in both towns and villages in Akoko. The town farmers go to villages where their farms are located in the morning, only to return to their towns in the evening. Village farmers on the other hand, stay permanently in the village, only to go to town occasionally on Fridays, Sundays, and during any other festivals as previously indicated.

Akoko is an agrarian community that relies on subsistence production due to its topography. Each household cultivates a number of plots scattering over the mountainous landscape. The total area of land used for farming each year is fragmented and small, less than one-half hectare on the average. Figure 3.6.1 below shows an example of a mountainous area where some agricultural activities are taking place. They employ the use of local agricultural implements, which require much physical exertion. In addition, rural communities in Akoko lack the economic power to revitalise their subsistence resources such as land and tools, thereby putting considerable pressure on their health, especially the adult men and women who form the bulk of the labour force. The use of local agricultural implements often results in the poor productive performance of the rural Akoko communities as reflected in the declining agricultural production and local manufacturing. As a result of this, economic resources are limited, a situation that leads to intense competition among household members.

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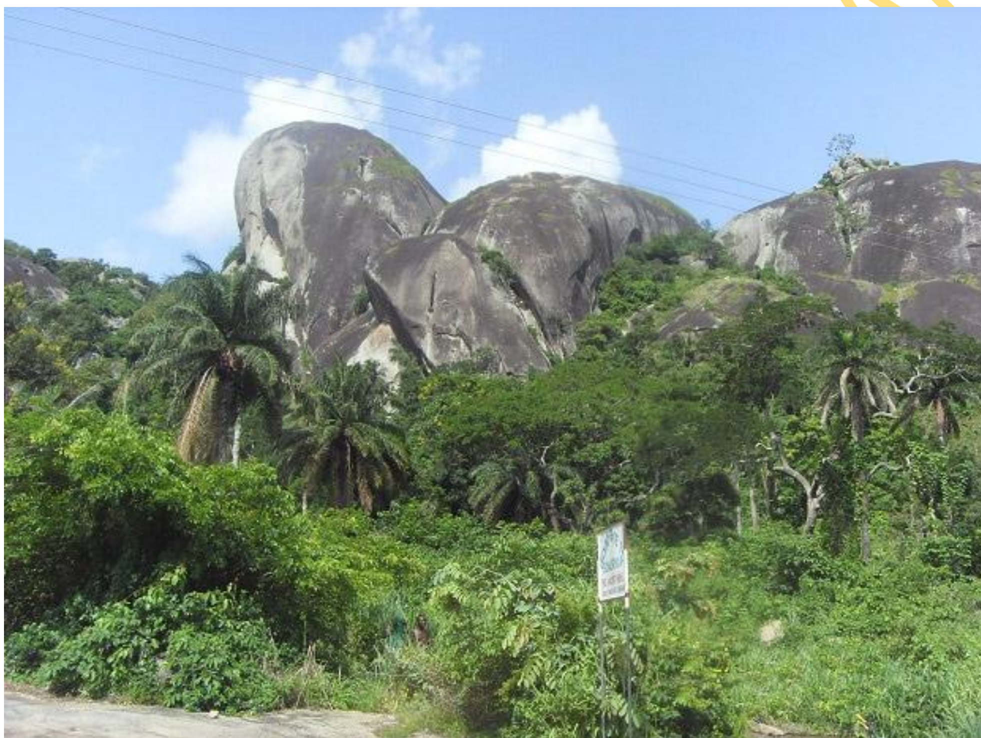
Figure 3.6.1 showing mountainous and hilly areas



Source: Fieldwork in Akoko

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Besides farming, there are also a good number of professional craftsmen, as well as traders, engaging in different economic activities to ensure the means of livelihood within the household. They engage in pottery, basket weaving, palm wine tapping, and much other modern artisanship. The products from these activities are locally consumed and the surplus is usually taken to the market for sale on market days.

As the population of household begins to increase more than the available resources, the sharing of resources within the household becomes complex as competition over household resources increases due to increase in fertility rate. Hence, the complexity within the household begins to feature unbalance relationship that breeds conflicts, chaos and upheavals among members of household. This may explain why the society is stratified to cope with the situation. The effect of this on a household unit in Akoko is that many members of the household are deprived of the needed resources. Mostly affected are women and girl children. This is why women are more economically insecure in the household in Akoko community. In Akoko, there are relatively large numbers of government workers, who are civil servants. In Akoko rural communities, such categories of workers are few and mostly limited to teachers and health workers. Some farmers combine this artisanship with farming. The average income of the majority of the people is approximately ₦7,000.00 per annum, which is ridiculously low especially in the villages. In the town, the average income level is a bit higher than that of the villages. Incomes are generated from the sales of farm produce, petty trading and handicrafts. However, the low level of income does not deter the practice of polygamy.

Women are subordinate to their husbands, and they do not possess economic independence. They lack access to land and their sources of labour are in their husbands' farms. They usually engage in the frying of *gari*, cracking of palm nut, palm oil processing, traditional soap-making and retailing of farm products, especially in the villages. In the towns like Ikare, Akungba and Oka, there are relatively large numbers of women who engage in office work and in large scale retailing. Women do not have absolute control on their income because they are liable to their husbands. Even when family health is threatened, they always wait for the husbands to release money. Only very few women, especially those in the monogamous families use parts of their incomes to assist their husbands, especially in family health and in their children's schooling.

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Husbands make decisions for the family, regardless of the economic prosperity of a woman. Women regard and submit to the authority of their husbands. Each of the towns and villages in Akoko has traditional markets where goods and services are traded. Marketing activities feature people from far distance, especially from neighbouring communities to buy and sell. The market is usually held at five days interval except at *Oja-oba* market in Ikare-Akoko, which is held daily. This usually allows women from the suburbs to market their products on daily basis.

The stage was set for the growth of organised market system. Sellers and buyers converged at designated spots on stipulated days to transact the business of buying and selling. Flourishing markets grew up at strategic places in Akoko. However, a central market was said to have started at Ikare, the spot of which is still known today. This market later gave way to a more central and popular *Osele* Market. Others markets have since been set up at Oka, Akungba, Okeagbe and Isua. Oka in Akoko is noted for the finest *gari* in Ondo State. Traders come from far and near to buy *gari* and other agricultural products. Oka's main market (*Ajoke*) is the largest market in Akoko. Apart from its general session, which is held every four days, the market is open every day, prominent among the products, which attract traders from far and near are kolanut and palmoil.

3.7 Political Organisation

The administration of the Akoko is rudimentary but very democratic. Akoko is made up of autonomous communities numbering forty, created into four local government councils. Each local government is made up of no fewer than eleven wards from where councillors are elected in the administration of their local councils. Other than this, there still exists low level of traditional political system practiced in each town and village to compliment the modern political system. In towns, there is a king-*Oba* being the head of the town, while in the village, there is *Baale,* as the head of the village. A chief is selected from each quarter of the town, which forms the council of chiefs. These chiefs, together with the head, see to the administration of their domains, as political organisation is organised around quarter-heads (chiefs) and elders are responsible for the settling of disputes and seeing to the wellbeing of the people.

There are three tiers of administration; the Oba is the highest authority. On the next pedestal is the *Opon,* or the oldest person in the village. He is highly respected

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and honored. It is on the authority of these two persons that the community assembly is summoned. The community assembly is always summoned through the town crier and/or bellman who in a very loud voice announce the assembly. If women are required to attend, the crier will make it specific, otherwise women never attended village assemblies. The village assembly is usually summoned to discuss urgent and important issues such as the threats to security and the welfare of the community. The second tier of administration is the elders council. The elders are made up of three age grades. The lowest grade is the *Ude* or *Edula*. These are those who had just graduated from the lower ranks. The age of graduation is between 70 and 75 years. The grade above *Ude* or *Edula* is the *Ikan* age grade. After six or seven years, the *Ude* or *Edula* will become *Ikan* in some parts of Akoko the system of graduation is different and the *Ikan* will become *Ihare*, in other part of Akoko the system of graduation is different. The *Ihare* are usually above 80 years. They usually wear an apron (*Ibate*), which is triangular in shape, with a strap at each of the three angles. The straps at the two ends of the longer side of the triangle are tied round the waist while the strap at the end of the frontal part of the apron wads are passed between the thighs and tucked into the joint of the other two straps.

When a group is about the age of twenty, the group members will come together to form a club and adopt a name. They would join the twelve or their thirteen age groups that make up the youth assembly, a very powerful body in the community. The group moves up rank-by-rank every seven years until they become sixty-five or more years of age. At this age, they attain the highest rank among the youths. This rank is known as *Hele*, or *Ula*. The group heads the youth assembly known as *Jamaa*. These names *Hele*, *Ula* and *Janma* may not be applicable in some quarters. *Janma* refers to the general assembly of the youths. In the same way as it refers to the Muslim congregation. *Hele* and *Ula* are the local names of the highest age grades in the youths' assembly. Every member of the community, male and female from the age twenty years to seventy years is expected to participate freely in compulsory service whenever called upon. The construction, maintenance and care of community utilities and properties such as market, school, road, and water supply are undertaken by compulsory community service.

At about seventy years of age, the *Hele* or *Ula* age group will be elevated to the *Ude* or *Edula* rank. This event is called *Igoke-Agba* which signifies the coming of age or the transition from the rank of a youth to the rank of an elder. They no longer

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participate in the compulsory community service. The highest social structure in the community is the elder's council. *The Edula or Ude* occupies the lowest rank, the other ranks being the *Ikan* and the *Ihare* in the order of seniority. Any person who successfully attains the age of *Ihare* is considered to have lived long. "Wa dagba wa darugbo" or wagbo wato,wa to " refers to longevity of life.

With regard to political institution, Akoko women status is low, as men dominate the institution. This is obvious considering the fact that the kinship structure tends to favour high social status for men than women. However, this does not rule out the possibility of women assuming some political posts in Akoko society. The main body that takes political decisions in Akoko comprises mainly of men. The inner council which constitutes the highest ruling body is made up of men. Women are not represented in the council. It is obvious that such bodies will always support traditions that give men superior status. This practice is no doubt, borne out of kinship factors, which exalt men and denigrate women. Since Akoko is mainly patrilineal society, women are left out in major decisions, which affect the entire community at various levels. However, in an exceptional case, women do participate in some community forums to deliberate on some issues for development.

Furthermore, men are the principal dispute settlers at all units of organisation in Akoko. At the family level, the husbands adjudicate disputes among members of his immediate family. Similarly, at household level, disputes are settled by the household head, who in most cases is the oldest man in the household. The chiefs adjudicate cases within his quarter, especially those which cannot be settled at lower levels (family and household). The supreme adjudicator is the king of a community in Akoko. He also arbitrates in small judicial matters, which might have not attracted modern litigation. He defends the community land and can alienate such to any individual for residence and farming. The head of a Yoruba community is held in exalted position, who enjoys his people's obeisance. Traditional roles accredited to the head include mobilising his people for community development, and passing information to the people.

3.8 Belief system and ideology

Just like any other contemporary Yoruba society, the people have diverse beliefs systems and religious forms which are shaped by variables like occupation, education and family background. They believe in the Supreme Being known as

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Olodunmare as earlier indicated. Akoko people are intensely religious. Religion features prominently in almost all the spheres of their activities. In pre-Christianity era, the people exclusively practised some forms of African Traditional Religion (ATR), but due to the Christian missionary intervention in the early 19th century, Christianity exists side by side ATR. Islam has also penetrated Akoko land.

Akoko people believe in prayers, since it is a belief among the Akoko that when one pray fervently one would overcome the challenges of life. There are some community prayers rendered publicly by large numbers of people. There are individual prayers rendered by individuals in their closets. Akoko people also believe in the existence of departed ancestors and could be called upon to intervene in a particular situation. They invoke the spirit of ancestors to remedy unpalatable situation and /or to punish any unfaithful member of a household and/ or community.

There are norms of worshiping in Akoko who make the people to be religious. It is a belief in Akoko that one of the primary assignments on earth is to worship God. This belief is held by all kinds of religious affiliations in Akoko. Though worshipping take different forms, the purpose is still the same. Every religion has its own coordinator who serves as the head.

In Akoko, much value is placed on sacrificing. It is believed that making sacrifices to supernatural beings is a means of securing themselves under the protection of the Supreme Being. Like other people in Yoruba land and elsewhere, they believe that gods and goddesses and departed ancestors are capable of causing disasters and epidemics, if they are not well propitiated. If they are well propitiated, they can ward off disasters, repel evil forces, and ensure the general wellbeing of society. Akoko people believe in performing rituals to remedy economic failure, especially, bad harvest.

Women in rural Akoko communities carry out remedial acts in terms of ritual performance during economic failure, especially bad harvest. A remedy is sought for in the form of ritual performances in various forms which include engaging in prayer and fasting; embarking on ritual sacrifice. Christians and Muslims engage in prayer and fasting, while the traditionalists engage in ritual sacrifice. Women do devote their time to these activities because of their sensitivity to spiritual things. The women appease the god/goddess or ancestral spirits believed to be responsible for economic failure that implicate on household economy. At community level, aged women do

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embark on processions, wearing only inner skirt and holding brooms in their hands to chase away evil that is threatening their household economy.

In Akoko, supernatural power does not work according to the natural; it may not be dealt with casually. There arises a set of negative rules- things one must not do, or disaster will follow. These are taboos. Objects, persons or places can be considered as taboos. Taboo things in Akoko are not to be touched, for their power can cause harm. Thus, those who touch them may themselves become taboo. Taboo surrounding food are not to be eaten, places not to be entered, animals not to be killed, people not to be touched sexually, people not to be touched at all, and so on. In Akoko, members of some household could not eat the animal that is their totem. The function of taboo in Akoko is predominantly psychological, originating in man's fear of dealing with forces he does not wholly understand. In Akoko, it engenders respect and cautious fear for the supernatural. Secondly, it sustains the awesomeness of the supernatural by reinforcing the attitudes of care and mystery and by punishing the attitudes of carelessness and profanity in dealing with it.

There is the ritual of planting and cultivation in Akoko. This ritual performance varies from community to community in Akoko. There are rituals one has to perform before one cultivates. This is done to appease the gods of abundance to bless the cultivated land. Also, after this, then what follows is the ritual of planting. This is done in order to let the planted materials to bring good harvest. Akoko people have the belief that there is a god of abundance somewhere who is responsible for abundant harvest.

There are rites of transition popularly known as rites of passage. The rites are those connected with the biological aspect of the phases of life. This start from birth to puberty; puberty to maturity; maturity to marriage; and marriage to death. Every transitional period in the life of individuals in Akoko is ritualised. The rites of passage have been fundamentally secular in nature. Rites of passage in Akoko history have generally been regarded as religious events. It is thus considered in relation to their social system, playing important function to the maintenance of society as a system of component parts. It is a transition in the life of an individual (marked with ceremonies) from one stage of human development to another. Rites of passage require a number of formalities which loosens the ties which binds the individual to his former environment. The individual is thus admitted into the wider community with ritualised ceremonies.

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The people always consult *Ifa* (Yoruba divination system) for disease diagnosis and whatever the medium says or recommends becomes the basis for propitiating their gods, goddesses, and spirits. This belief system has influenced the Akoko perception of certain phenomena while directing the people's attention to supernatural attachment.

3.9 Inter-relationship in Akoko

Akoko people have a good relationship with themselves and with other non-Akoko community. They have relationships in terms of marriage, religion, education and trade with their neighbouring communities. Each community in Akoko has its own autonomous political existence and their inhabitants relate based on the above factors. Their interaction is guided by customs, beliefs and values of the community where the individual is socialised.

The mode of interaction is seen in the way the people live together as an entity. They stay in the same family house, share family discussion together and hold political positions in the community in spite of their different religions affiliations. They have interaction in different ways through customs, social activities, education and dialogue. In Akokoland, the Traditional age group, community and social services join the people together irrespective of their religious affiliations. They are all duty bound to serve the community when a call for such work arises. In this way, the people interact together to pursue a goal. Akokoland is a society of different people with different religious ideologies but united for the sake of their welfare. As a group, they are duty bound to interact together despite the fact that they have different religions doctrine.

The facilitating factor responsible for peaceful interaction is a mutual understanding between the adherents of Islam, African Traditional Religion, and Christianity. Some of the practices of Islam and Christianity are in line with African culture. Christianity, Islam and African religions have certain things in common culturally; therefore religions understanding make peaceful interaction possible. All the religions in Akoko share in common the view of the existence of a Supreme Being but worship Him in different perspectives. The absence of religious fanaticism between Islam and Christianity in Akoko gives room for good inter-relationship. It is to be noted here that Islam, Christianity and African religion have existed in Akokoland side by side more than any other part of Yoruba land.

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3.10 Healthcare system in Akoko

Before the advent of the missionary, most rural residents depended on traditional health services, but presently there exists a variety of healthcare types and services in Nigeria. The combination of these health patterns determines the health situation of a community in Nigeria. In Akoko, their health situation is typical of that found in most rural areas of Nigeria. There are overlapping sectors of healthcare which constitute the healthcare systems. The content of these sectors differs across Akoko communities, their structure is the same. Essentially the healthcare system is structured into what can be referred to as popular, folk and professional sectors. Each of these sectors offers a particular approach to understanding the cause of, and prescribing the treatment for illness or disorder. Each sector also defines the sufferer and the healers in its own way and has its own rules for interaction. The model for understanding the healthcare systems in Akoko has been very influential and so we will consider each of the three sectors in turn.

The popular sector is the largest sector of the healthcare system in Akoko. However, it is important to realise that it is not formally defined as a "sector" and does not fit into an overall planning healthcare system. Instead, the popular sector is where everyday ideas about health and illnesses are discussed by "lay" non-professional people. Healing knowledge and advice is passed through informal discussions. This sector is where popular notions of health and illnesses live. It is here that they label it and decide how to react to it. Thus family, friends, colleagues and others whom one encounters in everyday life are parts of this popular sector. These people will be sources of ideas about what gives illnesses and diseases and so on, how you know when you have them and what to do to get rid of them. The experience of suffering is often shaped through belief extant in the popular sector. As this sector is where suffering is first experienced, it also this sector which usually determines whether someone seeks help from folks or professional sectors in Akoko. The popular sector is an expression of the community's belief about suffering and how to avoid suffering. This is usually associated with 'home remedies'. Thus jogging, eating raw eggs, taking cold baths, and not sitting in draught are all ideas salient to health and expressed through popular sector. This sector in Akoko is the vehicle for the promotion of health in Akoko households because it not only reflects popular beliefs, but also works through community mechanism. The popular sector of the healthcare sector includes self-treatment, treatment based on the advice of family or friends,

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church groups, self-help groups, community groups and seeking out other people who have experienced similar forms of suffering. Part of this sector includes the commonly accepted ways to stay healthy and beliefs about staying healthy.

Apart from the popular health sector is the professional health sector of healthcare system. This sector is composed of organised health professions. This sector has been dominated by scientific medicine. It has been successful in Akoko not only in terms of making other approaches to healthcare subservient to medical profession (paramedical, profession allied to medicine and so on), but also in terms of setting the health agenda. This sector of healthcare system in Akoko tends to define, treat and evaluate suffering within a medical frame of reference. The practitioners in this sector include orthodox medical doctors, nurses, midwives and others. This type of healthcare sector in Akoko takes its inspiration from western societies. The assumptions built into western healthcare systems are a direct consequence of having a professional sector based on expert knowledge around the ethos of biological reductionism.

Apart from the two sectors of healthcare discussed above is the folk sector of healthcare in Akoko. The folk sector combines some aspects of popular and professional sectors. It is characterised as being non-professional (in the sense of formal qualifications), non-bureaucratic (in the sense of being immediately available and not constricted by rules) and specialist (in the sense of folk healers having expertise in particular problems and/or treatments). Folk healers are relatively common in Akoko. They include faith healers, mediums, fortune tellers, root doctors, witch doctors, traditional birth attendants, bone setters and great arrays of spiritual healers. This category share and articulate the social meaning of suffering as understood in Akoko culture.

