THE IMPACT OF SOCIO-ECONOMIC INEQUALITIES ON HEALTH : THE DOUBLE BURDEN OF THE NIGERIAN POOR

By

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A. *Introduction*

This article focuses on the social and economic determinants of the health status of Nigerians. It is often stated that the burden of disease is unnecessarily heavy in an underdeveloped country such as Nigeria (Bryant 1969; Hughes and Hunter 1971; Oduntan 1973; Ransome Kuti 1973) *(1)*. From the sociological perspective the problem of health within populations can be seen as an outcome of the dynamics of on-going social structures. An analysis of structural relationships and socio-economic conditions are «useful above all when the unit of study (of health) is the social group and not the individual» (Laurell et al. 1977) *(2)*. Thus the present health situation among various segments of the Nigerian population can be best understood in terms structural dynamics. In particular, two socio-economic dimensions which are believed to have important bearing on the population's health, will be discussed in this paper.

The first dimension has a bearing on the fact that the many infections and preventable health problems are associated with Nigeria's overall level of poverty. There has been a continued inability to generate enough national wealth for the various socio-economic programmes, despite the presence of natural resources. This inability to develop economically has been attributed to dependency (Aboyade 1976) *(3)* or a country's disadvantaged position in the international economic system (Cock roft, Gunder Frank and Johnson 1972) *(4)*. Thus Nigeria's structural relationship with advanced nations can be said to have health consequences. Secondly, within the nation itself, the uneven distribution of such essentials as food, housing, jobs education and income has differential impact on the health status of various categories of people. This further serves to depress the health situation for many. There is a growing body of literature on Nigeria which attests to the inverse relationship between socio-economic status and health. (Afonja et al 1973; Adetuyibi 1976; Lewis and Aderoju 1978; Odebiyi and Pearce 1978 etc.) *(5)*.

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The main thesis of this article is that members of the lower status groups in Nigeria carry a double burden, given the discussion above. Any serious attempt to tackle their health situation must bring into perspective the two socio-economic dimensions within which they conduct their lives. What follows is an outline of the health condition of lower status groups, as it reflects their disadvantaged position on both the international and the national socio-economic systems.

B. *Health Status as a Consequence of Economic Underdevelopment*

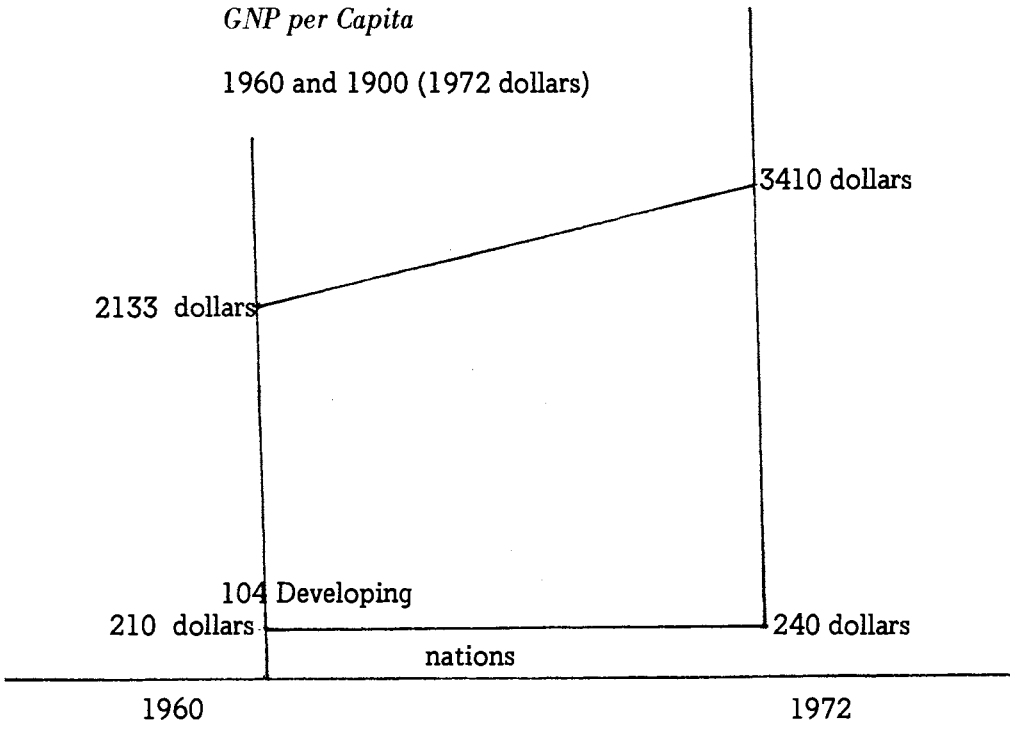
The overall poor health status of the Nigerian population vis-à-vis the populations of any advanced nation is a well documented phenomenon (Akinkugb et al 1973; Uche 1975; Ekanem and Farooq 1976 etc.) *(6)*. As has been argued above, it is one of the more obvious results of the inability to attain economic independence and development in the post-colonial era. While it is true that the benefits of economic development are still unevenly distributed among segments of the advanced nations, the level of development has benefitted all to some degree. As Navarro (1974) has argued, the decline in mortality rates and changes in the pattern of morbidity in the West have been affected first by «the agricultural revolution in the 18th Century, which was the result of changes in the production and distribution of food; second, the industrial revolution of the 19th Century, which brought about an actual increase in standards of living and real wages; and third, the sanitary revolution at the end of the 19th Century and beginning of 20th Century which led to an improvement of the physical environment, primarily in water supplies, sewage systems and housing» *(7)*. Thus economic and social transformations brought a general improvement in the quality of life for the average citizen of countries such as England, France and The United States of America. The outcome of this was recorded in a decline in mortality rates prior to the recent developments in scientific medicine (M'keown & Mclachan 1971; Dubos 1959) *(8)*.