These three sectors constitute a healthcare matrix which informally interlocks in some places and contradicts in others. Within each of these sectors, the understanding of suffering is different and the means of removing suffering varies tremendously. People are socialised in a way that healthcare is seen as an ultimate thing in their lives. There is the norm of preventing illnesses through engaging in several precautionary acts. The people value good health or living a healthy life. It is believed that only someone with good health can participate efficiently and effectively in economic endeavours in Akoko.

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3.11 Infrastructural facilities

In recent times, Akoko has benefited from the developmental efforts of the intervention of agencies set-up, to address the hardship confronting people living in the area. This initiative is done because rural Akoko communities have remained largely under-developed, lacking basic infrastructure. The communities lack pipe-borne water and the few government installed motorised boreholes are not sufficient to meet the water requirement of the people. Most households, especially in rural communities of Akoko depend on wells and streams for their water need; sometimes people travelled many kilometers in groups in search of clean water. Apart from this, electricity supply is almost nonexistent as it is marked by irregularity in supply, despite the fact that virtually all communities in Akoko are connected to the nation's electricity grid. To a large extent, the area is devoid of secondary economic activities. This is why a large percentage of the people have to rely more on their primary economic activities than on industry-based economy.

In addition to the above, the economic situation in the households has made many Akoko men to migrate to urban areas in search of better working conditions and this has created a new household structural management that has left a few people with the burden of taking care of the household. This situation also has adverse effect on the health of many people, thereby increasing the morbidity and mortality rate in the community. Indeed, in spite of the various health intervention initiatives in Akoko, many people in the communities still face adverse health challenges, as health insecurity remains high. Several health-seeking behaviours have been engaged by the people to ensure healthiness, but many socioeconomic constraints have been hindering the attainment of good health among the people. In forty towns that constitute Akoko, only Ikare, Akungba and Oka-Akoko have public hospitals. These hospitals hardly function to optimal expectation due to lack of basic amenities such as drugs and equipment. This signifies that the area is highly marginalised in terms of healthcare facilities. Serious medical problems are usually referred to the Federal Medical Center in Owo town but only a few people can afford the cost of care. Though both traditional and modern healthcare systems are practised in Akoko, greater emphasis is placed on the traditional healthcare system and home remedies. This is as a result of the strict adherence to traditional ways of life as reflected in various household economic practices of Akoko people.

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CHAPTER FOUR

METHODOLOGY AND RESEARCH DESIGN

4.1 Methodology

The study was descriptive and ethnographic. It described how cultural strategies employed in household economy influence health-seeking behaviour with focus on the choice and utilisation of healthcare resources. This was done with a view to establishing their importance in healthcare intervention. The study employed qualitative method of data collection in order to generate data on both covert and overt behaviour on the interface between household economic interaction and health-seeking behaviour of rural Akoko people. The choice of this methodology is motivated by the need to ensure case-specific information, with the purpose of generating a comprehensive data.

The study employed research instruments such as Key-Informant Interview, Focus Group Discussion and Non-Participant Observation.The qualitative instruments provide sufficient data, from an ethnographic perspective, and in turn provide some degree of holistic representativeness. Therefore, the study addressed its problem by selecting a fairly large sample. As the study involves a relatively large population, it becomes easier to contextualise informants' opinions within the context of objectivity and generalisation within the study area.

The study adopted both individual and household as its unit of analysis. This is as a result of holistic perception of the problem under study. Individual unit of analysis is motivated by the need to examine how an individual perceives his economic roles and responsibilities, and the implication this has on his/her choice and utilisation of healthcare resources. Household unit of analysis is motivated by the need to examine group influence on individual action and on the household as a body. To ensure a balanced research perspective, both etic and emic views are carefully considered as the perspective focus for the study, though it relies mostly on emic perspective. In this case, the study seeks to avoid biases, which may arise from the exclusive use of either the emic or etic perspectives. This was based on the fact that both economy and health are objectively and subjectively determined within and outside the household unit. Again, the combination of both etic and emic assumes greater importance as healthcare is not an exclusively insiders affair but includes outsiders' relationships.

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4.2 Study Population

The targeted population for the study consisted of men and women who were actively engaged in the most common economic activities in rural Akoko communities. These categories of people included farmers, hunters, palm oil and *gari* producers. The purpose is to generate quality data from economic groups engaging in economic activities that have direct bearing on local subsistence in rural Akoko households. The informants were included in the study on the basis of their capacities to provide information on issues related to the themes of the study. This was determined by the number of years they have been in the professions. The respondents were matured persons within the age range of 18 and 80 years while aged persons from 81 and above were excluded because they might no longer be active enough to effectively participate in the study. Secondly, some traditional and modern healthcare providers were also included as target population. The inclusion of these categories in the study population was to provide information on the general attitude of rural people towards choice and the utilisation of traditional and orthodox healthcare. However, more focus was placed on orthodox healthcare providers because they are more likely to document reliable health information in Akoko community than traditional healthcare providers. In addition to the above, community leaders, traditional chiefs and community elders were interviewed at the pre-field survey stage of the study to provide information on the historical background of the study area. They also served as key informants during the pre-field stage of the study and were later engaged for snowballing.

4.3 Entering the field

Fieldwork for this study started from the first day the researcher visited Ikare-Akoko, the local capital of Akoko community. Following his arrival at the central motor-park in Ikare-Akoko, the pre-fieldwork began with the researcher asking a bus conductor for direction to the king's palace. The bus conductor directed him to an okada-rider (cyclist) who took him to there. Unfortunately, the king was not available at the time and the guard in charge of the palace suggested that the researcher should have a return visit the second day. As both the researcher and the cyclist left the palace, the researcher engage the cyclist in a conversation by first introducing himself and disclosing his mission in Akoko. On the second day, the same okada rider took the researcher to the palace. This time the king was in his palace. The researcher

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introduced himself to the king and told him about his mission. The king was delighted and promised to cooperate and be of assistance if there was any problem. Fortunately, there were some High Chiefs in the palace at the time so the researcher seized the opportunity to tell them about his mission and how they might assist him in the course of fieldwork. Then, the king narrated the history of Akoko, how various communities in Akoko were ancestrally linked and the role which Ikare-Akoko played at the time of their coming together. However, he made the researcher to realise that various communities have their own peculiar history. Some of the chiefs also contributed to the discussion by providing relevant information regarding the origin of the community. Afterwards, the king gave the researcher a book containing important historical information on the origin of Akoko and Ikare. He also gave him a signed consent form, suggesting his approval for the researcher's mission and urged the other king in Akoko to cooperate with him.

On the third day, the researcher called the okada rider and contracted him for two days during which he was able to get in touch with the local government chairmen at their respective offices. He first went to Akoko north-west local government where the chairman directed him to a public relations officer, who gave him some documents related to necessary things he needed to know about the local government. The same thing happened in all the other three local government areas. The next day the researcher travelled to Akure to collect the latest census figure about Akoko and maps of Ondo state and Akoko at the National Population Commission's (NPC) office and the state ministry of work respectively. The information in the data collected was used purposely for the study.

The following week, the researcher went round all the health centres in all the communities that were purposively sampled for the study. In each of the centres, the researcher informed the relevant health officers of his mission and the area in which they could be of help to the study. They told him when he could come and interview the health officials as well as others who needed to be interviewed. After the foregoing familiarisation with the research areas, the researcher observed a week of rest and prepared for the actual fieldwork. During this period, information and official documents collected were properly studied. The following week witnessed the take-off of data collection.

A pilot study was done to test the study's instruments for validity and reliability and to enable the researcher to get acquainted with the research area. It was

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during the pilot study that some key-informants were identified. At the end, a total of 20 informants were involved in the pilot study in all the study sites. The pilot study yielded an opportunity to modify the research instruments where necessary and ascertain the availability of potential informants. Following the pilot study was the selection of key informants to begin the collection of data through in-depth key informant interview.

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Figure 4.3.1 Pre-field interview with community leaders in Akoko

Source: Fieldwork in Akoko, 2008

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4.4 Sampling method

For this study, a multistage purposive sampling method was adopted. It began with the purposive selection of Akoko community in Ondo state. Apart from Akoko, other communities in Ondo State are Ilaje, Ikale, Ondo and Owo. Akoko community has four local government areas (LGAs) and is further divided into smaller political units called political wards. The local governments in Akoko are Akoko North-west, Akoko North-east, Akoko South-east and Akoko South-west. Akoko community was purposively sampled due to its remoteness to the political centre of Ondo state, and its predominantly rural nature of economy. In addition, cultural homogeneity and informal and affective kin relationship also influenced the sampling of Akoko community for the study. Akoko community consists of both rural and urban communities. The rural communities are characterised by poor infrastructures and low economic activities, the people being mainly peasants.

Following the research theme, all the four local government areas in Akoko were purposively selected as the research communities. The selected local governments are Akoko North, Akoko North-west, Akoko South-east and Akoko South-west as earlier indicated. Another round of purposive sampling was engaged in, in selecting one rural community from each of the four LGAs. This was done to make sure that all the local governments in Akoko were represented in the study. The sampled communities are Akunnu, Ese, Ikun and Ipe-Akoko. Each selected local government has between 10-15 wards. The last sampling stage featured the selection of the research interviewees. Key informants and discussants for focus group discussions were purposively selected through snowballing (a non-probability sampling strategy whereby referrals from earlier participants are used to gather the required number of participants). The economic groups (farmers, hunters, and palm-oil and *gari* producers) were for the first phase of key informant interview (KII group A). The categories of people were selected through elderly persons who had been on those professions for years. These categories of people were chosen because their professions have affinity with subsistence economy in the household, which is crucial to household economy. The second phase of key informant interview was with orthodox and traditional healthcare providers (KII group B). They were also selected through snowballing. They were chosen to provide information about prevalent diseases and illnesses as well as the utilisation of healthcare resources in the community. The orthodox healthcare providers were chosen through the head of

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departments. They included 2 medical doctors, 6 nurses and 4 midwives, while traditional healthcare providers were selected through elderly persons who had been on those professions for years. They included 4 witch doctors, 4 herbalists and 4 traditional birth attendants. The study interacted with 92 key informants in the four communities sampled.

The discussants for FGDs were purposively selected through the heads of households. In each community selected, 2 sessions were conducted with mixed male and female (FGDs Group A): 1 session comprising only male (FGDs Group B) and 1 session comprising only female (FGDs Group C). This was to allow free expressions of opinions that were free from opposite sex constraints. The groups comprised people selected on gender consideration with different socio-economic backgrounds. This was to generate robust data emanating from diverse perspectives. A total of sixteen sessions of FGDs were conducted for the study. The study interacted with 128 discussants in all the study locations.

4.5 Methods of Data Collection

Actual data collection, which lasted for fourteen months, began in March 2008. The fore-knowledge gained from the pilot study was utilised. The qualitative methods adopted were concurrently applied so that the deficiencies in any of the methods were rectified by the others. The methods used for collecting data in the study were key informant interview, focus group discussion and case study.

Key Informant Interview

Two phases of key informants' interviews were conducted. The first phase of key informant interviews (KII Group A) was conducted with economic groups (farmers, hunters, palm-oil and gari producers), while the second phase (KII Group B) was conducted with healthcare providers (orthodox and traditional). Also, notable people who possess rich information about economic activities and the cultural strategies engaged in Akoko community were selected as key informants for phase one. On the other hand, traditional and orthodox healthcare providers were chosen to provide information about prevalent diseases and illnesses, and the utilisation of healthcare resources in the community. The criteria for selecting the key informants in the two phases had been highlighted in the sampling method above. Figures 4.5.1 and 4.5.2 below show KII with Group A and B respectively.

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Figure 4.5.1 shows KII (Group A) with a *gari* producer

Source: Fieldwork in Akoko, 2008

Figure 4.5.2 shows KII (Group B) with orthodox healthcare provider

Source: Fieldwork in Akoko, 2008

The selected key-informants were interviewed using study guide. Field notes and tape recorders were used to record the interviews. All these were not done by the researcher alone. Field assistants assisted in writing down the views and comments of the key informants. This was done to avoid errors and omissions while the interview was in progress. The study guide served to keep the interviewer aligned with the research themes, and the interviews were placed within the study contexts. However, care was taken to allow the inclusion of second other questions, which were instrumental to generating a holistic data.

At every point of the research, the researcher ensured that the interview sessions did not disturb the potential informants' activities. This was achieved by giving the interviewees time to finish their personal activities before the interview. During the interview, the researcher equally engaged in unstructured observations as earlier stated, while the interview enhanced deep interaction with the informants (both males and females).The key informant interview allowed informants to freely express their knowledge, feelings, recollections and experiences without external restriction.

Specifically, the key informant interview generated information concerning the management of household units, cultural strategies adopted in household economy, the implication of those strategies on the choice and utilisation of healthcare resources and prevalent diseases and patterns of healthcare in rural Akoko communities. Key-informants also provided information on how the study communities perceive the household economy and how that translates to care and support in healthcare. The study guide was not strictly followed in some cases as some circumstances often demanded reflexivity. In our investigation, the method deepened comprehension of phenomena that appeared vague and ambiguous when apprehended through other methods, for the single reason that a degree of time-consuming introspection and mediation was sometimes necessary for the informant to articulate his/her responses, and for his/her meanings to become clear. Informants were allowed to attend to their pressing needs whenever the interview was going on. Thus, key informant interviews yielded very rich, holistic and expressive data on the Akoko understanding of household economic practices and elicited information on some contested issues on healthcare among rural Akoko people. The key informant's interviews, which lasted for eight months, generally strengthened the descriptiveness of the data and provided opportunity for the study to incorporate the informants' voices in the report.

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Focus Group Discussions

Focus Group Discussions (FGDs) was another method used for the study. The discussants for FGDs were purposively selected through the heads of households. Most of the discussants engaged in farming, trading and production of *gari* and palm-oil. In each community selected, two sessions were conducted comprising mixed male and female: one session comprising only male and one session comprising only female. This is to allow free expression of opinion that is free from gender constraints. They comprise people selected on gender consideration with different socio-economic backgrounds. A total of sixteen sessions of FGDs were conducted for the study. The study interacted with 128 discussants in all the study locations. The interactive nature of FGDs helps to unravel the nuances in the study themes and further assist to generate a robust data emanating from diverse perspectives.

The FGDs were conducted in relatively informal settings which gave participants freedom to express themselves without inhibition and in effect stimulated general participation. In situations where some were reluctant to participate, they were persuaded. The research facilitators such as local chiefs assisted in mobilising the discussants for discussions and assured them of the confidentiality. Most discussions took place in the evening time when the participants might have had enough rest after the day's work. The discussions often started with the introduction of the moderator, note taker and recorder and explanation of the need for participation and recording. Thereafter, exchange of pleasantries followed. Discussion usually began with common community issues, to make the atmosphere more relaxed and to draw the attention of discussants to the ethnographic milieu of the study. For instance in Ipe-Akoko, questions about preparation and importance of "*Iru*" (locust bean) and "*Ikoko*" (local pots) in the community were asked. Also, in Ikun-Akoko, the prevalence of guinea worm was noticed and so the researcher asked about the community and government effort in combating it. This preamble practically achieved the purpose of reducing anxiety before the discussions were shifted to the specifics. In order to avoid boredom, each session was almost forty-minutes to one hour. In a situation where discussants could not properly communicate in Yoruba, an interpreter was used.

The discussions were tailored towards question guides generated through study themes. Like the key informant interview sessions, discussions were also

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reflexive and recognition was given to second order questions. Discussions centred on cultural strategies employed in household economic practices and their implications for the choice and utilisation of healthcare systems and factors limiting health-seeking behaviour. In each session, responses were tape-recorded and important points were jotted down as well. In some cases, when discussion became complex and rowdy, moderator usually calmed down the situation through the use of diversion and cheering. Discussions were stimulating and produced rich insights. The figures (4.5.3; 4.5.4; and 4.5.5) below show FGDs conducted with group A B and C respectively.

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Figure 4.5.3 shows FGDs with mixed male and female(Group A)

Source: Fieldwork in Akoko, 2008

Figure 4.5.4 shows FGDs with only male discussants (Group B)

Source: Fieldwork in Akoko, 2008

Figure 4.5.5 shows FGDs with only female discussants (Group C)

Source: Fieldwork in Akoko, 2008

Observational Method

Apart from the foregoing methods of data collection, observational method was also employed using case study to take note of certain implicit cultural behaviour and attitudes that are related to interface between household economy and health-seeking. Since the study is ethnographic, observation method was adopted side-by-side with other methods to generate a robust data. This was usually obtrusive as the role taker aware of being studied. Ten people were purposively selected for case study in each of the communities studied. Their attitude towards economic endeavours and health-seeking behaviour was observed. In this observational technique, specific attitudes, knowledge and practices, both overt and covert, relating to philosophy and ideal culture of the people, were also observed. Since ethnography involves much more than casual observation, the study explored more about specific events than what could just be obtained in either focus group discussions or key informants interview. Figure 4.5.6 below shows an interview with a traditional healthcare provider who was among those people observed.

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Figure 4.5.6 shows an interview with a traditional healthcare practitioner

Source: Fieldwork in Akoko, 2008

4.6 Method of Data Analysis

The process of data analysis began with the reading of the field notes and editing of the recorded responses. These were done carefully several times to get familiar with the generated data from the field and ensure that no information was lost. Having seen that there were several intricate, complex and ambiguous data, the transcripts were reviewed and relevant quotations that lucidly captured the themes and ideas expressed in each question were noted and compiled. However, the process was complex to a certain degree as most of the discussions were held in Yoruba and translated to the English language (which is the language of instruction in Nigeria higher schools). As much data were gathered in Akoko versions of Yoruba language, many concepts and terms from the informants were difficult to translate appropriately in English. This was resolved in two ways. Firstly, a return visit was made to the field to inform some informants about the inferred meanings of some of their complex ideas. Secondly, before the writing of the full report, the data translated from Yoruba to English were given to a secondary school teacher in the locality for editing. The editor holds a Masters degree in Teacher Education (English). This then gave us a better degree of validity in field data. Following the assurance of validity, the researcher embarked on data classification in order to group the data based on research objectives and the study themes. In this process, other secondary themes that emerged were also identified and patterned.

Data generated were grouped according to similarities and dissimilarities of opinions and later classified into categories using systematic coding. Thereafter, a list of unique opinions was made. In addition, the researcher counted the occurrence of each of these opinions. This was based on the research objectives and each objective was coded. The use of Nvivo software for qualitative analysis was employed. The Nvivo software allows classifying, sorting, arranging of information and examining relationship in the data. This followed the content analysis of the responses, which produced description of the data. On the other hand, direct quotations of responses (that indicate respondents voices), which entail verbatim reporting of opinions, idioms and proverbs that support important findings in the data were done. The direct quotations of informants were later translated into English for proper reporting.

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4.7 Limitations of the study

Some houses were difficult to access because they were built on hilly and rocky environments. This required ascending high stairs before one could get to some informants. This situation imposed limitation on the number and extent to which some informants could be reached. This situation was addressed by substituting most of the informants in such households with those that live in level land area. Secondly, the community leaders who were facilitators assisted by sending someone to call them when necessary.

Another difficulty encountered was the absence of informants in their houses. A lot of our informants were not met at first contact. Many of them who are mostly farmers engaged in migratory farming, whereby they travel to distant farms for some days of the week, only to return during the weekends to have Friday's congregational prayers in cases of Muslims and Sunday church services by Christians. Some of the households that fell within our sampling frame could not be accessed for interview though they were later substituted with the nearest households.

In addition, language was a source of barrier. There are several dialects spoken in Akoko community, though they all have Oyo-Yoruba as their general language. Some important ideas and concepts did not have equivalent meanings in different Akoko dialects and there was the problem of common interpretation. This situation was addressed by not including such ideas and concepts in the field reporting.

Furthermore, some informants were reluctant to respond appropriately to the questions regarded as private and sensitive in determining status. This situation was addressed by informing the informants that all information was going to be used for research purpose only.

4.8 Ethical Consideration

The study involved human subjects and as such some aspects of bioethics were considered. The researcher took into consideration the informants' rights of participation in the study. As a result of this, the consent of chiefs and other informants were sought. Prior to initiating the research, sufficient information about the study was communicated to prospective subjects. These included purpose, expectations during the course of the study and the consequences of their participation. The informants were also briefed about the expected outcome/benefits. The informants were informed of their rights to withdraw from the study even after

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they might have given their consent. There was an opportunity for the informants to ask questions before giving consent. This was to reaffirm the validity of the consent. The researcher was sensitive to and respects the culture of the rural people in Akoko community. Therefore, he made sure that the interviews were conducted in atmospheres that guided against any form of psychological or physical harm to any respondent. The researcher neither coerced nor enticed the informants with material benefits. He also made sure that he did not make false promises to informants as a way of getting their cooperation.

Sentiments were not introduced into the study and limitations of the study were not concealed. Data were not manipulated to suit the presumed results. Efforts were made by the researcher not to lead the research participants to commit any infraction among themselves, especially during the FGD sessions. All the data generated were kept in strict confidence to protect the confidentiality of the informants.

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CHAPTER FIVE

FINDINGS AND INTERPRETATIONS

5.1 The management of household units in rural Akoko communities

In Akoko the basic human organisations where economic activities are involved are family, household, community and society. Primarily, these four units of organisation exist to promote access to resources such as land, social support and security. Community and society are the two largest units of human organisation in Akoko and are marked by a specific and identified territorial boundary. Thus, there are many communities in form of distinct settlements with marked territories which are called towns and villages, and which constitute the entire Akoko society. Thus, in the context of this study, communities refer to different settlements marked by differently identified territories. Akoko communities share similar cultural identities in terms of customs, values, beliefs and other practices. Despite this, each community that makes up Akoko society has its own defined territory where economic activities are organised. On the other hand, each community is made up of a number of family and households with peculiar names for identification.

Family and household are the smallest units in Akoko society. However, both family and household in rural Akoko communities remain ambiguous and complex to the extent that it is difficult to make a clear distinction between them due to their closeness in meaning and in settlement structures. Nonetheless, family and household are not territorially bounded like community because members could spread abroad. In some cases, membership of both household and family is indiscernible. The issue of indiscernible was discussed during FGDs sessions, where counter-claims were raised among different discussants.

Most discussants opine that the distinction between family and household is narrow and blurry. Some saw the distinction as complex and ambiguous. As a result of this complexity and ambiguity in rural Akoko communities, diverse opinions about definition of family and household exist. As recorded from focus group discussion sessions, a sizeable number of our discussants could not properly distinguish family from household. This category of discussants held the view that there is no remarkable difference between family and household. However, with their explanation, family in Akoko is purely a unit of human organisation comprising individuals that are biologically related (through blood), while household is an ideological construct that links a large number of people with expanded economic

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connection beyond biological affiliation. Household is an imaginary community. It is a socio-economic unit which is not demarcated by pole nor does it require a specific number of people for its formation; it resolves and dissolves due to nature of its composition. It is not uncommon in Akoko community to link household members to people connected from various sources through social, blood and marriage, to form a socio-economic unit with head.

> A family consists of people born by the same parents. The family unit is called *Ebi* (which literally means connected by birth). A household consist of individuals who identify themselves by social and birth (affinal and consanguine) relationships. This is called *Idile,* and it may consist of people that may or may not have blood link, but rather connected by social and economic interest. As stated earlier, households in this area are usually made up of sets of families and those who share similar socio-economic interests.
> (FGDs with group A in Ipe-Akoko, March, 2008)

In Akoko those that are mere acquaintances can become members of households as they employed Yoruba proverb that says "T'eru ba pe nile a d'omo", meaning if a slave stays longer in the household, he or she becomes a child. There are conditions in rural Akoko communities that make non-blood members to be incorporated into a household. Such conditions include caring, honesty, hardworking, loyalty, fixed capital and helpful intelligence. Information gathered in all the study sites indicates that a household is an unbound construct in the sense that it is not based on biological condition like family. It was also gathered that what matters is identity and recognition of connectivity subsumed in socio-economic relationship.

The issue of identity is significant to welfare creation. Many informants in FGD sessions also indicated that apart from fathers, mothers and their children that made up different family segments, other members of household unit may include fostered children, hired-laborers, migrants, uncles and in-laws. This category of people might not in some respect be permanent members due to some circumstances as indicated by the informants. They are integrated to a sub-unit of families that constitute a household, and the source of integration might be traced to ego.

In FGDs, many discussants gave cases of their household and highlighted various links. From their explanations, household in rural Akoko cannot be really conceptualised and operationalised without family units. Each family segment in a

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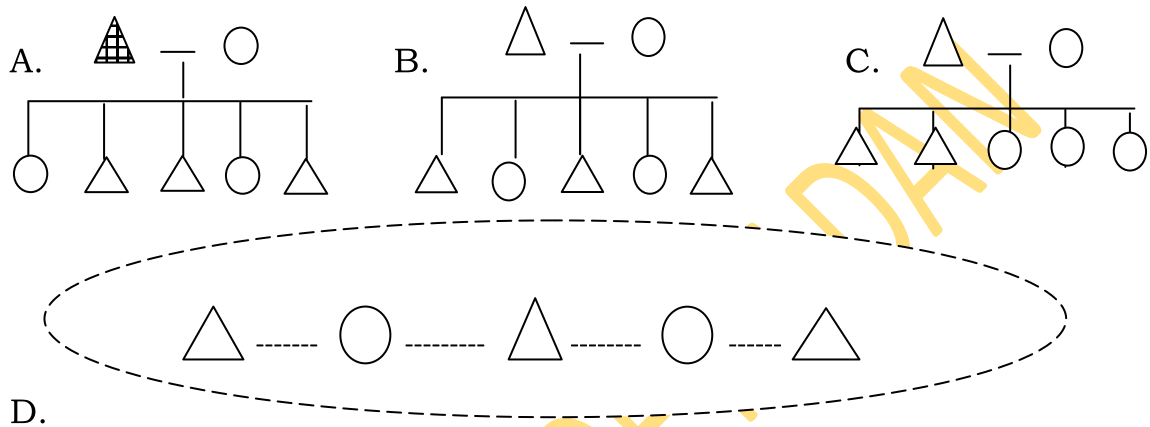
household consists of father and his wife and their children. Household is almost synonymous to extended family, but the difference is that a household incorporates people beyond those that are biologically related. The figure 5.1.1 below illustrates a typical household unit and non-biologically relationship that constitute a household in Akoko.

Figure 5.1.1 Composition of a household in Akoko Community



Group A, B and C above are family units that are biologically related, while group D comprises foster children, hired-labourers and housekeepers. All of the four groups identified constitute a household. They may live in a big compound or clusters of houses forming a close. However, in most cases, household members are scattered all over places.

Note:
A – C = biologically related family members

D = non-biologically related family members

The above figures show the distinction between household and family. A, B, C and D, in figure 5.1.1 above are different families and the groups constitute a household. While family membership is ascribed, household membership is derived. One is born into the family without a choice of alternative. In a household, a member has choices because one is brought into it. These features determine economic relationship in a household. In rural Akoko communities, a migrant-labourer incorporated into a family becomes a member of the household because he or she engages in economic and social activities with other members of the household. Other

non-blood related members of the household also become members of the household because they have social and economic ties with the "ego" and the household. Economic interest makes the family in Akoko to be different from household, as a family contains ascribed and undetached link.

Socio-economic interest is the prime factor joining individuals together in a household, while biological connection is the primary factor that connects members of a family. Members of a household are called "*Emba*", which means a member. An individual can be linked to two households but can never be linked directly to two families. An FG discussant (a woman) in group C in Ipe-Akoko highlighted the derived nature of economic connectivity in household and stressed: "I am a member of "*Obakuro*" family because that is where I was born, but now I am married to a man in another family. My husband's family then becomes my new household because we share the same homestead, land and provide labour assistance for each other". This suggests that household can make an individual (especially women) to have dual opportunities as it involves economic activities that are broader than what family can undertake.

In rural Akoko communities, membership of a household is semi-permanent for some categories of people in the household. Members that are not biologically related (such as house-help, hired-labourers, foster children and in-laws) may cease to be members any time they go back to their places of origin. However, those claiming membership through, especially, kinsmen tend to be permanent within the household and they sustain the household in perpetuity. According to many informants, this often explains why many households often refuse non-biologically related members to return to their places of origin. The issue of permanency in rural Akoko communities is significant in the construction of mode of inheriting economic resources such as land.

In rural Akoko, members of a household live together either in a homestead that is made up of a common house or a cluster of houses that form a large compound. This is significant to creating and monitoring members' welfare as earlier stated. Findings also suggest that, as each community in rural Akoko began to expand and engage in economic activities outside the household unit, members of a particular household became located outside a particular community and even beyond Akoko community. Some informants asserted that in the past, when agriculture was the main

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economic activities, household members lived together in close proximity to one another due to the small size of the population and the need to defend their land.

The idea of living together has changed as household members are not obliged to live together due to dynamic nature of society. Access to economic resources and social support binds household members together, such that either the members live in the same community or are scattered in many other communities. Members of a household are bounded together as an imaginary community. This further suggests that if some household members do not live together, such members still retain their membership through sustained economic network. Imaginary nature of household seems to be more real and feasible especially when members are engaged in social and economic activities. They define themselves as a group when they have common economic interest such as access to land, sharing labour, raising capitals for production, and when those activities are not needed, members cling to their different cohort families. An informant explained as follows:

> I am a farmer and I used to farm in a village near Aisegba-Ekiti and it is about 115 kilometres to this community. I spent more of my time in the year in that village. I do everything I am required to do in our household. Living outside the community most times does not mean I'm not a member. I do come home when it is necessary. When a member of a household migrates to another community either for business or otherwise, such person is still regarded as a member when he does not fail to perform his economic and social responsibilities in the household.
> (KII with a farmer in group A in Ese-Akoko, March 2008)

Key informants highlighted the connectivity pattern in household and narrated how it is significant to welfare creation through expanded economic cooperation. In rural Akoko communities, socio-economic cooperation is very vital in household formation and its management. Thus, findings among key informants and focus group discussants indicated that in rural Akoko communities, family unit is small with more limited economic activities. Indeed, for economic supports such as access to labour and capital, most people in Akoko depend on household. As gathered from many informants, neighbours, friends and other acquaintances can assist one another in accessing credit, land and labour within household units. However, there are opportunities of supports in the household because of large number of people. As

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stated earlier, though socioeconomic relationship is interdependent in household, some level of individual autonomy on certain issues is still acknowledged or guaranteed among members. This was supported by one of our key informants who states as follows:

> A household has great influence on individuals as regards what to produce and consume. In many instances, this is due to the kinship connections that emphasise welfare creation. Nonetheless, every member also has the right to decide the kind of economic activities to engage in to enhance livelihood as contribution to the welfare of one's household members.
> (KII with a farmer in group A in Ikun-Akoko, March, 2008)

In most of the FGDs sessions, discussants indicated that members of a household are usually obliged to be loyal to one another when it involves cooperation and giving social support. The issue of loyalty is often emphasised so that economic relationships are well coordinated and sustained among the members. This is often necessary so that internal solidarity within the household is not obstructed by undue interference and misunderstanding. The mechanisms to foster this solidarity vary from household to household and community to community in Akoko. In some households, the members embark on rituals, such as common ancestral worship, where they invoke the spirit of their ancestors to deal with any member that betrays the loyalty. There are also a set of common conventional rules and regulations that deter an individual from being disloyal in Akoko. One of the rules is that no one should violate the law of the household. The other one is that no one should collude with outsiders against any member of a household. These are regulated through imposing fines and sanctions. They serve as mechanism through which members are checked. The two mechanisms are mostly engaged among the *Akoko Kukurukus* and *Bini-Akokos*. This does not rule out the total possibility that these mechanisms could be found in other areas, but they are not so popular in many households. However, in households where these are not popular, they still have some other peculiar ways of ensuring loyalty especially in economic dealings. In some communities, such as *Ipe-Akoko* and *Akunnu-Akoko*, there are taboos that confine individuals within the context of social orderliness. It is a taboo to confiscate any property of members and subject such people to suffering. Apart from this, it is also a taboo for one to hinder the welfare of any member in favour of oneself. Sanctions are based on anticipatory punishments as

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individuals believe that whosoever is not loyal incurs divine curse as a consequence. Some informants explained how members have kept loyalty so that they would not incur divine curse.

Within the household unit in Akoko, there is a hierarchical structure of members which serves as a basis upon which power, privileges, opportunities, roles and responsibilities are shared. This is purely anchored on patriarchal system. As a household is a unit of human organisation in Akoko, there are a number of beliefs, values and customs involved in the assignment of duties and responsibilities among its members. Field observations suggest that hierarchy in Akoko household is anchored on stratification system that forms the administrative structure through which rights and resources are assigned. Men occupy the apex and are made to coordinate the affairs of the household. The heads of the household are usually chosen among eldest men. Household, being hierarchically structured in Akoko communities, determines how power, privileges and economic resources are assigned. In Akoko, a Yoruba patriarchal society, women are the last in the structure because the culture sees them as strangers, which also have dual economic opportunities in both consaguinal and affinal household units. Figure 5.1.2 below illustrates the hierarchy of power and access to resources in household unit in rural Akoko community.

Figure 5.1.2 below indicates that women are subjugated because of their dual opportunities and patriarchal system that denigrates women. All these suggest why women are culturally barred from rising to headship of households in Akoko. This also extends to family units that constitute a household. In a family unit, when the head of the family dies, the deceased brother is assigned the task of overseeing the affairs of the family unit rather than a woman becoming a head. This suggests an unbalanced gender relationship in rural Akoko communities. This further explains why women in Akoko are barred from being a substantive king in the community. Although an Akoko woman can be appointed as a regent following the demise of her father who was a king, the candidacy of regent expires as soon as the community appoints a substantive male king who then replaces the regent.

Each household often appoints a head among men who usually oversees the affairs of the household. The selection is often based on age and the oldest man in the household is often appointed as the head of the household. Figure 5.1.2 below explains the hierarchy starting from the household head selected among the family units that constitute a household in Akoko.

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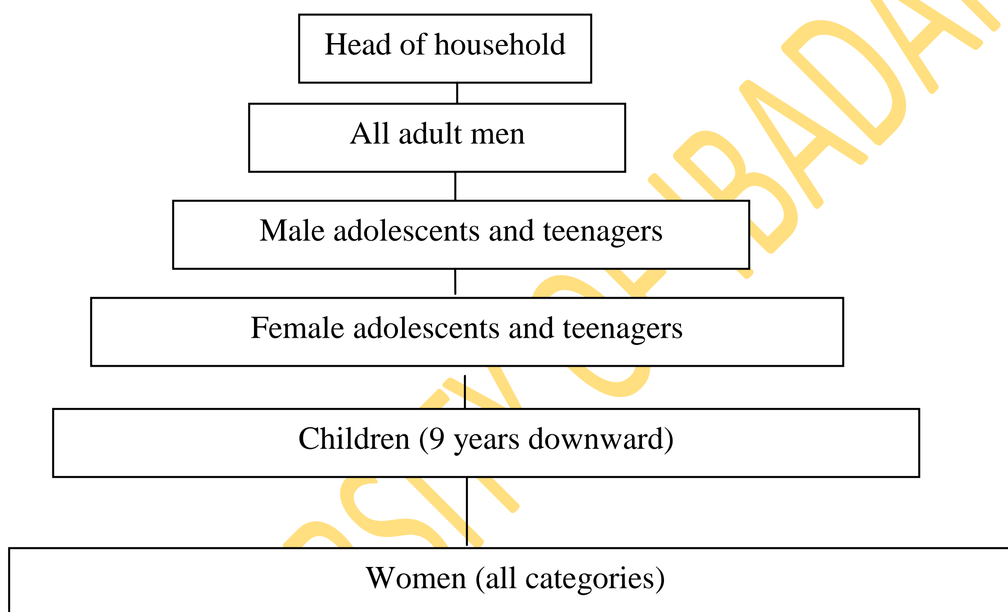
Figure 5.1.2 Hierarchy of power relation in Akoko household



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The head of the household is called *“Opon*”. He is in charge of general welfare of household members. The head coordinates common economic interests in the household and settles disputes among the household members. A household head is expected to carry members along in matters that affect the household. His power is limited within the context of local customs, traditions and beliefs in both household and community.

In rural Akoko communities, there are different levels of social network organised based on age and sex in the household. This is meant to strengthen the socio-economic relationship in the household. There are different socio-economic group organised in the household in that regard. The most common one is *Egbe Olobirinle*’. The ‘*Egbe Olobirinle*’ is a women-only group and it functions largely to guide women in managing their homes. It involves a lot of economic ties which are meant to improve household economy. Other socio-economic organisations include age grade societies where adult members in a household are categorised into different age grades. The age grade is simply the categorisation of people who happen to fall within particular culturally distinguished sets of age ranges, popularly known as *Etu,* who form socio-economic groups. Membership of any social network in rural Akoko is voluntary.

There are lots of socio-economic advantages attached to different social networks in the households. Apart from economic support gained from these associations, they are also meant to strengthen social integration and make it easier for social orderliness to be maintained within the households. Specifically, members of household-based associations assist one another economically. In some cases, they contribute money which they access on rotational basis. Secondly, they constitute a pool of labour for members that are in need to reduce cost of production. While household members are usually advised to be of good behaviour within their various households, any member found to misbehave is often sanctioned. The sanction serves as deterrent to others. Cooperative society is another form of social network that mostly binds a number of households together. The cooperative society is usually called “*Ayameleho*”, and it consists of mainly the members of households that are resident and engaged in economic activities in rural Akoko communities. Through the cooperative society, members contribute some money and have access to loan to support their household economic activities. There are certain values and norms that

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are learnt, which are later integrated into one's household. Such norms and values include how to be courteous and appreciate members. It also helps members to inculcate the act of giving and rendering support to other members while obeying the rules and regulations of the household.

Management of factors of production in rural Akoko community

In rural Akoko communities, access and distribution of resources such as land, labour, capital and entrepreneurship influence household economy.All these constitute basic factors of production among the people. These factors connect household members together and their accessibility is guided mainly by customary norms, values and beliefs in rural Akoko community. Land is crucial to rural Akoko local economy as farming constitutes their mainstay. It is one of the prime factors that connect household members together. In an in-depth interview with a farmer who is also a traditional chief, he asserted that land is given a prominent place in the socio-economic life of the people and buttressed the assertion of an informant who maintained that "Land is one of the major resources through which we sustain our livelihood, as majority of people in this community engage in farming and the natural resources endowed in this land also constitute inputs for production of other economic commodities".

Another discussant in FGDs also indicated that land resides in the family units that form a household while a group of family having customary rights on land can have a group interest that relates with security of the land. From the discussants' assertions, there is clear indication that land is fragmented among different families in a particular household, while the household as a whole still protects each family against land encroachment from outsiders. Outsiders in this context are the non-members of the household with no customary rights to land. However, on occasion where families in a household do not have their land in the same location, the household ensures that such families are still protected. Each family unit in a household is given a code (usually in form of a name) which serves as an identity for allocation. Land is therefore attached to the family, while households only protect the land against encroachment, and supervise its sharing among family members.