Today Nigeria is still unable to effect an improvement in the quality of life of its citizens. Food production is still inadequate (Olayide 1976) *(9)*, the majority of people live in overcrowded and run-down buildings (Third National Development Plan 1975; Adewuyi 1977) *(10)* and the scarcity of treated water for domestic consumption is an acute problem. These and other problems continue to be reflected in the health statistics as shall be observed shortly.

The task of upgrading the standard of living has become increasingly difficult as the economic gap between rich and poor nations widens (as shown in Fig. I). This continued advantage has meant that the advanced nations have been able to buy or control world resources and markets thereby expanding and strengthening their economies (Chinweizu, 1978) *(11)*

Fig. I. The Concentration of Wealth in Developed Countries

1960 – 1972



Source: Ray Elling. International Jn. of Health Services: Vol. 7 No.2 1977 pg. 215.

Correspondingly, the advanced nations have been able to capture an increasing proportion of world trade (Ayeni 1978) *(12)*, thus leaving diminishing room for poor nations to manouver the economic take-off essential for improving the quality of life. When a trade composition index was calculated *, it highlighted the extent to which some nations are favoured in the uneven distribution of world trade. (Cuba 1977) *(13)*.

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* *Trade Composition index is based on a country's foreign trade and measures the extent to which a country is on top of the world division of labour, exporting manufactured goods and importing raw materials.*

Table I

The Trade Composition Index (Some Selected Countries)

(1)	Japan	+ 106.68
(3)	U. K.	+ 74.30
(4)	Federal Republic of Germany	+ 67.42
(8)	Switzerland	+ 39.70
(17)	U. S. A.	+ 13.70
(111)	Niger	– 140.72
(112)	Zambia	– 144.06
(116)	Gambia	– 148.14
(117)	Uganda	– 162.70

Source : J. Galtung (1978) pg. 17 Figures calculated by A. Cuba. World Indicators Program : Oslo 1977.