Land is freely allotted to members of the family, but for outsiders, considerations in form of a specific payment of cash and gift items such as drinks are required for access to be granted. Land is very significant in the people's kinship

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ideology which is ultimate in welfare and hospitality among household members. It also suggests that land constitutes an important asset to the family and household in Akoko. Its acquisition is often difficult due to shortage of land as a result of the topography of Akoko community. Thus an informant maintained:

> Land is considered as gold because of the topography of Akoko community. Land is one of the major things that hold people together in a household. Our fore-fathers told us that households primarily exist to delineate land into group portions and defend such land from encroachment. Though land is a free gift, its resources are attached to individuals. In the case of Akoko, land resources are tied to households and codes are given for identification. That explains why some household bear semblance with land; such as *ilegbusi*, *ilemobade* and *iletan*. Land is an economic assets for household.
> (FGD with group A in, Akunnu-Akoko, April 2008)

The topography of Akoko affects the use of land for building purposes. Many houses are built on hilly and rocky environment in Akoko and this makes physical access to both human and economic resources difficult. Apart from this, KII and FGDs also reveal that it is very difficult to access land unless one is attached to a household through a family unit. Access to land varies and depends on an individual and what they need the land for. There are some portions of land that are jointly owned by the members which a single individual cannot cultivate or sell, while there are some that are distributed among members of the household.

> It is very difficult to get access to land except when one is attached to a family or a household. I am not referring to land for building a house in township alone, but also where you can farm or have access to natural endowment on a farmland**.**
> (KII with a hunter in group A in Ipe-Akoko, June 2008)

In addition, they indicated that the topography of Akoko featuring hills and rocks makes availability of land for farming to be limited. In spite of this however, the people remain one of the biggest producers of food crops supplying Ondo State and South Western Nigeria. It is also noted that Akoko people do not exploit the natural resources found on their land for economic purposes due to the beliefs attached to them. Natural resources such as rocks, hills and rivers are sacred and many of them are deified, especially when they are closed to human settlements. As for such resources that are remote to villages and towns, the people still attach an aura of such

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beliefs to them and maintain that they are mostly sacred. While quarry is done in some places such as Supare-Akoko, Ebo-Oka and Ikun-Akoko, the quarry activities are undertaken by companies not owned by the Akoko people and their economic effects are less felt by the rural Akoko people.

As a patrilineal society, ownership of land is more opened to males, while women can only have access to the use of land. Women's access to land is neither permanent nor transferable. This is to restrict women from competing with men and also to reinforce the culture of male dominance. It is also to restrict women from cultivating permanent cash crops on land to which they have access, so as to avoid their permanent claim to the land. Land is mostly transferred through inheritance and rarely by sales. It can also be by gift and loan, mostly among siblings. Farmlands are also transferable only by inheritance, loan and gift and not by sales, but in some exceptional cases some portions of land are offered for sale especially for building purposes. The shortage of land is responsible for why people are building houses on the hilly environment when there is relative shortage of level land for building houses as earlier indicated.

Inheritance of farmland by male members of the family in rural Akoko communities is allowed upon marriage. Unmarried male members can have access to land only by loan or gift. This medium fails to confer permanent ownership of land to the beneficiaries. Upon the death of the beneficiary or when the beneficiary no longer uses the land, the land is returned to the principal owner if it was a gift. On loan, the land is covenanted for a specific period ranging from one to five years. Married males who inherit land are obliged to allow their wives access to such land and can use the land for farming only. In form of ambilineal, a woman in her natal household has access to land through her father, paternal uncles and brothers as shown in figure 5.1.3 below. Such a right is only restricted to the use of land for farming.

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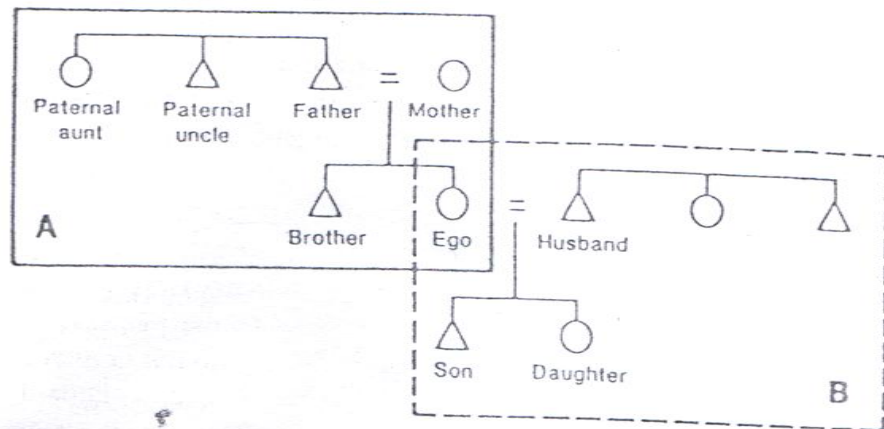
Fig.5.1.3 Women's Position in Akoko Household



> As further explained in key interviews, Group A above is a woman's natal kin group and Group B is her marital kin group. The ego may retain rights to access land and her status in her natal kin group after marriage. But the right and control on the land rest on the woman's father, paternal uncles and brothers. Group B is the woman's husband kin group. The ego may have rights on land through her husband, depending on if she produces children, and in most cases, male children. She loses rights to access the land in this group on the death of her husband. In all cases, when a woman loses her husband to death when she is still under child-bearing age, she is given to another man in her husband's household and her rights on her late husband are transferred to the new husband as a trustee. The woman still has right to access the land, but the children of the deceased upon becoming adults take over the land.
> (Exerts from both KII and FGDs, 2008)

It was also indicated that power relations in the household can influence right of access to land. They also asserted that individual positions in the family such as political and economic standings determine the power source. Information obtained from KII and FGDs further revealed that individuals, either male or female, that are politically influential, such as the head of the family, heir apparent and members of the family holding political offices in the community within the family, may have more rights of access to land either for farming or building purposes. Similarly, individuals that command buoyant economic fortunes may have similar opportunities. As observed in the field, women still rarely have these opportunities as Akoko local politics is still male dominant and women lack enough economic opportunities that can give them economic power. The above findings suggest that other than the household in rural Akoko communities, a family unit in a household has actual control on land while children, women and less privileged members of the household do not enjoy the equal right of access to land compared to adult males who are biological members of the household. Access to land in rural Akoko communities indicates how crucial culture is at play in acquisition of land. However, this does not rule out the fact that the topography of the community also prevents general accessibility.

In rural Akoko communities, apart from land, labour is another factor of production which forms an important aspect of household economy, and it is accessed

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and organised in a culturally defined pattern. Labour is basically generated within the household as well as through external sources, especially where relatively large scale farming is involved or when the household cannot provide enough labour by itself. Each family unit, constituting a household, recruits labour for its economic activities. The issue of labour in rural Akoko is significant in the context of the community kingship ideology known as *Moye* (which emphasises welfare creation among members) as it helps to simplify or defuse potential economic tensions. Information gathered through KII and FGDs reveals that members of the family such as wives, children and husbands are the primary sources of labour. It was also gathered that when such family labour is not enough, especially among farmers with relatively large cocoa plantations, yam and cereal farms, the people would resort to the use of hired labourers and/or engage in cooperative labour from members of the household to complement the family labour.

Cooperative labour involves some members of the household, who have informally agreed to work together in rotation. They do not charge cash for their labour, but the host has the moral responsibility to take care of their welfare (providing food and housing) during the period of their services in the host's farms or project. Furthermore, hired labourers are sourced mostly from among the neighboring *Edos, Igalas*, *Idomas* and *Tivs* who charge both cash and feeding for their labour.

In FGDs with group A, the organisation of labour in rural Akoko was discussed extensively. Discussants indicated that gender factor and intensity of economic production matter in the organisation of labour in Akoko community. Though there are many economic productions in rural Akoko communities, farming production constitutes the largest labour recruitment. In labour recruitment, women and children are excluded from certain aspects of farm production. Mostly in cocoa production, women and children are meant to pack the cocoa fruits from where they are plucked to where the cocoa beans/seeds are to be extracted. Men do the breaking of cocoa pods and women and children collect the seedlings. Women and children also carry the seedlings and these seedlings are usually heavy as a result of the water that is collected in the pods. The drying of the pods is also done by women and children, while men and women undertake the sales of the dried seeds, though women assist in some cases to sell. In addition, men are responsible for cutting the cocoa fields and spraying the plant with fungicide and other chemicals. During the spraying,

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women and children collect water from sources that are often located far away from farm locations.

Plantain and palm oil production are regarded as low intensive farming activities, and thus, they are exclusively left to women. The production of yam rests squarely on the men folk but vegetables and pepper are produced by women. In both vegetables and pepper, women dominate the labour recruitment for packaging the yams from the farm to either the markets for sale or the village for storage. All the above explain the labour recruitment in farm production within a micro family unit in rural Akoko community.

Another form of labour in rural Akoko community is one that is known as "*Abo*". This involves inter and intra-labour recruitment that may extend beyond family units and households generally. This labour arrangement is sought when an individual does not have the required capital or dependants that could provide the required labour. This system involves limited members of the household ranging from two to three individuals, unlike the cooperate labour that may require about ten or twenty people in service. Like the cooperate labour, it is also done in rotation among the consenting participants. Most informants claimed that they prefer engaging in *Abo,* especially when there is no support from anyone. It is adopted, especially when one has a big farming project that requires several days/months to complete. A farmer whose opinion buttresses the above claims states why he engages in *Abo* to compensate for shortage of labour:

> I engage in *Abo* because I do not have people that can help me.All my children are too young to take active part in farming. I have to device a means I can engage in that will simplify the task involved**.**
> (KII with a farmer in group A in Akunnu-Akoko, April, 2008).

Apart from the above, some informants in FGDs indicate that they engage in the use of hired labourers at times and augment it with labour provided by their wives and children. Some informants said they avoid the cost of hiring labour to save cost as well as increase productivity. Some men in rural Akoko engage in polygamous relationships and have many children. This was often done in the belief that those women and their children would provide much labour. This is usually common among full-time farmers and other people engaging in expanded productive

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businesses. The household set-up often determines the way individuals coordinate their affairs. Women and their children relieve the men of hectic labour tasks and reduce the overall cost of production to the barest minimum. Men without this privilege would often engage strictly in *Abo* for their labour need.

Some discussants who like to engage in *Abo* also claim that it does not require an overhead cost and that it goes a long way to increase the production capacity of an individual, as well as household in general. Some informants also comment on the uneconomical aspect of hiring labour with cash. A farmer in Ipe-Akoko said: "my wife and children are the people I use for labour in my farmland to reduce the cost of production". Majority of those who claim to be full-time farmers made it clear through their statements that it is not economical to hire labourers; they opine that one would spend a lot of money cooking for them and paying for their services. The money that should be used for this form of labour could be used to meet other domestic needs. This claim is evident in the assertion of a farmer as follows:

> Hiring labourers to me is not economical. Though some people are doing it, I prefer using my children and wives as my labourers. This is because we are all going to benefit from it and it will reduce the expenses to the barest minimum. Hiring labourers often requires huge expenses. The money that is supposed to pay hired labourers will be used for other economic needs within the household.
> (KII with a farmer, in group A in Akunnu-Akoko, April 2008)

Ajugba is another system of organising labour in Akoko. In this system, labour is offered for needs, food and other things other than money. Within this arrangement, there is a negotiation between parties as regards the measurement of labour to be exchanged for some particular needs. When negotiating labour for housing, only household members that have social ties in the household are involved in the negotiation. They also include outsiders (hired labourers) that have been integrated into a particular household. They provide labour in exchange for accommodation and accessing farmland.

Labour recruitment system states that as women and children are cut out of access to land, they are still saddled with the burden of providing labour. In all the labour recruitment systems, women and children constitute the bulk of labour, especially in farming which is the predominant occupation in rural Akoko households.

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Women and their children relieve the men of hectic labour and reduce the overall cost of production. This goes a long way in increasing productivity for the members of a household.

Capital also constitutes another factor of production associated with household economy in rural Akoko communities. The important capital includes money, farm equipment, working implements and household utensils. Access to these resources varies from one household to another. Nonetheless, there are four common ways through which an individual gets access to household capital in rural Akoko. These are through marriage, inheritance, loan and individual donations and gifts. A woman in the household has access to capital because of the marriage contract she has with her husband in the house. A woman can share some items that belong to her husband, insofar as they are on a good marital relationship. Children also benefit from material capital owned by their parents. Upon the death of their husbands and parents, both women and children inherit the property left behind by the deceased. The access to capital is also facilitated by loan. The money for the purchase of farming implements, cultivation of the farm and processing of farm products can be obtained through loans from other members of the household. This is to enable the individual concerned to benefit from household capital and to boost economic production. Individuals can equally benefit from gifts and the donation of capital items for economic production. Members of a household may donate some amounts of their cash to an indigent member or loan out farm implements to deserving members as a gift to boost their economical activities. This is usually anchored on the concept of *Moye* (a kinship ideology that emphasises welfare creation), a concept that is predicated on the idea that mutual assistance to one's kinsmen is obligatory.

There is a cultural belief in rural Akoko communities, that entrepreneurial skills should be transferred through socialisation in order to draw the attention of the gods of abundance. The belief is that if a child is socialised into an economical skill, the knowledge imbibed would be perpetuated and would remain with the individual forever as a means of boosting economic efficiency. Though attitudes and skills for economic production rest on individuals, they are also subjectively determined. In terms of entrepreneurial skills, the individual is socialised in such a pattern that there is a premium on economic values such as prudency and diverse skills of production, especially in agriculture. Information from FGDs indicates that some members of

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household are known to be very skillful in the production of some economic goods. Such skill needs to be passed to their offspring in order to replicate such in the household. It was also gathered that in the rural Akoko, women and children are more entrepreneurial with more vocation and production skills than men. Women are also more skillful in the sale of agricultural goods than men. Women market farm products for their husbands. The KII conducted with group A reveals that men are conscious of women's sensitivity to money and so they try to keep women from being aware of the sales so that women would not capitalise on that to ask the men for cash.

Role Differentiation in Household Economy

Role differentiation is one of the major strategies adopted in household economy in rural communities of Akoko. In the FGDs conducted with group C, the discussants indicated that the differentiating roles are significant to creating efficiency and orderliness in the household economy in rural Akoko communities. This involves allocating roles based on age, gender and social hierarchy. While in some cases such role differentiation remains complex, especially when determined by social hierarchy, gender and age, there tends to be a sharp differentiation. This is manifested in all household economic activities and relationships in Akoko community. The discussants in the FGDs also asserted that before a production activity begins, gender and age factors are put into consideration before assigning roles. The nature of production, the purpose for production and the risks involved in the production determine what sex and age category the people to be assigned the roles belong to. Vibrant economic and political activities such as farming and political decision making in the household are dominated by men. This is anchored on the belief that men are the pillars of the homes and are responsible for the care of both women and children.

As the pillars of households in Akoko, one of the men's vital roles is to cater for the capital expenses in the household. They are to pay the children school fees, apprenticeship fees and finance big capital projects (such as building houses, buying implements), while women are to take care of minor expenses in the households (such as providing little amount as running costs in the household). This does not rule out the possibilities of role exchange, when one of the parties is deficient due to one reason or the other. Any person who could not meet up with his or her role is usually seen as an irresponsible entity and commonly called *Ero-usa* which meaning

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worthless entity. Men often struggle to meet up with their roles, because a man's personality is evaluated by his ability to exercise his roles and responsibilities.

One of the role differentiations in rural Akoko community is decision making. The vital decision as regards what to produce, distribute and consume within the household is the exclusive preserve of men. These are decisions that are very strategic in promoting and enhancing efficiency in household economic endeavours. Women and other members of household are to suggest ideas that could contribute to better decision making by men in the household. Indeed, any idea has to be opened to and subjected to endorsement by all members of the household before any action is taken. Every member of the household has control on his or her private affairs without hampering the welfare of other members of the household.

Roles are also differentiated in the production of both agricultural and non-agricultural commodities in rural Akoko communities. In the production of agricultural commodities, women are not allowed to take up some roles which they believe might be dangerous to their health. This idea might deprive women of the intensive labour that could make them gain control of capital. For instance, in yam cultivation in rural Akoko, men control the land and the labour of the household. Men do the clearing and the procurement of yam seedlings for cultivation because clearing is believed to be stressful and tedious for women to undertake, and the procurement of yam seedlings is believed to be a significant aspect of yam production, which men control. It is believed that if women are engaged in procuring yam seedlings, they would take control of the production by appropriating such role to mean ownership of the yam farms.

However, women are involved in the planting of seedlings and weeding of the farm, with the help of their children, when necessary. While women are also engaged in owning their own yam farms, the procurement of yam seedlings for such farms is still left for their husbands or brothers on behalf of the women. In the opinion of a key informant with group A, he said if a woman is allowed to procure yam seedlings for planting even in her own farm, she takes exclusive possession of the farm and she will wrench control from the men. Another informant also affirmed that since a woman is not regarded as a permanent fixture of the household by the reason of the fact that they could be divorced and or they could leave the household where she owns a yam farm, if such a woman procures the yam seedlings, which she planted by herself, she may transfer the farm to her new husband. While women in rural Akoko can take part

in the cultivation of food crops, they are totally excluded from cultivating cash crops like cocoa and kola nut. Nonetheless, they participate in the processing of farm produce into finished products before offering them for sale.

Palm oil production is a common activity in the study area, which requires complementary roles from men and women, irrespective of age. While it is true that both men and women are involved in palm oil production, it is equally true that it is a female dominated terrain of economic activity. Traditionally, in the past, palm oil trees were not deliberately planted; the seeds were dispersed through natural agents such as wind, erosion and unintentional human impacts. As a result, there was no gender influence in its cultivation and the situation has remained much the same today in rural Akoko. The men are involved in the harvesting of palm seedlings, which requires climbing tall palm trees. Both women and children do the collection of the palm bunches and the removal of the seedlings from the husk. The women and the children also gather the seedlings and boil them. They are also involved in all the other processes connected to the extraction of oil, which include washing, collation of raw oil, stirring and the refining of the crude palm oil through heating. Palm oil production is very significant in the sense that, almost all cooking requires the use of palm oil.

However, in rural Akoko communities, non-agricultural activities within the household are less determined by gender and age. For instance, the production of local soaps, shoes and pots is not barred by gender and age, especially when those involved are youths. However, only adult women are involved in the production of local soaps and pots and only adult men are involved in the local manufacturing of shoes. The above analyses suggest that women and children constitute the dominant labour requirement of household economic activities in rural communities of Akoko in Ondo State.

The men control the economic resources in the household, while the women help to safeguard the resources. The men's control ranges from supervision to monitoring and distribution of resources. Though women are not allowed to have control over some economic resources in the household, there are exceptional instances where they are allowed to make use of certain resources with conditions attached. They cannot do anything to these resources outside the knowledge of the men. These resources include household proceeds from agricultural commodity to be offered for sale, cash crops, tools, farming implements, among others.

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Women's contributions to household economy

The home is regarded as the main office of the women in rural Akoko communities and based on this, they are known as home managers. They have vital roles to play in household economy despite their disadvantaged and subordinate position in the household. Their contribution is manifested in the various ways in which they participate and coordinate most of the household economic activities. The women, with the assistance of their daughters, mainly undertake female tasks, performing domestic activities which are very significant to household economy. The women take up reproductive roles, raising children and supporting their husbands' relations. As a cultural rule in household economic practices, they are generally expected to assist the men in economic activities. The rural Akoko people feel that husbands play the most important economic role in the household as providers and economic managers. So the wife's economic contribution is construed as helping. The culture of Akoko places women as instruments that subsidise and complement the efforts of men. This is usually evident when men and/or household heads are not economically strong to take proper care of their members. Women stand out to take up such responsibilities in order to alleviate the challenge. There are exceptional cases where a few households (about 7%) are being financed and sponsored by women, mostly in Akoko rural communities. However, this is not a common occurrence in Akoko culture.

Women in rural Akoko communities provide cheap labour for their households, most especially in agricultural activities, as Akoko is mostly an agrarian community. Women do 70 percent of agricultural activities, especially farming activities. Apart from the clearing and cultivation of the land which is usually done by men (though some clearing and cultivation are done by the women when the need arises), weeding and harvesting are done by the women and children. In cocoa production, women assist their husbands in the breaking, extracting and drying of the cocoa seeds. Apart from this, women in rural Akoko communities are responsible for marketing the finished agricultural commodities in the market. This is anchored on the belief that women are endowed with sales acumen which can increase the household income.

Women also manage land in addition to other economic resources put into their care. Apart from land, some of the resources (such as tools) are kept in "*Odin*" (a

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small store attached to women's room, usually without window and dark). As earlier stated, the women of the household do not have control over these resources, but they act on behalf of the men and the entire household to manage the resources. The women manage land in the sense that all the cultivated and the natural endowments on the land are monitored, collected and tapped for consumption and or sold on behalf of the entire household as previously indicated. Most of the natural resources would have been wasted if they had not been monitored and tapped by the women. For instance, a woman in Ese-Akoko narrated how she plucked and gathered unprocessed locust beans from their farmland and sold them and gave the proceeds to the household head to augment household expenses.

It is when one is in good health that one is capable of carrying out economic activities. This is one of the beliefs in rural Akoko communities. Most of the household economic activities in rural Akoko communities involve ascending and descending the hilly and rocky environment, which can only be possible for healthy person(s). Women have contributed a lot to secure the health of their household members in order to make them fit for economic activities. Women do this in several ways. One of the ways is by cooking medicinal soups; another is preparing concoctions to prevent and/or cure illness. Also, women go out to find leaves, barks and roots to prepare *Agbo* (medicinal drinks). Women, with the support of their children, engage in fetching water and wood (which is time consuming) to prepare *Agbo* and other concoctions. Apart from this, women do engage in popular health discussions with their colleagues in market places to elicit more information about households and the caring patterns. All these health seeking behaviours of women promote productivity and reduce the amount spent on healthcare to the barest minimum.

Women mitigate the economic deficiency of households in a numbers of ways. This is done through engaging in local thrifty societies organised within the household as earlier indicated. This is a local set up in which some groups of individuals contribute cash together in a joint account and later lend it out at a low interest rate. The initial amount contributed by individuals could be withdrawn to augment deficiency of husbands/and or households. Many of our female discussants narrated ways in which they had augmented household expenses through these means. Apart from this, some women have stalls in markets where they display and sell consumer goods, while some have sheds in front of their house for the same purpose. Most

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times, proceeds from this trade are not much, but women claimed it provides some amount to augment their husbands and or household expenses.

Women in rural Akoko communities carry out remedial acts in terms of ritual performances during economic failure, especially bad harvests. A remedy is sought in the form of ritual performance in various forms which include engaging in prayer and fasting; and embarking on ritual sacrifice. Christians and Muslims engage in prayer and fasting, while the traditionalists engage in ritual sacrifice. Women do devote their time to these activities because of their sensitivity to spiritual things. The women appease the gods/goddesses or ancestral spirits believed to be responsible for the economic failure that has implications for the household economy. At the community level, the aged women do embark on processions, wearing only underskirts and holding brooms in their hands to chase away the evil that is threatening their household economy.

In many of the households the researcher visited, especially in the core rural Akoko, such as Ikun, Ipe and Ese, many old women take care of the young children. The old people gave reasons for doing it. They explained that some of the activities that are supposed to be engaged in by the women to generate certain amounts for the household are usually made impossible by the need to care for their children. Most times, nursing mothers would not be able to go for their normal businesses as indicated by the informants. Those that could manage to attend to their work complained of their children disturbing them. In most households visited, especially where the women travel to other neighboring towns and villages to trade, women in the households babysit for their fellow women. This allows the nursing mothers to go for their economic endeavours to cater for their household dependants.

> Most of these babies would not allow their mothers to walk in the farm, or to buy and sell conveniently, you know that traders in the market need to run and rush towards customers and in the process they (the children) could be disturbing. Many have been complaining that they could not offer tangible things as a result of this. That is why we help them to take care of their children so that they will have time to concentrate on their economic activities and have something tangible for the household.
> (KII with a palm-oil producer in group A in Ese-Akoko, July, 2008)

5.2 Cultural strategies in household economy in rural Akoko communities

The production and the consumption at the micro level of organisation in rural Akoko do not exist in a vacuum but are guided by customs, beliefs and values which dictate the economic relationship within the household. These constitute the means through which they strategise in their economic endeavours. In all the study sites, informants indicated that emphasis on cultural factors on this relationship is to guard against any undue and unruly act, and also to ease the flow of interactions. It was gathered that strategising is also a way of adapting to the topography of Akoko (that is in the form of a hilly and rocky environment) which constitutes a challenge to their economic security.

Based on the above reasons, there are cultural strategies adopted in the household to enhance economic security. There are two concepts in rural Akoko communities that define the means of operationalising household economy. They are *Abo* (the system of organising services/labour) and *Ajugba* (the system of exchanging labour for economic goods). They are concepts that capture strategies adopted in household economy in rural Akoko communities. Strategising simplifies the economic tension and eases the economic relationship. The strategies reflect in all economic endeavours in rural Akoko communities. *Abo* and *Ajugba* are anchored on the concept of *Moye* (a kinship ideology emphasising welfare creation) which demands mutual assistance in economic activities and makes responsibilities towards one's kinsmen an obligation.

The *Abo* and *Ajugba* are culturally inclined and pervade all household economic activities in rural Akoko communities. The two concepts are very important in reducing economic hardship in the household. According to some informants, the concepts of *Abo* and *Ajugba* serve as modes of operation in Akoko household economic system. Both strategies serve as mechanisms through which members of households are channelled towards economic security. Apart from these, there are some other sub-strategies which are subsumed around *Abo* and *Ajugba* strategies that transcend their customs, values and beliefs and serve as underlying structure for economic interactions.

One of the strategies is making rules and regulations that guide economic interactions in the household. This constitutes a standard through which one exercises appropriate behaviour towards one's kinsmen. It was gathered that no matter the

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advocacy for peaceful co-existence in the household, one is bound to err in one way or the other. A key informant in Ipe-Akoko maintained as follows:

> It is very true that where more than one person cohabits and interacts, there is the tendency to err, as some people would still want to behave wrongly. In order to guard against this, there is the need to have rules to guide the relationship so that things would work well. Where there is no law there is no sin.
> (KII with a hunter in group A in Ipe-Akoko, June 2008)

The rules and regulations are accompanied by anticipated punishments (in the form of fine and sanction) that serve as checks and balances. This strategy is the lens through which one's economic behaviour is measured and evaluated, because it constitutes the cog through which the wheel of economic interactions rotates in Akoko community. Informants indicated that the rules and regulations are strictly adhered to in order to avoid being a victim.

Another strategy adopted in household economy is making welfare creation an obligation towards one's kinsmen. This strategy is anchored the principles that make economic activities more complex and tasking in rural Akoko communities. FGD revealed that the concept of *Moye* advocates mutual assistance in economic activities among the household members. The concept is a kinship link that specifies where to generate labour and exchange goods and services. It is a means of bridging economic disparities among members. It is even a taboo for one to ignore the act of taking care of one's kinsmen because it attracts a serious consequence. A key informant who is a farmer highlighted the need and consequence of the failure to observe it, and said; "the culture stipulates that one should take care of one's kinsmen and draw them nearer; it is even a taboo for an individual to see his fellow kinsmen suffering and put his face off when he is in a position to help, such action could attract the wrath of ancestors".This strategy is highly significant in the mitigation of economic insecurities and aligns with other strategies to maintain unity in the household.

Another strategy adopted is instituting the norm of economic networking. This is also where the concept of *Moye* is important because it specifies various directions of links for networking. This strategy is also where *Abo* and *Ajugba* actually come into play in a household economic context. *Abo* is the exchange of labour for labour/service in order to augment labour deficiencies and also to reduce the cost of production in the household. *Ajugba,* on the other hand, is the exchange of labour for

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goods or goods for goods. *Ajugba* promotes access to goods that are considered necessary for people's welfare. Both *Abo* and *Ajugba* make one to have access to labour and economic goods without incurring any cost. Individuals are obliged not to breach any contract subsumed in *Abo* and *Ajugba.* Both *Abo* and *Ajugba* are said to have impacted on every aspect of the economic life of members in the household. FGDs revealed that they are so important in the time of dire needs and constitute a way of coping with economic insecurity in the household as earlier indicated. The system has become so popular and acceptable in the socio-economic life of the people that many ignore other means of recruiting labour and acquiring economic goods, especially outside *Abo* and *Ajugba.* One informant narrated how he has engaged in both practices as follows:

> I have a large plot of land that I cultivate yearly that requires many months to finish. I engage in *Abo* so that I can recruit many hands to make this possible. I also engage in *Ajugba* to have crops planted in the cultivated lands. At the end of the day, I realised that everything is okay. I do not even wish to recruit labour outside *Abo*. Likewise I also engage in *Ajugba* to acquire whatever I want to plant in my farm.
> (FGDs with group B in Ikun-Akoko, March, 2008)

Another aspect of economic networking is the pooling of economic resources together by household members and redistributing them at an agreed time. It was meant to strengthen kinship ties and to help indigent members to ascertain reliable means of survival. A certain percentage of their outputs is required to be given to the household or the equivalent be paid in cash as substitution. All goods that members of the household co-produce centrally were also brought together and later re-distributed based on specified criteria. Apart from the goods and commodities that were brought together, they also combine their labour forces to produce economic goods that can generate income for the household. In rural Akoko communities, it is not uncommon to see some members of a household offering their labour to other households to generate goods and other commodities that can benefit their household members. Members that are not around within the communities usually contribute their quota by sending home cash or other commodities required from them.

The idea of pooling resources is also to fulfill the welfare issue created by the concept of *Moye*. The pooled resources are later redistributed based on stipulated rules of sharing. *Ajua* (care-taker) is appointed by members of household or by the

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Opon (oldest man in the household) and acts based on some certain qualifications. It is *Opon* that would instruct *Ajua* to redistribute the pooled resources acting on stipulated rules. The *Ajuas* are fearless and militant in nature. In some exceptional cases, they act based on the discretion of the head of the household in conjunction with the opinions of members of the household, when necessary. At times, they are allowed to use their discretion to distribute by capitalising on the various economic challenges of individual(s) or groups.

Another strategy adopted in household economy in rural Akoko communities is gender based allocation of economic roles and responsibilities. This strategy takes its inspiration from patriarchy that dictates the direction of power relations in the household. The patriarchal system in Akoko confers economic power and the rights of making decision as to what to produce, distribute and consume within the household on men. Other members of the household depend on the decisions of men (which may or may not be in agreement with the wishes of women and children at times). This is associated with the belief that men are often the head and they are naturally endowed with the gift of coordinating a home. This is actually applicable to things that concern the welfare of the entire household. This does not rule out the individual autonomous decision making that could promote their welfare. The purpose and effects of the practice were extensively discussed in focus group discussion sessions. Discussants expressed their views and highlighted the defects attached to it. From their comments, it became clear that cultural reference to male supremacy in decision making does not often bring an optimal result in all situations. In some instances, it kills the initiative of others that probably would have stimulated the economic progress of household members. A woman whose view supported the idea, but highlighted the likely defects asserted:

> The men are our husbands and heads; we need to respect them and obey them as well. We need to follow their instructions and decisions, since it is what the culture stipulates. Nevertheless, their decision making on some issues do not bring out a desired result in some cases. Most times others in the household have better ideas that are more useful for decision making.
> (FGDs with group C in Ipe-Akoko, June, 2008).

Another aspect of gender allocation of economic roles and responsibilities that is similar to the above is the gender aspect of crop cultivation. Men are given the

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reserved power to cultivate cash crops, such as cocoa, kolanut and rubber which generate a huge amount of capital; while women are limited to cultivation of food crops such as cassava, cocoa-yam and groundnut which attract low income and are consumable at home. This act also reflects patriarchal norm integrated into strategy of allocating economic roles in rural Akoko communities. It is a cultural strategy to suppress women from competing with men financially in the household. Also, it is believed that men have more chains of responsibilities that require huge amount of cash to perform than women. Women are seen as home managers who provide food for the household. A farmer in FGDs, in trying to justify the act, maintained: "Women have less financial responsibilities, they are to compliment men's financial responsibilities and assist in solving men's financial deficiencies to a limit, otherwise, such responsibilities are negatively perceived". It generates controversies in most of the FGDs sessions where some female discussants later argued that women spend on things that would benefit members of the household and that most things that men spend money on are things that give them pleasure outside the home. A female informant eagerly said: "what women spend on are more than men in this area, men spend more on things outside the home, some spend for their concubines and take alcohol with their colleagues; all those things glorify the devil and attract poverty at last". Most female informants suggested that restricting women from cultivating cash crop does not provide for balanced economic efforts, which could have implication on the economic advancement of the household at large.

Apart from the strategy discussed above, another cultural strategy adopted in household economy is instituting power relation into economic interaction. This strategy also draws its inspiration from patriarchal system. It is meant to balance-up any economic relationship that can obstruct welfare in the household. This is reflected in many economic dealings in rural Akoko communities. A man has the right to stop his wife from engaging in a business or work that would not let her have time to take care of the children and other members of the household, even if the economic activity generates a large income. It was gathered that such a woman does not have the right to hesitate because the culture believes that she has to submit to her husband's order. According to some female informants, this act could create some economic defects within the household. A female discussant shared her experience:

> I used to buy dry fish in Lokoja and sell at our local market here. I made a lot of money then. Then I did not

> have to wait for my husband before I spent a penny for the household. All of a sudden, he stopped me from travelling, complaining that it was far, risky and did not give me time for the family. I had to comply because it is culturally stipulated that you have to obey your husband. Now, I am at home engaging in small business that fetch just small token which could not be compared with the former one. Now I depend much on my husband for household expenses and it has affected both of us and the household at large.
> (FGDs with group C in Ese-Akoko, July 2008).

Apart from the above, powers relations extend to system of accountability in the household. Men are not accountable to anybody in the household after the sale of economic goods. There is a custom of independent earning and autonomous spending by men while women do not a have full autonomous spending from household income. Women are required to account for the sales of commodities offered for sale on behalf of their household. If a woman fails to comply, she is regarded as unfaithful and rebellious and such action could incur the wrath of ancestors. Men are not accountable to anybody. Some female discussants justified the purpose for this practice, but they highlighted some of its implications. A woman whose opinion summarised those comments said: "the idea is somehow good because some women are very arrogant; when they get a little amount of power, their husbands become their boys. However, if we look at this act in another sense, it kills the morale of women and does not give room for household economic progress".

Another cultural strategy adopted in household economy is the system of conserving economic goods. It involves the means of conserving and, preserving economic goods for future utilisation in rural Akoko communities. This act is meant to prepare for the future. This is to cater for unanticipated future expenses. It manifests in several ways including keeping cash, putting harvested crops in barns, and rearing and domesticating of domestic animals. The most common act is keeping of domestic animals because it is significant to warding off evil. It is culturally believed that rearing of domestic animals is a way of warding off evils and economic loss. Most informants expressed their view and argued that any evil or loss that may happen to them is transferred to the animal. Based on investigation, it is gathered that such practice is economical, because the pets could be offered for sale whenever an individual or household runs out of cash and or when there is an urgent economic

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needs to be met. In addition, to some extent they could be slaughtered to serve as meat source.

5.3 Household economy and health seeking behavior

Household economy forms one of the basic things by which one enhances livelihood. It has both positive and negative effects on health and health-seeking behaviour among the rural people of Akoko. Farming, which constitutes 80 percent of economic activities in the study areas, requires ascending and descending the hilly and rocky environments which makes production more stressful, and consequently makes people vulnerable to some health challenges (such as fever, leg-pain and body-pain). In KIIs and FGDs, informants asserted how farming activities, which are more prevalent, are done in arduous conditions because the implements (cutlasses and hoes) used for farming are crude. Most of the lands they cultivate have small stones which make cultivation and planting relatively stressful. According to most informants in FGDs, the stressful activities often result in health challenges such as body pain, leg-pain, body-pain and fever. Palm-oil and *gari* productions which are forms of economic activities require different stages. These activities are also very stressful due to constant ascending and descending of the hilly and rocky environments in search of firewood and water in rural Akoko communities. Both *gari* and palm-oil productions require fetching of firewood and water. The frequency and constancy involved make it very stressful due the nature of the physical environment of the area as earlier stated.

> It is not an easy thing at all, to fetch water and firewood from this area as it creates stress due to ascending and descending the hilly and rocky environment. One has to do this as a responsible person and before you know it, your body would respond to them. That is why many people complain of leg pain and fever in this area.
> (FGDs with group C in Ese-Akoko, July, 2008).

However, rural Akoko people embark on actions to overcome these challenges. They make sure that their implements, especially hoes and cutlasses, are very sharp so that the activities are less strenuous. In consequence, there is a reduction in body-pain, fatigue and injuries. In order to overcome the stress involved in ascending and descending the hilly and rocky areas, they seek cooperative work that would lessen the stress involved in the frequency of ascending and descending the hilly and rocky

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environments. The number of times an individual needs in ascending and descending the hilly areas for every stage of production is reduced through cooperative work such as *Abo* and *Ajugba.* For example, for gari production, every stage which includes planting and harvesting the cassava, peeling and steaming, refining the steaming through frying are done through cooperative labour to lessen the stress in order not to have health challenges. This is also applicable to palm-oil production which includes harvesting the palm-seeds, boiling, extraction of oil and refining the crude palm-oil through heating. According to informants, it is difficult for one to single-handedly undergo all these stages without exposing oneself to a high degree of stress.

In rural Akoko communities, production in the household forms a part of household economy. It takes different forms and requires labour that makes rural Akoko people susceptible to various health challenges. They guide against these challenges by engaging in joint labour as mostly evident in household labour recruitment. These arrangements, according to informants, are to increase the level of household production and reduce stress in an individual's work. This system of labour recruitment showcases the concept of *Abo* whereby labour is exchanged as a way of procuring health. The task which a person is supposed to do will be done by two people or more. It is a sort of relief system to increase efficiency of labour to maximize production. It was evident from respondents that when the level of production increases, welfare level will also increase and hence, healthiness is guaranteed. When there is much pressure within the household on how to cope with challenges of limited hand for labour recruitment to increase production, rural Akoko people engage in diverse means to overcome these challenges.

One of the ways to overcome the challenges is usually by engaging in polygynous relations so that the wives and children would be a source of pooled labour. This system is usually adopted in order to maximise productivity and minimise production cost, both in the long and short-run. Some of the interviewees justified the essence of this practice. Though not all polygynous relations are for this purpose, most of them in rural Akoko are for productivity, purposes especially among those that engage in agrarian activities. According to many informants, the system minimises the risk of fatigue and stress. Since many people are involved in a task, there is the tendency for an individual to enjoy certain relief; hence, has positive effects on the health of the individual.