Nigeria remains one of the poor nations of the world with a per capita income of N205 (334.00 Dollars) * in 1974 (Third Development Plan 1975). This compares unfavourably with a country such as the U.S.A. where the figures were 5.90 Dollars (N3430.00) for 1975. (World Population Data Sheet 1975) *(14)*. When health statistics are compared, the result of this poverty is made clear. For example, the infant mortality rates recorded for Britain and the U.S.A. are comparable and much lower than those for Nigeria. In 1973, Britain had an infant mortality rate of 17.2, (Demographic Year Book 1975) *(15)* while that of the U.S.A. was 17.7. The figure for Lagos was 70.3. Data on the South-Western portion of Nigeria (1971–3) shows that for most states the statistics exceeded 100.0. Crude death rates for 1971 have been estimated at 20.2 for Eastern (1972–3) and 18.9 for South-Western (1971) Nigeria (Ekanem + Farooq 1976) *(16)*. The corresponding figures were 12.1 (1972) and 9.4 (1972) for Britain and the U.S.A. (Demographic Year Book 1975) Data on life expectancy shows a similar pattern, with

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* *Conversion rate of N1.00 to 1.63 Dollars used. October, 1978.*

68.2 years reported for American males and 75.9 for females (1974). The life span of the average Nigerian is only about two thirds of this, being 44.0 for both sexes in 1974 (Ekanem Ebigbola 1978) *(17)*.

The health of children (1 – 5 years) is often taken as a good indicator of a country's general situation, since this is a dependent and physically valuable group. Thus it is not surprising to note that in Nigeria the picture is grave for this group. Mott (1974) *(18)* reported a childhood mortality rate of 295 per 1000 in some locations in Nigeria. He felt that well over 30% of Nigerian children died before the age of five. Information on the Western nations reveals that all of the U. S. A. and Europe have childhood mortality rates of less than 2% (World Health Statistics 1977) *(19)*. The types of diseases that threaten the lives of Nigerian children are gastroenteritis, bronchopneumonia, malaria measles, anemia etc., as noted in a Lagos hospital survey (Ransome-Kuti 1973) *(20)*. These are considered to be preventable and dependent on the poor environment conditions in the country.

To summarize, it has been argued that the poor health condition of the Nigerian population is one of the reflections of the low level of development and general poverty that still exists. The types of diseases prevailing are the communicable and infectious ones. There is evidence from the West to show that these types of illnesses and the overall burden of disease decline as a nation improves its economic status. In terms of health, an individual chosen at random in an advanced nation is less at risk than one living in an underdeveloped nation. Changes in the environment affecting total populations serve to alter the level and pattern of disease. Thus, plans for development that help perpetuate «satellitic dependence» (Ekong 1978) *(21)* and forestall true economic advancement, only serve to hinder changes in the overall health condition.

C. *Socio-economic Determinants of Health Within Nigeria*

While the general level of development has an effect on the size of the budget available for environmental and social services, the social inequalities within a nation have an additional negative impact on the health status of many. Increased national wealth is a necessary but not sufficient condition for altering the situation for the lower socio-economic strata. Data from some of the most advanced countries still show a continued inverse relationship between many health problems (e.g. infant mortality rates, prematurity, tuberculosis, malnutrition) and social class indicators. (Anatovsky Bernstein 1976; Schatzkin 1978) *(22)*. This pattern is now observable in Nigeria from the growing volume of health studies conducted in the country.

The Nigerian population is by and large on of poor rural peasants. Sixty-seven percent of the economically active population is engaged in agriculture and 95 percent of the output comes from small peasant

holdings. (Olayide 1975) *(23)*. Vis-a-vis the urban population, rural families lack the amenities which would upgrade their environment, although their productive acitivities have been the mainstay of the economy (Ekong 1978; Sokoto 1978) *(24)*. Even though the majority of the social and environmental services are to be found in the fast growing urban centers, most of urbanites are also poor. The 1975 figures for Lagos (capital) reveal that of the estimated 2,483,210 persons, 68.4%, 23.3% and 8.1% were from the lower, middle and upper income groups respectively. The mean monthly wages for each group were N53.84 (dollar 88.00), N128.68 (dollar 210.00) and N534.82 (dollar 872.00) (Ayeni 1976) *(25)*. Most of Lagos, and residents of other urban centers, live in substandard housing, in neighbourhoods with poor Sewage systems and shortage of water etc.

Data on morbidity rates show that these urban/rural, income/occupational differences are reflected in the health statuses of various group. In table II below, the crude death rates for South-Western and Eastern Nigeria Highlight the general situation of rural residents. With the exception of Kwara State, rural communities have higher death rates.