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Other forms of productive endeavour in rural communities of Akoko are wood carving, palm-wine tapping and trading. They form an aspect of household economy in which the people seek livelihood. Trading involves buying and selling of economic goods (especially farm produce) from farms located at different towns and villages. The proceeds from these activities are used to support the household needs. Some informants that have experienced this complained that traveling to other villages and towns to buy and sell is strenuous. This, according to them, makes them vulnerable to fever, body-pain and rheumatism because of long walk and sitting on the back of trucks for long. Some of the informants who buy and sell in nearby towns and villages said they walk because they know they will still sit down for long in the market. According to them, walking is used to exercise themselves to avoid health insecurities as well as to minimise cost and maximise profit, so that they could have enough to buy things for the household. According to the informants, these were anchored on the belief that when one is able to meet up with necessity of life, health is also guaranteed. The following summarised what a respondent said:

> I often go to farm as early as possible in the morning to find thing that I can sell in the market to have some money to buy ingredients for soup or any other necessary things needed at home. At times I trek to the next township market in order to avoid transportation cost so as to have enough money left with me to provide those necessary things. Walking is also part of exercise that would not let your body accommodate some illness. (KII with a farmer in group A in Ipe-Akoko,June 2008).

Consumption is part of household economy and is also done in various forms that constitute health-seeking. Culture in relation to food sharing makes rural Akoko people have the belief that "food is life" and that anybody that is totally denied of food will eventually die. This is why taking food is acknowledged among humans with belief that food sustains life. Food sharing in Akoko is based on age and sex. Although there are exceptional cases where this does not hold, in most cases, it is through age and sex. Men occupy a supreme position in food sharing in the household. Priority is usually given to men and children. The reason is that men are very strong and engage in energetic works that absorb food easily, while children are still in their tender ages that require food for growth. Most times when there is insufficient food to go round the members, women do sacrifice their own portion for

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others. This arrangement, according to the informants, is one of the ways through which welfare is sought. Most times, women give out their portions to other members in order to guarantee their satisfaction to fulfill their role as home managers. At times, the members of the household do compel it for them to be fed last, because it is believed that they might have eaten some when cooking. Many women are underfed in order to satisfy other members of household. Orthodox health practitioners indicated several implications that underfeeding has on individuals in the household. One of the health workers asserted as follows:

> If someone is not properly fed due to low calorie intake, one would not have the energy for carrying out one's necessary productive and reproductive function, especially pregnant and nursing mothers. In a situation where a pregnant mother could not feed adequately, the fetus would be feeding on limited available nutrients in her mother's body and make them vulnerable to ill-health. Similarly, when a nursing mother is not feeding well, feeding of her baby would impact negatively on her health.
> (KII with a nurse in group B in Ese-Akoko, July, 2008).

As Akoko is an agrarian community, most of their food is carbohydrate oriented. They believe in eating heavy meals so that it would give them energy to carry out their activities. It includes those characterised by large amount of calorie such as *Eba* and *iyan*. This affects their health as orthodox health workers informed that most children have stunted growth and 'Kwashiorkor' as a result of too much carbohydrate. They also claimed that it makes rural Akoko people vulnerable to diabetics and obesity.

Akoko people are conscious of the need to feed regularly so as to compensate for the constant loss of energy due to strenuous activities. As most of household economic activities are stressful, consumption of food is time-conscious in order to compensate for the loss of energy. It is believed in Akoko that body nutrient is highly consumed through strenuous activities. The evening meals are often consumed early between 5.30 and 6.30 pm. They believe that the time would give allowance for quick digestion that would replenish the nutrient loss through stress. According to informants, early meals would avert constipation which might be caused by indigestion and could lead to sleeplessness. As a result of this, they often go to bed early so that it would enable them to wake up early for their daily assignments.

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Informants indicated that most of the social amenities to keep them late to bed are almost non-existent.

As food consumption is physiologically demanded, food is consumed by everybody in Akoko to sustain life but some categories of individuals are not allowed to take certain foods in order to safeguard their health. Pregnant and nursing mothers are restricted from taking some food in order to check their recklessness and secondly to save the fetus and infant babies from health disorders which can be caused through their mother's consumption. According to informants, such foods include snail, snake, okro and fried groundnut.

In rural Akoko communities, another household economy that is concerned with health-seeking includes the systems of consuming some food to generate healthiness without much financial stress. This extends to the belief of consuming some food to generate healthiness with little or no financial implication. This belief encourages them to make use of local food supplements for health purpose. Many of our FGD discussants indicated that in some cases when one is sick with a particular illness, instead of seeking care from healthcare providers, one first embarks on the consumption of some food supplements as alternatives to seeking orthodox healthcare. It is their culture to cook soup with "cotton wool" leaf for those that have pains in their joints. This soup has to be consumed for 7 days. This system, according to informants, has proved efficient in treating joint pains. In rural Akoko communities, the use of a particular herbal soup is believed to cure all diseases and illnesses. The soup is made with "*Ito*" (cucumeropsis edulis) *"Iyere*" (capsicum annuum), *"orukita*" (leucaenia gluaca). This herbal soup is believed to cure any ailment as indicated by the informants. It is also believed that it serves two purposes as food supplement and medication. There are also many other plants and food supplements in rural Akoko communities that the people consume for health purposes. In most cases, food supplements were consumed to prevent illness and to combat illness. Dry pawpaw seedlings are consumed with pap to cure constipation and typhoid. It is also consumed to kill and expel any worm in the stomach. Black beans is consumed to prevent arthritis and also to cure diabetes. Many other things are also consumed for health-seeking. Information gathered reveals that the practice reduces the cost of healthcare and the stress involved in seeking care from health providers.

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Similar to the above, cooking *Aaru* seedlings for pregnant and nursing mothers is to let them have enough blood for the natural reproduction assignments. It is a belief in Akoko that, if a woman does not have enough blood, she will not be able to carry pregnancy to terms and a nursing mother would not be able to sustain the rigour of nursing. There are also other things consumed in the household to guide one from being infected with disease and or getting ill with sickness. The general belief towards using food source as a means of health seeking is that God has created everything for our use and for our welfare. Most discussants in FGDs claim that they have been using the seed before the introduction of modern pharmaceutical blood tonic. The view of most informants is that if one eats *Aruu* very well, one will have sufficient blood which will help one not to fall sick and enable one to carry out economic activities effectively. It was also gathered from informants that the money that they would have used to buy modern blood tonic would be used to cater for other economic needs in the household.

> The kinds of work we do in this area require that we should be conscious of our health. I work in the sun almost every day. When am frying *gari*, I am expose to scourging heat which is not good to one's health. It even drains ones blood if one is not careful. One needs to be eating something that would give one blood to replenish the loss ones. I do not have money to be spending on pharmaceutical blood tonic. There are many seeds and green herbs that one could consume to give blood that would not cost you money. I am not rich enough to buy blood tonic every time. I have many other things I need to spend on. Therefore, I cook soup prepared with *Aaru* seed which gives blood free of charge. The money that I'm suppose to buy blood tonic with would be used for other more pressing economic needs
> (A FGDs with group C in Ipe-Akoko, June, 2008*).*

There are several things that rural Akoko people do to enhance economic security and to cope with the challenges of life in the household. One of those things is that people within the household save money to buy food, to build houses, to buy car and to pay school fee. More emphasis is placed on things that would enhance economic benefits. Akoko culture does not give room for prioritizing health financing in spending or saving-up some amount for healthcare. According to some informants, it is difficult to save for health purpose based on the belief that links saving with

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health. It is believed that there are more economic needs that are waiting attention than reserving some amounts for health. In addition, it is a belief in Akoko that ill-health hinders an individual contribution to household economy and any amounts spend on ill-health is loss. It is also a belief that anybody that saves against sickness shall surely fall sick. To them, sickness is not something to glory in, as no one can celebrate sickness. A traditional health practitioner who is also a native gave his view on prioritising health financing in spending:

> Sickness is not what anybody is eager to have. But it does come and we cannot deny this. It is a belief that anybody that saves for sickness would definitely fall sick. This may appear funny. There are many pressing needs or other things that one can save for; though, this act has impacted negatively on health of the people. It has left many people to meet their untimely death, especially in term of emergency. When problem comes, they (Akoko rural people) begin to run here and there to gather money, and in most cases the problem which should have been solved in time often gets out of hand and led to casualties.
> (KII with herbalist in group B in Ipe-Akoko, June,2008)

The above quotation indicates what the rural Akoko people experience when they face health challenges due to the failure to save for sickness. However, the concept of *Moye* creates social support through joint production. This system integrates a lot of networks of household dialogues and follow-up systems on welfare issues including healthcare. Though individual's choice and utilisation is affected because one cannot independently decide the kind of healthcare resources to utilise at this moment, nonetheless, the concept of *Moye* facilitates group contributions to prevent and cure illnesses.

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5.4 Cultural strategies in household economy and utilisation of healthcare resources

The cultural strategies adopted in household economy made them vulnerable to some health challenges and also influence the choice and utilisation of healthcare resources in rural Akoko communities. The cultural strategy, which makes welfare creation an obligation to one's kinsmen, impacts on rural Akoko people's choice and utilisation of healthcare resources. This is created by the concept of *Moye* that

advocates mutual assistance among household members. Though it fosters balanced economic wellbeing, it exerts coercive force on their psychological framework. The fear of incurring the wrath of ancestors by not taking care of one's kinsmen makes the people conform to *Moye* concept. The concept of *Moye* increases committed responsibilities of individuals toward ensuring the economic welfare of their kinsmen. FGDs conducted in all the study areas indicated that more time was devoted to economic activities in order to fulfill chains of economic responsibilities that required attention. This exerts coercive force on their expenses in order to meet up with chains of responsibilities that await attention. Therefore, this makes it difficult to maintain proper healthcare.

> Let me take my own situation as case study. I have my immediate family and my siblings, uncles, sisters and parents that I'm economically responsible to. It is not normal to fail these responsibilities; it creates a sort of necessary burden that expend on ones income when ones is trying to meet-up with the responsibilities. In consequence, I find it difficult to take good care of myself because of responsibilities that have chocked me.
> (FGDs with a farmer in group B in Akunnu-Akoko, April 2008).

Many FGDs discussants also claimed that providing for their kinsmen impacts on their welfare, because some of their generated products must be given to their kinsmen. This reduces the quantity available for consumption and sale. It thereby makes income generated low in rural Akoko communities. The low income makes healthcare financing relatively inconvenient. They further claimed that it suggests creating a cheaper means of maintaining livelihood and taking cheaper healthcare services in order to maintain balance. They opined that they saw no reason why they should use a huge sum of money for healthcare when there are other exigencies requiring more financial attentions. KII also revealed that rural Akoko people avoid patronising orthodox healthcare in order to avoid the huge cost involved; they claimed that such money would be useful to meet other financial obligations.

> There is nothing that could fetch us huge amount of money in this community. It is small amount of money we realise from our productive endeavour. If there are any health challenges, there are various means to minimise the amount of money to spend. I cannot spend

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> the whole meager money I have for treatment. Are we not going to eat again? There are many other things in the house that I can use money for. So whenever I'm sick, I tend to have a re-think and count the cost. I try to find means to get over any health challenge through other means that I know would not cost me much.
> (KII with a *gari* producer in group A in Ikun-Akoko, March, 2008).

Apart from the above, the chains of responsibilities make people intensify their efforts in economic activities in order to meet up with their economic responsibilities. Many rural people sacrifice their leisure hours as extra-time to engage in economic activities for this purpose. Most rural Akoko people intensify their efforts by working extra hours. As it is earlier stated, most people work from morning till late in the evening in order to have enough so that they could effectively meet their economic responsibilities. *Moye* concept creates high demands on the time and energy of Akoko rural dwellers and creates health challenges due to Akoko as a hilly topography. It was gathered that almost all household economic activities in the study areas require ascending and descending the hilly and rocky environments which make production more stressful and results in their vulnerability to some health challenges (such as leg and body pain) in rural Akoko communities. Thus, exposure to strenuous work creates fatigue and leaves little time for resting that could guaranty strong health. The possibility of having enough time to maintain their health is almost hindered due to much work engagement. This makes them to seek a more convenient alternative way to relieve them of any health challenge. The various comments and opinions of informant were corroborated as a key informant in group A maintained:

> In this community, there are cultural norms that validate the idea of hospitality among members of household. The cultural norm predisposes individual to consider the welfare of others as a matter of interest. The committed responsibilities do not give room for excess wealth accumulation. When you continue to cater for this and that, before you know it you are left with almost nothing. You cannot imagine seeing your people suffering while you spend money somewhere. Most times I find it difficult to properly take care of myself as I want. There was a time that I was not feeling fine and I needed a proper medical attention, but because I need to settle some financial responsibilities, I began to manage myself by taking herbs so that I would have time to work.

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(KII with a gari producer in group A in Ipe-Akoko,June 2008).

FGDs conducted with group A also revealed that rural Akoko people are committed workers as most are not salary earners. They need to work in order to meet up their economic responsibilities. This made them to avoid what would not let them have time to concentrate on their work. So in time of health challenges, they apply home remedies that would not cost them money and at the same time allow them to have more time for their economic activities. It was also revealed that they consult orthodox healthcare when their illness is at advanced stage after all efforts to get well might have proved abortive.

> Sometimes ago, I was sick and my husband make herbal drink for me thinking that it would heal me so that he would avoid taking me to a clinic. After some days, he realised I was not getting better rather it grew worse. He was forced to take me to the hospital where the health personnel in charge alleged him of delaying proper action on my health issue.
> (FGDs with group C in Ipe-Akoko,June,2008).

FGDs conducted in all the groups revealed that many informants are not encouraged in patronising orthodox health providers due to the economic circumstances that surround them. Such circumstances include their financial capability, the limited time for economic activities and the need to fulfil their economic responsibilities to their kinsmen. They are rather more delighted in taking both preventive and curative measures when they observe any symptom. This makes them to rely on herbal and other home remedies.

> We cannot avoid being sick; sickness will come and it will go. God created the plants and other creatures for our use. We make use of those plants and others for food and for medicine as well. Whenever I'm sick, I prepare some concoction and take them and I'd be okay. All what I know is that if one eats well and have sound sleep, one will not be sick. I do not go to hospitals unless I cannot handle the case any longer.
> (FGDs with group A in Ese-Akoko, July, 2008).

The cultural strategy which involves instituting and strengthening the norms of economic networking also affects choice and utilisation of healthcare resources. The concepts of *Abo* and *Ajugba* provide an arena for economic networking. The rules and regulations that characterize both concepts make them complex. Consequently, this

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attracts healthcare challenges. FGDs conducted with all the groups revealed that an individual A would have contracted arrays of labour to exchange for either labour and or goods, with individuals B, C, D and E, which individual A is culturally obliged to redeem them all. This often creates a sort of conflicting demands on the part of A in an attempt to redeem all the obligations. This is one of the reasons why *Abo* and *Ajugba* depict cultural attributes that make economic activities more complex and tasking as earlier stated. This also creates more service demands that attract health challenges as a result of high pressure on one's time and energy.

FGDs conducted with farmers indicated that they devote more time to farming activities in order to cope with economic challenges and fulfill economic responsibilities awaiting attention. The situation subjects them to much of work engagements on which they expend their time and energy. This reduces the available time to maintain their health. This made them to seek more convenient alternative ways to relieve them of any health challenge. A Key informant maintained:

> When engaged in various contract in *Abo* and *Ajugba* in order to meet economic responsibilities ahead of me, it usually absorb my time because I must redeem all what I have contracted. In most cases I do not have time to prevent myself from being sick. Even when I feel any symptom, I do not have time to take proper care of myself.
> (KII with a farmer in group A in Ipe-Akoko,June,2008).

Apart from this, *Abo* and *Ajugba* encourage subsistence production which usually supports subsistence living. In most cases, production of cash crops is low, as focus is more on food crops, which directly support subsistence. Few goods are often available for sales, thereby making Akoko rural dwellers returns/ income to be relatively low. It was also gathered from FGDs that some of the proceeds from farming activities would have been exchanged for labour, while some would have been given out to support their kinsmen. This usually has implication on their capability to reliably finance health challenges. In an interview with a farmer, who is currently a retired forest officer, he said: "a larger percentage of what we produce are consumed at home and the few offered for sale usually attracted low income. In most cases we do not generate enough funds to compensate for the stress and in a larger extent to finance any potential ill-health".

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Cultural strategy which involves conserving economic resources also affects Akoko rural people's choice and utilisation of healthcare resources. Storing goods up in barns reduces the quantity of goods that could be offered for sale and this tends to reduce the income generated and affect the action that favours prompt health financing. This is because the conserved goods could not be converted to cash at short run to finance emergency. Also, the domestication of animals and pets as a way of conserving economic resources also impacts on the choice and utilisation of healthcare resources. The concept of *Ajugba* encourages exchange of animals and pets in rural Akoko communities. Some people would go out early in the morning searching for their goats and pigs, and after, they go out to find food for them. These, according to informants, are also stressful and could result in health challenges like leg pain and fever. Field observation further revealed that most people would have spent all their money in raising pets and animals that it later becomes difficult to finance their health challenges. This is because those commodities could not be easily converted to cash when such cash is urgently needed for health caring. This usually prompts them to rely on home remedies for care whenever such a situation happens.

The cultural strategy that involves gender allocation of roles and responsibilities in household economy also impacts on the choice and utilisation of healthcare resources in rural Akoko communities. Customs that ascribe cultivation of cash crop (such as cocoa, kolanut and coffee) to men and cultivation of foods crops (such as cocoa yam, cassava and groundnuts) to women have differentiated implications on their healthcare seeking behaviour. This is a strategy in patriarchal system that is well grounded in rural Akoko communities. The female discussants indicated that food crops are mostly consumed at home for subsistence and cash crops usually attract huge cash rewards which make men more economically buoyant than women. This is anchored on the belief that women are to support the home while men are the chief providers. Even when some excess of the food crop is offered for sale, the proceeds are used to take care of home, in terms of household domestic needs. This custom makes a woman to be less independent economically in the household and strengthens the reliance of women on men for healthcare financing in rural Akoko communities. FGDs with group C further revealed that this local practice makes men stand a better chance most time to conveniently seek for qualitative healthcare because of their economic opportunity in the household. This also explains why women rely on palliative care than men.

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> Men are those that can cultivate cash crop and women to the cultivation of food crop. Because what women produce are consumed at home, it is difficult to get money to replenish the loss strength. Whenever I am not okay, I prepare local herb and take and wait for God to perfect it.
> (FGDs with group C in Ese-Akoko, July, 2008).

Apart from the above, the customs stipulate that men have the right to ask for women what she realises from the sales of food crops and women are not permitted to ask men to give account of their sales of cash crops. Women cannot spend independently from income generated from the sale of household farm produce. This also has difference gender implications on their healthcare seeking behaviour in rural Akoko communities.

> When some goods are offered for sale by women, they cannot independently spend the money; they must account for it. And if men sell their cash crops they are not accountable to anybody.
> (FGDs with group C in, Ese-Akoko, July, 2008).

The cultural strategy of instituting power relations in household economy also impacts on the choice and utilisation of healthcare resources in rural Akoko communities. The power relations in household economy has considerable implication for the timing and the type of treatment to be sought, depending on whether or not a male entity is willing and able to pay for the medical care. Information from KII and FGD revealed that the husband or father of a sick woman or child may decide to delay modern treatment and rely on cheaper traditional medicine for a while, depending on their own assessment. Adult males could also judge the illness of a woman and/or child as not serious enough to merit medical attention, considering the economic responsibilities awaiting attention, thereby suggesting alternatives. This explains why women rely more on traditional and palliative care more than men in rural Akoko communities.

Information revealed that most people in rural Akoko communities are not salary earners; they depend on the sale of their produce for their expenses and as a result, they devote more time to their work in order to take care of their responsibilities. They hardly have time for their healthcare. KII conducted with orthodox health workers revealed that rural Akoko people are more focused on their

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work than seeking healthcare. So they seek orthodox healthcare only when an illness is at an advanced stage.