TABLE II

Crude Death Rates for South-Western (1971) and Eastern (1972–3) Nigeria

State	Urban	Rural	T O T A L
Lagos	9.0	11.5	9.6
Western	15.7	20.5	17.8
Kwara	30.1	23.7	25.3
Mid–Western	16.1	21.4	20.8
S. W. Nigeria	16.2	21.1	18.9
E. Central	5.3	21.2	18.0
S. Eastern	9.9	19.4	17.8
Rivers	18.7	33.4	31.1
E. Nigeria	8.8	22.9	20.2

Source: Ekanem + Farooq: 1976 p.69.

Again, Table III shows the occupational differences in the propability that a child born to parents will die. This table speaks for itself.

Table III

Age Specific Death Rates : South Western Nigeria 1971

Age of Mother	Professional	Petty Trader	Agric. Worker
15 – 19	0.00	.44	.30
20 – 24	.17	.41	.49
25 – 29	.17	.43	.45
30 – 34	.20	.50	.59
35 – 39	.25	.46	.69
40 – 44	.29	.53	.73
45 – 49	.29	.54	.69
40 – 49	.29	.54	.71

Source: Ekanem – Ebigbola; 1978: pg. 10.

With regard to morbidity patterns, the evidence, also points to an inverse relationship between socio-economic status and the incidence of disease. In his study of 147 «diabetic» patients at the University Teaching Hospital, Ibadan, Adetuyibi (1976) *(26)* recorded that 97 patients belonged to the lower class, 42 to the middle, and only 8 to the upper class. He also noted that the lack of education restricted people from taking up alternative appointments. Suggestions by physicians that the diabetic patient should seek other jobs led to long term complications which often included unemployment. Therefore, not only are the poor sicker, but the sick get poorer. This is especially true in countries such as Nigeria where accident or life insurance benefits and adequate pensions are still the preserve of the elite.

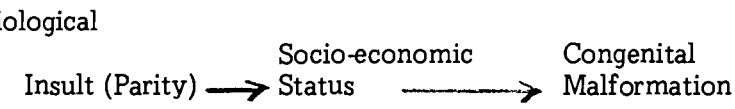
Data collected by the authors (Jan. – Aug., 1978) on the incidence of congenital malformations, again supports the thesis that members of lower socio-economic groups are at a higher risk than others. The study was conducted on 101 (93 complete medical records and 8 incomplete ones) malformed babies who were either born at, or referred to the University Teaching Hospital, Ibadan between January 1975 and December 1977. The aim was to discover the role played by socio-economic factors in the incidence of congenital malformations. Data were collected from the babies' medical records.

Medical research has tended to emphasize the importance of such biological factors as age, genetic predisposition, parity, viruses, (e.g. Robert and Powell 1975) *(27)* in the incidence of malformations. This approach has however been challenged. It has been argued that a variety of extrinsic factors may be equally important in accounting for malformations. It was discovered for example, that the season of birth was associated with a higher risk of Cleft-lip/Cleft-palate among 170 German babies, (kleinebrecht and Degenhardt 1975) *(28)*. The unfavourable period was March to May. The paper concluded that other extrinsic factors such as working hours of worker, season of conception, smoking habits of parents need to be investigated.

Given the above argument, the present authors felt that the parents' position on the socio-economic ladder would affect the degree to which a baby was at risk, because of the uneven exposure to stresses, insecurities hard manual labour etc., of different categories of the population. Residence, education, occupation and religion were thought to be important aspects of life which indicated dimensions of people's social position in Nigeria.

It was therefore hypothesized that (1) the incidence of congenital malformations would increase as socio-economic status decreased; (2) when controlled for Socio-economic Status, the relationship between biological handicaps and malformations would be affected such that members of lower groups. Thus while high parity increases the likelihood of congenital malformations, the negative effects of this increases, as Socio-economic Status decreases. (see Fig. II below).

Fig. II: Theoretical Framework



Analysis of the data revealed that multipara mothers were at a higher risk than primapara mothers. (See Appendix Table IV). With regard to our interest in socio-economic variables, it was also discovered that the nonliterate mothers, the lower occupational categories and moslems* were more likely to have malformed babies (See appendix tables V and VI). Thus for example, there were almost $3\frac{1}{2}$ times the number of nonliterate women as literate women in the sample.

(*) *In an earlier paper (Odebiyi + Pearce 1978) it was reported that there was a significant relationship of p 0.01 between religion and education. Moslems tend to fall within the nonliterate group.*

Further analysis on the relationship between parity and the socio-economic variables supported the claim that lower status groups are more likely to have malformed babies than higher status groups even when the same biological handicap is introduced into all groups. Table VII shows that 81 percent of the highest parity group (4 ever born) were nonliterate women. This could be an indication that nonliterate women tend to have high parity and thus expose themselves more to the risk of bearing malformed babies (Gupta 1969). It was also noted that for each parity level, there were at least three times as many nonliterate as literate mothers. At the highest parity level there were over four times as many nonliterate as literate women.

Table VII

Parity and Education of Mothers

Parity	Education		Total
	Literate	Nonliterate	
Prima para	4	14	18
2 – 4	10	28	38
4	7 (19%)	30 (81%)	37
Total	21	72	93

A similar pattern was found between the different occupational categories. Table VIII also shows that the lower groups were over-represented at the highest parity level. Thus 51 per cent of the malformed babies were born to petty traders (this represented almost half of all the petty traders in the sample). Sixteen per cent each of the highest parity group were semi and unskilled workers. None of the professional and student groups had more than four children.

Table VIII

Parity and Occupation of Mothers

Parity	Occupation							
	Professional	Student	White Collar	Semi Skilled	Un-Skilled	Petty Trader	Jobless	Total
Prima para	–	1	1	4	3	5	4	18
2 – 4 Y	2	2	2	4	5	17	6	38
4	–	–	2 (5.4%)	6 (16.2%)	6 (16.2%)	19 (51.3%)	4 (11%)	37
Total	2	3	5	14	14	41	14	93

In this study, there appeared to be no relationship between illness during pregnancy and congenital malformations. Seventy-four per cent of the sample recorded no illness Gupta (1969) *(29)*, cautions however that reports on illness may be somewhat unrealiable. Nevertheless, when those who admitted having some problem (to the attending physician), were taken separately a higher proportion of them lower status individuals. For example, when religion was considered, 75 per cent of those with some problem were moslems. This represented 34 per cent of the moslems group. Only 15 per cent of the christians reported any illness. Among the educational categories, 83 per cent of those who had been ill were nonliterate mothers. This represented 28 per cent of all nonliterate mothers (as compared to 19 per cent of literate who reported an illness).

The above study tends to support the sociological thesis that the socially disadvantaged groups in a community carry a heavier burden of disease than others. Besides the information on parity levels presented here, the authors also concluded in an earlier paper that «the negative effect of advancing age (i.e. the higher risk of malformed babies) was more marked among the various lower status groups» *(30)*. With age (of mother) the incidence of congenital malformations rose sharply among these groups. (Odebiyi and Pearce 1978.)

In concluding this section, one must re-emphasize the fact that an increasing number of studies on health in Nigeria reveal the role played by socio-economic factors. Low income levels, inadequate education,