> The way people handle their health is somehow unexplainable. They are more concerned about their work than healthcare. The poverty level of the rural Akoko people makes them to work like a clock. When they are ill they still prefer to embark on self-care and manage to do their work. It is when they could no longer manage their condition that they know there is health centre somewhere. At times their condition would have become so serious that we would have to refer most of them to General hospital in Ikare or Federal medical centre in Owo.
> (KII with a nurse in group B in Ipe-Akoko, June, 2008).

Orthodox healthcare providers also indicated that when they manage to consult orthodox health providers, they do not strictly take to the advice and prescription of the providers regarding observing rest, drug taking and going for medical check-up. They also fail to come for check-up as scheduled because of their work. The healthcare providers complained about their failure to adhere strictly to medical advice and assert that their work is their main focus.

> Their ignorance has made them to ignore most of the pieces of advice given to them pertaining to rest. Many of them complain that they cannot observe rest when they have to eat. Some of the women do not have the time to take their drugs because they work late into the night. Many of them do not come for their check-ups on appointed date. When you asked them why, they would tell you that they are very busy. At the end of the day, they would say the treatment is not okay. They are more concerned about their work than their health.
> (KII with a nurse in group B in Ese-Akoko, July, 2008).

FGDs conducted with group A further indicated that home remedies constitute the main healthcare in rural Akoko communities to overcome health challenges through several precautionary acts. This usually involves consulting kinsmen, and in larger extent consulting friends and colleagues to give them health information and healing knowledge. This usually involves giving advice, which is passed through informal discussions. It is in this sense that they label it and decide how to react to it. These interactive sessions usually are the sources of ideas about what gives one the health challenges, and what to do to get rid of them are expressed. In an FGDs with group C, a woman who engaged in palm-oil production has this to say:

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> If I have any symptoms of illness, I discuss it with my mother or any of my relatives that are available at that period. They would tell me what I need to do. No matter the kind of sickness one may have, there would be somebody that has experienced it before that would tell you what to do. Sometimes ago I felt feverish and my cousins told me to go and cook *yanrin (*local concortion) and eat it with pap in the morning for three days. I did and I was okay. I do not have money to waste in hospital or for any doctor.
> (FGDs with group C in Ese-Akoko, July 2008)

5.5 Pattern of healthcare in rural Akoko communities

Health and healthcare challenges experienced by individuals differ, depending on the nature of one's economic activities. FGDs indicated that fetching of firewood and water for both palm-oil and *gari* production makes rural Akoko people vulnerable to leg pains, water-borne disease (dipthera, guinea-worm) and insect-bites (ants, tsetse fly), while, farming and hunting as earlier stated, expose men and women to rheumatism, malaria-fever, leg-pain and body-pain. According to orthodox healthcare providers, most people that are vulnerable to these health problems are women of child bearing age (18-44 years). Orthodox healthcare providers explained that, the major causes of morbidity and mortality among children in rural Akoko are malaria, diarrhoea, measles, pneumonia, neonatal complication, tetanus and protein-energy malnutrition. Many of these illnesses are associated largely with economic insecurity created by the cultural strategies adopted in household economy.

Apart from these health challenges, some other illnesses are found in rural Akoko communities. These are related to farming and other agrarian activities. They include fever, body-pain and rheumatism. There are evidences of accidents and sores resulting from cultivation and farming in general as well as cuts, snakebites and falling from palm-trees. Illnesses related to alcoholism appear to be common in rural Akoko as the study observed 7 of such cases with loss of hair, fragility, paleness and waning in some of the victims. Findings show that most of these health challenges have their roots in the nature of household economy, as earlier indicated. The health conditions are also complicated by poor health infrastructure such as access to clean water, regular electricity, good roads and environmental sanitation in rural Akoko communities. The government-installed motorised bore-holes are not sufficient and do not run effectively and most times due to the large number of people using them,

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and they are rationalised for consumers. Most times households depend on wells and local streams for water consumption.

The rural Akoko people seek healthcare in several ways to prevent and overcome these health challenges. These include the use of self-care, use of orthodox healthcare, traditional healthcare and faith-healing. All these healthcare facilities and providers are common across rural Akoko communities, but with uneven distribution in the study areas. The disparity of the distribution constitutes a challenge against health-seeking behaviour of the people, especially the utilisation of healthcare facilities. Most health facilities and providers are not within the reach of some rural people, majority of who encounter health problems in their day-to-day subsistence activities. Findings also show that rural Akoko people often use and/ or avoid orthodox healthcare for a number of reasons. Considering the rural set-up, informants were asked to state reasons for using or not using particular healthcare. This was done to determine the level of confidence which they have in each of the care. The responses of informants to this question justified the confidence they have in each of the care providers and the extent to which they patronise them.

In rural Akoko, there are almost overlapping patterns of healthcare as earlier stated, which suggest the general attitudes to healthcare system in the area. These patterns can be seen in various phases and relatively differ in forms across the study area, but their structure is still almost the same. Each of the patterns offers a particular approach in understanding the cause of and prescribing treatment for illnesses. Health-seeking patterns in rural Akoko therefore define the perception of the healthcare seekers and the providers in terms of how they interact. These models for understanding healthcare system in rural Akoko have been very significant as they define the healthcare seeking behaviours of the people.

In both KII and FGD, responses from informants indicated that home remedies usually constitute primary action taken to prevent and or cure illness. When the various actions taken are not successful they switch to other alternative healthcare options. Some informants said they turn to traditional healthcare, and when traditional healthcare prove unsuccessful, they later switch to orthodox healthcare. In some cases, when home remedies are not successful, they bypass traditional healthcare and switch directly to orthodox healthcare, especially when it involves emergency and serious injuries. In some cases, when the treatment proves unsuccessful especially when they believe it has spiritual undertone, faith healing is mostly adopted .In some

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cases, more than one of the healthcare options is sought concurrently as indicated by informants. Figure 5.4.1 below shows the framework of the pattern of healthcare services in rural Akoko communities.

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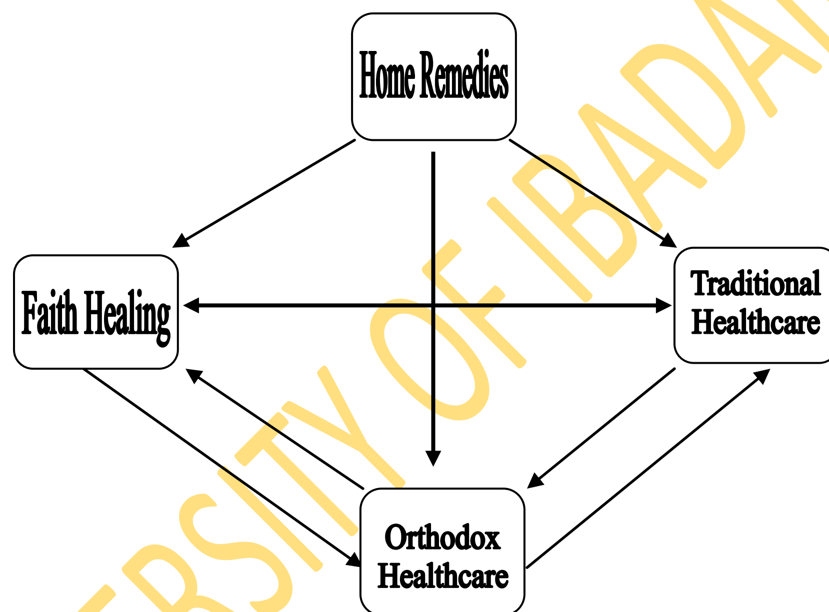
Fig. 5.4.1 Pattern of Healthcare services in rural Akoko Communities



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The informants in both KII and FGDs indicated that a significant proportion of the rural Akoko people have knowledge of home remedies. This explains why they embark on self-care as initial action taken to overcome illnesses. This is reflected in their consumption patterns. Similarly, rural Akoko people are able to identify secondary and lower cadre of primary health establishments. The facilities for orthodox healthcare services are largely concentrated in the urban locations in Ondo state and this tends to make them inaccessible to most of the inhabitants of the rural Akoko communities who are more vulnerable to health challenges. This has affected the level of awareness of most rural Akoko dwellers as discovered during the focus group discussions. This is because some rural Akoko communities are still relatively marginalised in terms of orthodox hospitals. Though there are healthcare centres and maternity homes in virtually all the rural Akoko communities, most of them cannot handle some complicated cases which are to be handled by well-equipped orthodox hospitals.

There are only 4 government owned orthodox hospitals in the whole of Akoko with 40 communities; they are located in Ikare-Akoko, Akungba-Akoko, Oka-Akoko and Ipe-Akoko. These hospitals are remote to many rural communities. Most people in these communities travel many kilometers to these healthcare facilities. This poses a problem of access to orthodox healthcare in rural Akoko communities. Transport is also a problem in the rural communities of Akoko, especially during the rainy season, due to poor road facility and unreliable public transport system. Transportation therefore compounds accessibility problem whenever there is a need for medical attention.

Though some orthodox healthcare facilities have been officially provided to improve the health security of rural Akoko people, many individuals are still exposed to alternative care to augment the deficiencies and inadequacies of these facilities. Nevertheless, few rural Akoko dwellers still prefer orthodox healthcare centres to other healthcare services because, to them, it is more reliable though they are still discouraged by the high cost and the time expended to seek them. This was the assertion of those that appreciate orthodox healthcare but those who restrict themselves from patronising them believe they are of no effect and as such stick to their conventional healthcare services. A farmer in Akunnu-Akoko justified this in his opinions as follows:

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> The services which our hospitals render are very reliable because of the level of exactness in their dosage, regimen and the expertise involved as compared to other healthcare. Nevertheless, it is relatively expensive and as such scares most people, including myself. For instance consider an operation for a pregnant woman which most times costs between thirty to forty thousand naira; how would it be convenient for an average individual in this community to afford so much money? In addition, it requires much protocol that waste people's time.
> (KII with a farmer in group A, in Akunnu-Akoko, April, 2004).

Ideally, anyone who requires medical treatment should first visit a health centre from where he could be referred to a high level healthcare institution. However, the findings of the focus group discussions show that this is not the case in rural Akoko communities. it is a small proportion of the people that fall sick that follows this ideal pattern. It suggests that comparatively less attention is being paid to orthodox medical care in terms of the overall treatment of diseases/illnesses in the area. This is largely due to their socio-economic condition and also the difficulty in accessing some of the facilities.

Apart from hospitals and healthcare centres, there are medicine stores and chemists that provide health supports for rural Akoko communities. These outlets are relatively few and operate in small scale enterprises. Rural Akoko people patronise or visit these outlets at will, based on their perceived illnesses and their severity. Patients visit these shops to buy drugs based on their self-prescription and or the advice of their people. In most cases, they seek advice from the untrained individuals who are the sellers of the drugs on how to use them and the appropriate time to do so. Parts of the information suggest that some of the stores/chemists, especially, those in core remote areas, offer flexible payment schemes to their trusted customers.

There are also some drug peddlers who go from house to house, street to street to sell drugs. Some of these peddlers have identified some customers with their problems and supply them at periodic times. Some informants claimed that in some cases, they visit medicine stores and chemists for their healthcare. Those that engage in this type of care said they use it to compensate for the lapses and deficiencies in other orthodox healthcare provisions especially in hospitals and health centres. Furthermore, they also asserted that it is cheaper and close to their homes, and

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appealing when the illness is mild. Moreover, they also claimed that such patterns of healthcare allow them to have time for their works.

The FGDs in various communities studied also show that self-administered remedies are widely used to cure various illnesses. Generally, the users collect them directly from plants and other herbs which they believe will cure their illnesses or those of their families. In few cases, the remedies are provided by relatives, friends, neighbours, or directly from traditional practitioners. The list of ailments handled by traditional health providers includes body-pain, leg-pain, stomachache, pile, malaria, water-borne disease, high blood pressure, high temperature, toothache, pneumonia, sore throat, gonorrhea, vomiting, headache and convulsion. The practice suggests a broad range of traditional healthcare knowledge among rural Akoko people. Most people have deep knowledge of plants and animals and how they could be used for healing.

Apart from self-medication with the use of herbs, consultations with traditional medical practitioners were found to be widely used by those who took part in the focus group discussions in different study sites. The people are quite knowledgeable about the availability of traditional medical practitioners in their localities. Discussions and observations carried out during the fieldwork show that both men and women, illiterate and educated patronise traditional medical practitioners when the need arises. Some informants argued that their patronage in the study areas is often justified by the local belief that some ailments have spiritual undertone which cannot be handled by ordinary medical interventions. According to some informants, their charges are relatively lesser and highly negotiable. They further opined that most of their acts are in conformity to the local culture. They could highlight the sources of spiritual problems that lead economic challenges that further create health problems. In FGDs conducted with group B, an informant has this to say:

> I had a leg pain sometimes ago. I was admitted at the hospital for three weeks and I spent a lot. Later, knowing the problem could be spiritual because it was not healing, I sought treatment with a traditional bone-setter where I discovered the source of my problem. I negotiated with *Mama* what I could afford for treatment. The amount she charged was very low. It was more or less free-of-charge.
> (FGDs with group B in, Ipe-Akoko, June, 2008)

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According to the conclusions which emanated from the focus group discussions, what distinguishes the traditional medical practitioners from others in the Akoko communities is not only their apparent ability to diagnose illnesses and prescribe remedies but also their perceived powers to prevent misfortune through protective medicines. The rural Akoko people themselves are able to distinguish between the traditional medical practitioners who use herbs to treat their patients and the witch doctors. The former is regarded as acceptable to the vast majority because their diagnoses are based on the examination of the patient and on the reported symptoms. The treatment given was primarily herbal although some use a combination of traditional and orthodox care pattern in treating their patients.

In some cases people consult diviners. These traditional practitioners use a combination of techniques to determine the cause of their patient's complaint: bone-throwing, questioning, examination and knowledge of the patient's circumstances. Their treatment could be herbal, but quite often diviners prescribe special `magical' protection of persons, livestock and/or property against evil spirits that cause bad luck and calamities. Quite often a feast for the ancestors' is recommended to placate any discontented ancestor who may be the source of their illnesses. However, some of the informants in the study area use primary health centres such as dispensaries, maternity-homes, and clinics at the advanced stage of illness. In FGDs conducted with all the groups, the responses of discussants revealed that they are critical of the services received *from* these orthodox healthcare institutions. With respect to dispensaries and health centres, the informants did not agree that service is quicker. With fewer people to deal with, lines are not generally long and people are not given attention earlier. They also claim that the cost is not relatively cheaper for treatment in orthodox hospitals. The most common complaints concerning primary health centres are that they are not adequately provided with drugs and their staff members are not courteous in most times. In such circumstances, it is not easier to travel to the distant hospitals that are located in urban areas that are only accessible by fast means of public transport.

Apart from the above practitioners, there are faith/spiritual healers that provide healthcare in rural Akoko communities. They carry out healthcare in various syncretic and Pentecostal churches. However, these practitioners are few in rural Akoko communities, they provide healthcare through their faith/spiritual knowledge. This kind of care is justified based on the premise that only God can heal and that doctors

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only care. Some informants that embrace this kind of care claim that the healing power of God surpasses human beings'. They further opined that, it often requires relatively low cost or no cost at all in some circumstances. An informant commented, "Prayer is the master key to every solution; there is nothing difficult for God to do as God's healing is guaranteed". Some informants who argue in favour of this kind of care opined that in the larger extent the payment may be in kind or cash and pledges are sometimes made which could be redeemed gradually after treatments are acceptable. It was also gathered that in most cases, the whole family or household could be treated as a single patient. In addition, health-seekers are usually under no pressure to redeem their pledges, they are often reminded of the need to do so. Special offering are also acceptable as a substitute for a pledge. Some informants who patronise this kind of care opined that it is convenient, especially when one could not afford the cost of orthodox or other alternative healthcare considering the economic responsibilities awaiting attention.

5.6 Discussion of findings

How cultural strategies that are adopted in household economy influence the choice and utilisation of healthcare resources in rural Akoko communities has been explored in this study. The significance of household economy to livelihood makes it the ultimate endeavour that cuts across all human groupings. The kinship connectivity in a household makes household economic relationship interdependent in rural Akoko communities. Structuring of household to promote access to land, social support and security strengthens the micro-economic interactions and makes the quest to enhance livelihood more crucial in rural Akoko communities. This is based on the fact that large numbers of people constituting a household in rural Akoko communities encourage economic security as they cooperate to promote the welfare of household members.

The customs, values and beliefs that serve as the underlying structure of household are the source of inspiration for cultural strategies adopted in household economy. The strategies create an enabling social milieu which guards against socio-economic insecurity. It is these cultural strategies that prevent potential contentions in rural household. However, this does not rule out the possibilities of having some elements of contentions due to cultural forces that make economic interaction complex in rural households.

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Strategies adopted in household economy are anchored on premeditating factors that have to do with perceived challenges in the study areas. Some challenges in rural Akoko communities make cultural strategies adopted in household economy seem ineffective. These include those that affect the efficiency of household economy. Lack of basic infrastructure has been identified as one of the major external factors affecting household economy in rural Akoko communities. This challenge can also be associated with the conservative nature of household economic activities in rural Akoko communities, and has affected their productivity. This scenario suggests high rate of poverty in rural Akoko communities. Infrastructure promotes economic activities, as well as improves the general welfare of the rural populace (Adewumi, 2011). The World Bank (2004) states that, where poverty is pervasive, a vast number of the people would be living on less than a dollar per day. This is actually the case in rural Akoko communities.

The hilly and rocky topography of Akoko community is another external factor that impacts on household economy. This environmental set-up influences how space and human relations are structured and organised in rural Akoko communities. This is evident in their settlement patterns and the kind of economic activities that they engage in. This finding is in line with Lawuyi's (2004) assertion that spatial consciousness has implication for the way a society is organised, its environment is managed and its socio-cultural development is pursued. Drawing from Lawuyi's assertion, we come to the realisation that in rural Akoko communities, the hilly settlement and the spatial arrangement of the communities have effect on the nature of the economic activities engaged in. The nature of the environment makes economic activities stressful and impacts on their productivity, especially in agrarian activities. Agriculture and agricultural produce are found mostly in hilly areas and in the deep valleys. Despite the topographic challenges in the study area, farming constitutes the mainstay of household economy. Farming constitutes 70% of the economic activities, even in difficult terrains, requiring the need to ascend and descend the hills and rocks in the study areas.

Most prevalent household economic activities in rural Akoko communities are those that are directly connected with their natural environments. Apart from farming, other economic activities play an appreciable role in contributing to the generation of income for the households. These activities overlap in the sense that, an individual in a household could engage in more than one economic activity to generate income.

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This idea constitutes a reliable means of overcoming economic deficiencies in rural Akoko households. In rural Akoko communities, relatively few people are engaged in white-collar jobs, as opportunities for wage employment are very limited because of low industrialization and underdevelopment of the rural economy in Akoko. The resulting economic environment is unattractive and this probably explains why rural Akoko communities rely more on farming as their main means of enhancing livelihood. The local environment does not attract huge capital intensive businesses because of the state of the economy.

The macro-economic situations in Akoko create a situation whereby many productive adults and youths are migrating to urban areas for better job opportunities. This development has altered the household economic structure and impacted negatively on farming activities as the mainstay of the economy. This buttresses the claim of Edward (2008) that the migration of youths to urban areas creates structural re-arrangement within the household with implications for household dimension of poverty. This further corroborates Ogwumike's (2010) assertion that the migration of an individual in household brings about role exchange within the household. In a household where a member is not available to make up the composition, a gap exists in the role performance. If such roles are taken up by another member, there is a possibility that it may not be fully accomplished as expected, thereby influencing the extent of role performance as a result of defective social dynamics, and impacting negatively on household economy.