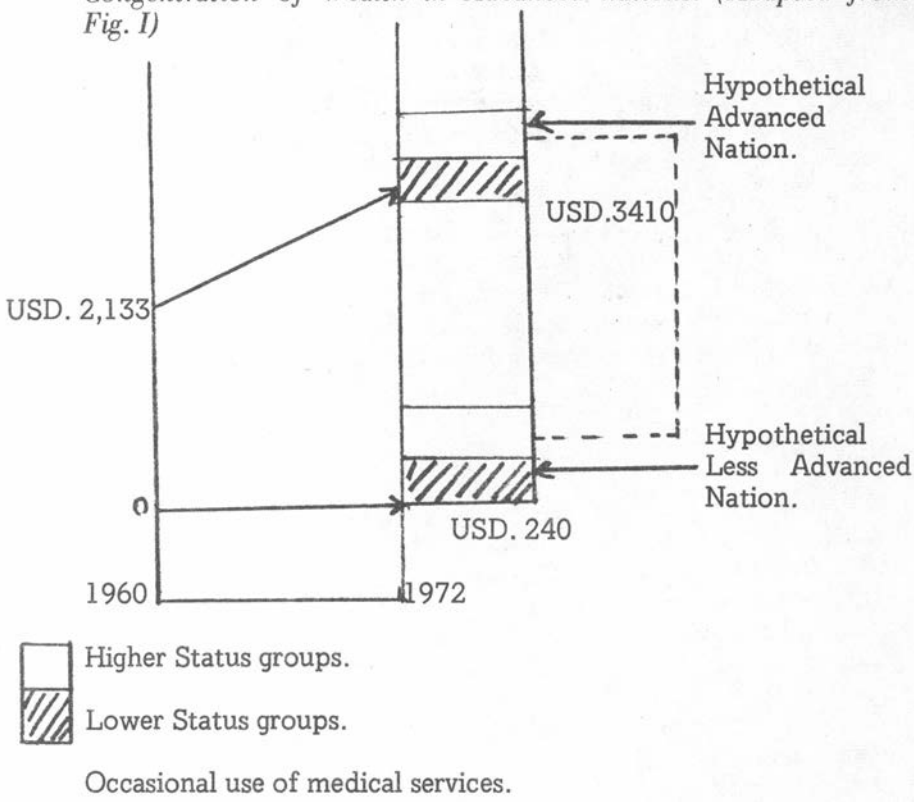
unskilled occupations and a rural location are some of the factors which determine low health status. From the authors' own study of malformed babies certain additional problems need to be highlighted. It is obvious from our data, that the *future* health of an individual is already affected by extraneous factors prior to his/her birth. Given an unfavourable outcome (such as a serious malformation) an individual may be seriously handicapped in terms of career possibilities. Thus if the lower status groups have a higher risk for malformations, more of their children will have a difficult time advancing economically. These same children no doubt become a special burden to families which are the least likely to possess the resources (income, room at home, knowledge of services, contacts etc.) for coping. In recognition of such problems, the authors intend to develop another study to investigate the coping mechanisms of the carious types of families (socio-economic groups) with malformed children.

D. *The Double Burden of Lower Status Individuals in Nigeria.*

In the first part of this essay, the focus was on the health of the (undifferentiated) Nigerian population as a reflection of her low status on the international economic ladder. This was followed by a discussion of the effects of socio-economic status on the health of various categories within the nation. Given these two socio-economic dimensions, it is important to emphasize the double burden or crisis situation of persons possessing lower status characteristics in an underdeveloped country such as Nigeria. If the world population is crudely divided into four groups, the unfavourable situation of the poor in a poor nation is readily seen. (see Fig. III page 76).

One would normally expect the socio-economic environment of the poorer members of a less advanced nation to be the most depressed. The gross lack of socio-economic resources are a constant threat to life and health. It is here that you have a situation where the majority of rural inhabitants use shallow stagnant pools as their main sources of bath, laundry and drinking water. Such problem as Guinea worm are rampant and often immobilize the population (Sokoto 1978) *(31)*. In the urban areas, the lack of drainage and open sewers take their own toll. The richer neighbourhoods are safer, although most are also subject to the continual distruption of social services (water, refuse etc.) which are difficult to obtain on a continuous basis. Although the focus of this paper is not on the contribution to health from the usage of medical facilities (but rather on the independent effects of the socio-economic/ ecological environment the resources of the rich enhance their health situation in the following manner. The personal resources of the upper strata (financial, contacts etc.) indirectly improve their overall situation by enabling escapes from the depressed environment whenever advanced technological therapy is indicated for recovery (preventive screening, treatment, rehabilitation) (see Fig. III).

Fig. III: *The Situation of Various Socio-economic Categories with the Congentration of Wealth in Advanced nations. (Adapted from Fig. I)*



Health statistics tend to support the above assertion concerning the unfavourable position of certain categories of the world's population. Table IX shows data on infant mortality. The nonmetropolitan and southern region of the U.S.A. approximate «the more rural areas of the country. These are also the economically poorer areas, which makes for a cumulative threat to infants» (Milio 1975) *(32)*. It is to be noted that the infant mortality rates of the disadvantaged areas of advanced nations are an improvement over those of the favoured zones of the less advanced nations. American Indians living on reservations are often considered the most depressed group in America. The infant mortality rate for this group was 30.9 (1972) (Milio 1975) *(33)*. The figures were 15.8 for the white population. This is still low in comparison to the Nigerian populations.