Apart from the external factors that affect household economy in rural Akoko communities, cultural forces (such as kinship ideology, power relations) which characterise household also affect a household's economy. The kinship ideology in rural Akoko communities makes social-economic relationship transactional and reciprocal. It entails a lot of sacrifices and this forms the mechanism for responding to challenges which expanded populations in household created. In spite of the benefits in household as a result of large population, it also subjects an individual to economic constraints that have implications for their capability for quality healthcare seeking. This finding is in line with Rogger's (2000) point, that households increase the opportunities to both give and receive social, emotional, instrumental and financial support, but may also lead to additional emotional and financial stress. Olasunbo (2013) also asserts that household crowding has detrimental effect on health, in part, due to increased social demands. Many demands without corresponding resources

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may lead to poorer health through pathways similar to those linked with support. This emerges from the perception that demands which exceeded resources can lead to poor health behaviour. This negatively affects the psychological well-being and activates the stress response, all of which impacts on health and healthcare seeking (Berkman, 2000).

Patriarchal system in rural Akoko (that gives credence to power relations) gives some categories of people privilege over others, where some categories of people in the household are denied access to some economic resources. The denial is often on things that could create economic efficiency in the household. The denials make it difficult for victims to fully realise their economic potentials, hence, it is difficult to maintain a healthy living.

This finding corroborates those of Malucio (1999) and Copper (2006) that point to the effect of denial in the household and conclude that it makes it difficult for the victims to realise their potentials. In a situation where one could not realise one's potentials, it is difficult to maintain a healthy living (Magee, 2002; Marmount, 1999). Likewise, Ajala (2002) asserts that women denial of economic incentives in the household, have a health implication for both mother and child. As women's welfare has a direct health implication on the mother and child.

Many health challenges mostly recorded in rural Akoko communities are those that are associated with the nature of their household economic activities. This includes minor fatigue, malaria, body-pain and malnutrition. Fetching firewood and water subject women and children to leg pains, water-borne disease (diphtheria, guinea-worm) and insect-bites (ants, tsetse fly), while farming and hunting subject men and women to rheumatism and malaria-fever as previously indicated. The major ones are protracted illnesses and those that cause instant mortality. These health challenges affect their productivity because the illnesses drain them of their energy. Also, most of the economic activities such as farming, hunting, palm oil and *gari* processing expose them to constant inhaling of smoke that is dangerous to health.

Several ways in which rural Akoko people seek healthcare suggest that individuals weigh the potential benefits of the recommended response against the psychological, physical and financial costs of the action when deciding to act. This is subjectively determined in most cases and objectively determined in some cases, especially when involved in major illnesses. This finding is also in line with Tipping and Sengall's (1995) assertion that health-seeking behaviour is not just a one-off

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isolated event. It is part and parcel of a person, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural and experiential factors. This is because the process of responding to illnesses or seeking care involves multiple steps.

Rural Akoko people seek care based on their interpretations and references to their household socio-economic conditions. The socio-economic condition is associated with cultural forces that characterise household economic relationships. Many studies (Banti 2013; Abiodun 2010; Olujimi 2006) have shown that the cost of health services affects the choice and utilisation of health care resources. However, this does not hold at all time, as some people are able to afford certain healthcare, but they do not utilise them due to certain reason(s). This study argues that there are precedents for this factor and it has to do with the cultural strategies adopted in a household economy. It is this area neglected by most health interventionists that makes intervention not to yield optimal result or success.

Rural Akoko people generally seek home remedies initially when they get sick and turn to any other alternative care if they are not successful. Their reliance on home remedies has to do with their affinities with their household economy, such that do not require the services of health professionals. They consult orthodox healthcare professionals only when incapable of directly treating their illnesses or if their self-treatment was unsuccessful. These results are similar to findings in previous studies (Jimba, 2003; Chau and Yu, 2010; Victor, 2013) that rural people are found to have a tendency to take various methods to manage their health, which include resorting to self-diagnosis and self-treatment, rather than seeking help from orthodox healthcare practitioners when they are ill.

Rural Akoko people seek orthodox healthcare only when their health condition worsens and when the efforts to address the health problems prove unsuccessful. This has negatively impacted on their health status as the rate of morbidity and mortality keeps increasing daily. This confirms the fact that the presence of government health facilities in rural Akoko communities does not have appreciable effect on their health status. Orthodox healthcare facilities are not fully patronised due to several challenges associated with socio-economic dynamics in the household.

There is a need for health planners to understand the cultural strategies adopted in household economy that have implications for the choice and the utilisation of healthcare resources. This will enable them to draft a comprehensive and

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holistic health policy for healthcare intervention. This will in turn address the increased rate of morbidity and mortality in rural communities.

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CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMENDATION

6.1 Summary

From the foregoing discussion, the influence of cultural strategies employed in household economy on health-seeking behaviour encompassing the choice and utilisation of healthcare resources has been succinctly explored and can be summarised as follows. In rural Akoko communities, the household is an arrangement which does not comprise only consaguinal kin but goes beyond that to include others, especially affinal and social kin that cooperate economically to enhance livelihood. Household as an imaginary community, however, seems to be more real and feasible in rural Akoko communities, as members are engaged in social and economic activities. Household members define themselves as a group when the imaginary construction comes into reality through socio-economic interaction and connectivity. In rural Akoko communities, a household stems from family units that are related by blood and incorporates non-biological kin that cooperate socio-economically. It primarily exists in rural Akoko communities to help individuals have access to some defined opportunities such as land, security and defense. The essence of household is to also guard against economic insecurities at micro level of organisation in Akoko community. A household head coordinates and oversees the affairs of the entire household.

There are customs, beliefs and values that constitute the underlying structure of households, which dictate and guide interactions in the household. Economic interest is the main thing that connects individuals together in order to enhance livelihood and survival within the household. Relationship within the micro-level in rural Akoko communities is possible through the structure of a household. Members of a household are stratified to ensure the allocation of roles and responsibilities. Household provides a frame for economic activities at the primary level in rural Akoko communities. Socio-economic relationship in household is inter-dependent. However, some level of autonomy is reserved for individuals to facilitate self-innovation for welfare creation. There are concepts in the household which act as framework for household economy. These concepts are *Abo*, *Ajugba* and *Moye: Abo* (a system of organising services/labour) and *Ajugba* (system of exchanging labour for economic goods). These two concepts are anchored on the concepts of *Moye.* Both

strategies serve as mechanism through which members of a household are channelled towards economic securities in the household.

The network of people that constitutes a household determines the degree of social complexity in a household economy. Moreover, the efficiency of household economy is also determined by the access to the factors of production (such as land, capital, labour and entrepreneur), population, gender composition and production capacity of each household. The above factors also determine the nature and pattern of household economy and further influence economic relationships.

Household economy is influenced by a number of customs, values and beliefs which constitute its structure. This structure determines the economic interaction within the household and further defines how economic roles and responsibilities are assigned. Household economic practices in rural Akoko communities are characterised with cultural forces (such as kinship ideology, patriarchy, power relations) through which it is coordinated and evaluated.

There are cultural strategies adopted in households to enhance economic security. The strategies simplify the economic tension and ease the economic relationship. The strategies reflect in all economic endeavours in rural Akoko communities. The various strategies employed in household economy depict cultural attributes that make members of household vulnerable to health challenges and also affect how healthcare is sought. Instituting and strengthening the norm of economic networking affects the choice and utilisation of healthcare resources. This makes economic activities in rural Akoko revolve around *Abo* and *Ajugba* and anchor on the concept of *Moye* which demands mutual assistance in economic activities and responsibilities towards one's kinsmen obligatory.

The concept of *Moye,* which makes economic activities interconnected, requires a network of economic responsibilities towards one's kinsmen. It also expresses cultural attributes that make economic activities tasking. Based on this, their economic nexus tends to be elastic because of the high population of people involved in the household. Also, individuals are mandatorily responsible to seek the welfare of others in a reciprocal form. As the population of a household keeps increasing, its economy tends to be more complex and complicated. The inter-relationship and intra-relationships between units of families that constitute the household become strengthened. The committed responsibilities of a member towards ensuring the economic welfare of other members increase and place burden on

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individual expenses. Hence, living per capital income is lower than the average and reduces their chances of seeking a qualitative healthcare.

Findings also reveal that rural Akoko people devote more time to economic activities in order to fulfill chains of economic responsibilities. Similarly, they committed most of their efforts on their economic activities which are done in a stressful condition that demands constant ascending and descending the hilly and rocky environment. This makes rural Akoko people vulnerable to some health challenges such as body pain, leg pain and fever. Nonetheless, the health challenges differ based on economic activities that they engage in. The study also reveals that more time is expended on economic activities that limit their available time to seek qualitative healthcare like orthodox healthcare and make them rely more on home remedies and traditional healthcare. Rural Akoko people are contented with home remedies for healthcare. This kind of healthcare allows them to have time for their economic activities in order to fulfill economic responsibilities towards their kinsmen.

Moreover, when there are noticeable economic deficiencies in the household generally, members pool their economic resources together and later re-distribute them based on defined criteria. This, according to findings, is necessitated to redress the economic disparity in the household and also to reduce economic deficiencies generally among members. The process of re-distribution usually takes much time which creates delay in addressing major health problems. The reason is that the whole process requires a network of dialogue among the household members involved.

Household members compete for limited factors of production and patriarchy excludes women and children from some household economic benefits. This has a significant effect on the women’s proactive capacity, especially in the area of farming where women cannot have the right to own lands. They can only have access to it through their husbands and/or cousins. The women are mostly petty traders and small scale farmers; this makes them relatively, low income earners, compared to men. However, the low income status of rural Akoko men and women generally further exposes them to ill-health and the women are more vulnerable. The restrictions of women from cultivating cash crops and limiting them to the cultivation of food crop also have implication on their income. This further has effect on their health-seeking behaviour as it makes women to rely more on palliative healthcare more, than men for healthcare.

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Household economy is couched within power relation that also has implication for the choice and utilisation of healthcare resources. By the virtue of men's position in the household, they can dictate the kind of healthcare resources which members of the household can utilise. This is usually based on their judgment, especially when considering the economic situations and responsibilities that need attention. A man can judge the sickness of a woman and other members as not serious enough for a particular healthcare.

Also, the concept of *Moye* creates social support through joint production. This system integrates a lot of network of household dialogue and follow-up systems on welfare issues, including healthcare. Based on this, the individual's choice and utilisation is affected because one cannot independently decide the kind of healthcare resources to utilise at this moment.

The cultural strategies employed in the economic system in rural Akoko communities make household members economically insecure. The strategies have strong influence in determining the choice and utilisation of healthcare resources. Their economic conditions make them rely more on home remedies and traditional healthcare. They focus on them, rather than seek healthcare. They seek orthodox healthcare at advanced stages of illnesses. This further makes rural Akoko people subject to health insecurities.

6.2 Conclusion

Household economy in rural Akoko communities does not exist in vacuum; there are rules and norms that guide and dictate economic interactions. This transcends customs, values and beliefs that make household economic activities complex in rural Akoko communities. The effects of these complexities make many rural Akoko people to be economically insecure in the household that subjects them to various health and healthcare challenges. The various strategies adopted in household economy in rural Akoko communities exercise much coercion on their economic security and make them intensify their economic activities.

The interface between household economy and health-seeking behaviours in rural Akoko indicates that the people are more focused on their work than healthcare and that they seek traditional healthcare system more than they seek orthodox healthcare. The people are usually unable to access and utilise orthodox healthcare due to various outcomes of cultural strategies adopted in household economy, and

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therefore seek alternative healthcare provisions like home-made herbal care, faith/spiritual and folk healing that are relatively cheap in terms of cost. These also allow them to have adequate time for their economic activities. They seek orthodox healthcare at advanced stages of illnesses, thereby exposing themselves to health insecurities that increase morbidity and mortality rate. To ensure a sustainable healthy status, attention must be given to cultural strategies employed in household economy, in such a way that they will provide insights into how it affects health security. This will provide the opportunity of creating a sustainable healthcare intervention. This will help in making the efforts of governments and health agencies, which have not been yielding optimal result in rural communities, to be appreciated.

The unproductiveness of health intervention projects in rural communities is an outcome of poor attitude towards healthcare intervention projects. Intervention projects bring about negative outcomes when they are not designed to address the appropriate problems. The exclusive focus on the biomedical aspect of health intervention as the main perspective of intervention is not sufficient to solve rural health and healthcare challenges. The non-biological root of many of the health problems indicates that they have roots in socio-economic dynamics that are outside the classic concepts of disease. This means that they are generally not solvable within the bio-medical contexts, as previously done by health interventionists.

Healthcare challenges in rural Akoko communities are largely to remain the same and ever more endemic in future, taking into consideration the various cultural strategies adopted in the household economy. Unless the government and NGOs recognise this, the quest for improved health and healthcare in rural Akoko communities may be unattainable. The cultural strategies adopted in household economic system have a strong influence in determining the choice and utilisation of healthcare resources in rural communities. Sustainable attention should be paid to the customs, norms, values and beliefs that are at play in the interface between household economy and health-seeking behaviours. This will aid policy formulation for healthcare interventions in rural communities.

Moreover, since the nature of the economic system of many of the rural households influences their health behaviour, it is suggested that the socio-economic dynamics in the households in rural communities should be put in place when formulating policies for healthcare interventions. This will make healthcare

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intervention more focused and result oriented. This will further reduce the morbidity and mortality rate in rural communities.

6.3 Recommendation

A study of household economy and health-seeking behaviours in rural Akoko communities has provided insight into how cultural strategies adopted in household economic practices bring about differing health-related actions. The non-comprehensive approach of welfare intervention in rural communities is mainly revealed as paying little attention to the cultural strategies adopted in household economy in rural communities. As the situation is at present, the millions of naira so far expended by Nigerian government on the study area has caused no positive influence on the poor welfare condition of the rural Akoko people. If sustainable welfare promotion is deemed to be concerned with how a person can meaningfully and productively live his or her life while contributing to his society, it is then certain that intervention efforts must move beyond the present preoccupation to adopt a framework that will allow agencies' spending to impact positively on rural communities. This can only be achieved with a holistic approach to development, which takes cognisance of the fact that human beings are the ultimate target of development. Based on the aforesaid, the following recommendations are made:

1 There is a need to create an enabling household economic environment to redress the household economic practices that impinge on effective choice and utilisation of healthcare resources. This includes mobilising rural people through their respective local organisations and through mass media to bring about such change. Also, programmes targeting rural communities welfare should be widened in scope as they call for a holistic approach of interventions. This also requires the service of experts in welfare intervention, and there should be follow-up to programmes.

2 Government should embark on promoting participatory development which emphasises local economy. When agencies partner with rural people to enhance the productive capabilities within the different spheres of local economy, not only will their output be boosted, but new know-how will as well be introduced into the system of operation. One area in which this can be attained is through the establishment of Development Finance Institutions

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(DFIs) to provide micro loans to farmers and other economic actors in rural communities.

3 There should be a supportive system to help rural communities realise their welfare goals. Such support system may include providing comfort to households. This can be achieved by the government in the provision of basic social facilities such as pipe-borne water, electricity, good housing schemes and effective transportation system to ease their household economic endeavours. There is also the need to encourage self-help activities among rural dwellers. Policy failure is a strong indication that the government cannot provide all the resources that mitigate health deprivation at the local level. Self-help activities in conjunction with home town development associations make it realistic that financial resources in urban and rural areas are jointly mobilised to build health infrastructure.

4 There should be coordinated efforts to design behavioural health promotion campaigns to inform and educate the rural people that the desirable health-seeking behaviour is to patronise health facilities for medical treatments by qualified healthcare providers. Government should put in place a policy framework that can persuasively provide the basis for the reorientation of rural people towards the access and the use of available health facilities, when necessary. Importantly, these policies should be designed to recognise the virtues of context specificity and peoples needs as necessary ingredients for realising the objectives for which they are set up.

5 There is a need for the scientific community to sustain research on how local economy influences health-seeking behaviour. Specifically, how household economic practices influence the choice and utilisation of healthcare resources should be emphasised. This can be achieved by replicating this study in other areas that are yet to be investigated. Also, the findings from this study should be communicated to the relevant agencies to form a framework for policy advocacy and policy formulation.

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APPENDIX 1

Dear informants,

I am a research student from Department of Archaeology and Anthropology, University of Ibadan, Ibadan, Oyo state. We are conducting a study on household economy and health-seeking behaviour in rural communities of Akoko, Ondo State, Nigeria. We very sincerely request your cooperation in answering some questions. These questions are strictly for research purpose alone. We appeal to you to give your frank and honest opinion to the questions, realising that the information you provide will help to advance knowledge and science. Please feel free to answer the questions as whatever information you give will be treated with utmost confidentiality.

Thank you.

Guide to Key informant interview (With economic groups)

1 What do you understand by household (probe for types, nature and composition)?
2 What is the difference between household and family (probe for any connection between the two)?
3 How do they manage household unit in this community (probe further for politics, kinship ideology, and rules and regulation)?
4 How are factors of production managed in this area? (The four factors of production should be discussed in turns).
5 How do these factors affect economic security of members of household?
6 What are the irregularities featured on the management (probe for any gender sensitivity)?
7 How is gender sensitivity affecting household management?
8 Is there any role differentiation (probe for areas, nature, purpose and significance)?
9 Is there any likely effect of the above on individual or group welfare?
10 How do individual and or groups cope with the challenges?

Cultural strategies adopted in household economy

1 What do you understand by household economy (probe for its relevance)?
2 What are the household economic activities in this community?
3 Which ones are most common that people mostly engaged in this community?

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4 Why these economic activities are common (probe further for any environmental relativity)?
5 Why do you choose to engage in the one you are doing now?
6 What are the ways in which you think you have contributed to your household economy?
7 What are the likely things that have hindered you from achieving this?
8 If any, what are the things you do to overcome the challenges?
9 Is there any cultural attribute that either encourages or discourages household economic practices?
10 If any, how do they affect people's economic activities within the household units?
11 How do your kinsmen have influence on your economic activities?

Implication of household economy on choice and utilization of healthcare resources

1 Are there any prevailing ailments caused by certain economic activities?
2 Do household economic practices have any impact on your health care?
3 How do your economic activities affect how you take care of your health?
4 How do you know when you have or are susceptible to illness?
5 What do you do when you realise this?
6 What are the usual outcomes of your reaction, and how do you feel later?
7 Is there any further action taken to overcome the above situation?
8 If no or yes, why?
9 Which type of healthcare do you normally adopt and why?
10 Is there any influence of culture on the type of healthcare adopted?
11 If no or yes, why?

Health status and pattern of healthcare

1 What do you understand by health (probe for significance)?
2 What are the common ailments in this area and why?
3 Is there anyone associated with economic activities?
4 What are the health care patterns adopted in this community (probe for more explanation)?
5 Which one do you think is more popular and why?

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6 Is there any cultural influence on the above reasons? (if any) give.

7 Comment on modern health care facilities in this area

Guide to KII with orthodox healthcare providers

1 What do you understand by health (probe for its significance)?

2 What can you say about the health status in this community?

3 How do you compare the health of women vis-à-vis men in this community?

4 What are the common ailments in this area (probe for further explanations on that)?

5 Is there any one of the above ailments that could be associated with economic activities?

6 Apart from the above, what are other health challenges in this community?

7 Comment freely on orthodox health care facilities in this area.

8 What can you say about people's patronage of orthodox health care facilities?

9 What are the things you think affect people's access and utilisation of health care facilities?

10 Suggest ways to improve health care in this area.

Guide to KII with traditional healthcare providers

1 How long have you been in this profession?

2 Why did you choose this profession?

3 What do you understand by health (probe for its significance)?

4 What are the common ailments in this community and why?

5 How popular is this practice to health care in this community?

6 What is your area of specialisation?

7 What can you say about people's patronage of this type of healthcare?

8 Comment freely on this type of health care in this community.

9 What are the things you think affect health care in this area?

10 Suggest ways to overcome these challenges.

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