Table IX

Differences in Infant Mortality Rates Among Categories of the World Population

Data Years	Country (Area)	Infant Mortality Rates (per 1,000 live births)	
1973	Norway	Urban 10.6	Rural 13.0
1966	U. S. A.	Metropolitan Areas 22	Nonmetropolitan Areas 24.9
	U. S. A.	North East 20.4	South 25.7
1971	South Western Nigeria	Urban 83	Rural 109
1972–3	Eastern Nigeria	76	126

Sources: – Demographic Year Book 1975:

– Ekanem & Farooq. «The Dynamics of Population Change in Southern Nigeria». *The Nigerian Journal of Economic and Social Studies*. Vol. 18, No. 1, 1976: 69.

– Milio's summary of data from National Center for Health Statistics, IMR: Socio-economic factors, US (Washington DC. Dept. H. E. W. 1972).

The data on life expectancy follows the same pattern. For urban Nigeria, males have an average life span of 50.6 years, females 50.8 years, (1971) (Ekanem and Farooq 1976) *(34)*. In the rural zones these figures are 47.2 and 47.0 respectively. Information for 1970 in the U.S.A. shows that whites had a life span of 71.7 years and American Indians (most depressed group) had one of 64 years (Milio 1975) *(35)*. These figures point to the very critical condition of certain sections of the Nigerian population.

CONCLUSION

This article has sought to emphasize the role played by socio-economic factors in health status. While advanced technological facilities (medical) may appear to perform miracles on the individual patient, *the task of raising and maintaining the health level of whole communities will require a focus on socio-economic issues.* From the arguments presented in this article, it would appear that the health condition of the disadvantaged groups in Nigeria can be upgrading by two strategies. The first is to improve the overall economic situation of the nation so that adequate allocations can be made to social services and agricultural output across the board. This will require economic as well as political independence in the post colonial era. (Aboyade 1976) *(36).* This first strategy however does not guarantee the best situation for the lower strata. There need to be additional structural changes in the internal system of the nation. Even in the technologically advanced countries it has been reported that favourable levels of health are more dependent on such factors as income, education, occupation etc, than the number of medical facilities in communities (Lewis et Al 1973) *(37).* In so far as the under developed nations can learn from the mistakes of the developed ones, there should now be a reflection on the most efficacious methods of upgrading the health of the most depressed groups. Money spent on the environment and efforts at socio-structural changes would appear to have higher and sustained yields where health is concerned.

Appendix

TABLE IV

Parity of Mothers

Parity	No.	%
Primapara	18	19
1 - 4	38	41
4	37	40
Total	93	100

TABLE V

Education of Mothers

Education	No.	%
Literate *	21	22.5
Nonliterate	72	77.5
Total	93	100.0

* in English

TABLE VI

Occupation of Mothers *

Occupation	No.	%
Professional	6	5.9
Student	3	2.9
White collar	6	5.9
Semi skilled	17	16.8
Unskilled	14	13.8
Petty Trader	41	40.5
Jobless/Housewife	14	13.8
Total	101	100.0%

* Occupational Breakdown.

Professionals – doctor, engineers, lawyers.
Students – University Students.
White collar –Executives, Offices workers.
Semi-skilled – Sewing nurses, hairdressers.
Unskilled – Farmers.

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RESUME

Le point essentiel de cet article est l'étude de l'effet que les dimensions socio-économiques du développement peuvent avoir sur la santé. Il est prouvé que l'état de santé des couches sociales basses dans un pays comme le Nigéria reflète leur position de désavantagés sur deux plans socio-économiques. Le premier comprend l'ordre économique international alors que le second est purement interne, c'est-à-dire qu'il prend racine dans la société elle-même. Quand on consulte les données statistiques habituelles concernant la santé, on s'apperçoit que ces groupes sont doublement victimes. Il est maintenant reconnu que l'amélioration de leurs conditions de vie réside plus dans des changements de structure sociale que dans une amélioration pure et simple des services médicaux.