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Rural Health Provisioning

Socio-cultural Factors Influencing Maternal and Child Health Care in Osun State, Nigeria

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Introduction

Maternal and child healthcare system is an important segment of medical system in every society. This is as a result of large number of human population involves in this health sector, coupled with the significance of this population to the overall sustenance of any human society, as it mainly involves both women and children. Despite the fact that this sector of medical system is affected by less difficult health problems, which are usually preventable, yet it remains one of the major health problems attracting higher prevalence of morbidity and mortality especially in rural communities of sub-Saharan Africa. Thus, maternal and child health has attracted attentions, probably more than any other health sectors in the region.

Similarly, the increasing wave of gender equality has significantly stimulated attentions towards the study of women and children. It is in the light of the above that this sector has attracted overwhelming attentions especially from health related researchers, health providers and health policy implementers (Jinadu, 1998; Smyke, 1991; Royston and Armstrong, 1989). Specifically, writers have exposed the risks of childbearing and child healthcare in their various writings and research findings. The works of Jinadu (1998), Smyke (1991), Royston *et. al.* (1998), Richard (1974), Nevarro (1974), Odebiyi (1977 and 1999), Aregbeyen (1991), Ebrahim (1982), Owumi (1989 and 1996), Iyun (1987 and 1994) and Oke (1987, 1993 and 1996) are very significant in this respect. All these works and the annual reports of World Health Organization (WHO) and UNICEF since 1970s show that there is high maternal and child morbidity and mortality especially in Nigerian rural communities.

As observed in all cultures, each society has its peculiar ways of dealing with bio-cultural problems affecting its human population. Responses to various interventions seem to differ considering the peculiar knowledge displayed by the population in each society. Environmental factors also play considerable role on the health seeking strategies, thereby making the health interventions and responses greatly different across the culture (Richard 1974; Nevarro 1974; Odebiyi 1977).

It is noted that maternal and child healthcare problems require a preventive approach (Aregbeyen 1991; Ebrahim 1982), hence it is considered very easy to arrest. As noted above especially by Richard (1974), each culture has a peculiar way of dealing with bio-cultural problems with differing responses; sincerely responses to these problems are not the same across the culture. In industrialized countries of the world, an appreciable success has been attained in reduction of morbidity and mortality affecting the lives of both the mothers and the children (Price 1994). Whereas in less-industrialized countries of the world, despite all

the attempts to reduce the severity of maternal and child healthcare (MCH) problems, it still remains a scourge which continues to claim the lives of a large percentage of their populations (Price 1994). No doubt, it still remains a major curious topic especially to behavioral scientists dealing with socio-cultural aspects of medicine (Erinosho 1998). As at 2008, health statistical indexes have shown that maternal and child morbidity and mortality is greater in less industrialized countries than what is obtained in industrialized countries of the world. For instance, infant mortality is indicated to be between 0.3%-0.6% in Finland, Sweden, Britain and United States of America, comparable with 12%-14.5% infant mortality occurring in Nigeria, Haiti, Sierra Leone and Zaire (UNICEF 1994, 1995, 1996; WHO 1991, 1992, 2008).

However, among the Yorubas of western Nigeria, especially in Yoruba rural communities, the traditional knowledge of maternal and child healthcare system is still largely upheld. In this society, MCH problems are explained through natural and preter-natural explanations. The belief in traditional practice is that diseases are sorts of punishment. Hence, health solution is in favor of appeasing gods through libations and other related rituals. The people also appease witches to get rid of their powers of snatching children from their mothers. Sometimes however, some of these health problems are adamant because gods, witches and other associated spirits refuse libations and appeasement. Hence, the traditional practices of maternal and child healthcare system featured tieing charms, amulets and bangles on mothers and children to immunize them against the wrath of gods and spirits. Yet all these attempts did not avail the Yoruba society of the security against infant and maternal morbidity and mortality. Diseases such as cholera, malaria and malnutrition often resulted in convulsions which eventually claim lives of many children usually the under fives (U-5) (Jinadu 1998). Thus in many occasions, there are many children born into a family that are claimed to be *ògbánje* or À*bíkú*[1] and passed away into earth beyond between age 0 and 5 (Fadipe 1970; Daramola and Aina 1967; Soyinka 1982; Clark 1981).

Upon the introduction of orthodox medicine into Yoruba society and diffusion of western scientific beliefs, knowledge and practices of modern medicine were witnessed. Although this new approach finds it difficult to finally extinguish the traditional medical approach, yet its prominence and preference is ascertainable in the urban communities, hence, leaving the rural communities to either traditional option, or plural medical care system. In this wise, the rural communities have the traditional medical system more utilized than the modern medicine. According to Aregbeyen (1992), Pearce (1978), Odebiyi (1977) and Owumi (1993), almost 75% of Nigerian population living in the rural communi-

1 Among the Yorubas of western Nigeria, "*Ogbanje"* or "*Abiku*" is regarded as sprit that often possessed children either in pregnancy or/and at birth and usually cause the children to die. The belief is that when a child is possessed with the spirit, there is no amount of healthcare given to such a child that can stop the child from dyeing at infancy.

ties utilize either traditional medical system singly or blend the provisions in both modern medicine and traditional medicine.

Over the years, despite the fact that the rural health care survives on either exclusive traditional health care system or the plural system, maternal and child health care problems still remain increasing. Thus, western medicine introduced some health care development programmes to avert the crises. Mainly these programmes were initiated through bilateral international and national agencies, and Non-Government Organizations (NGOs) in the areas of maternal and child healthcare system in rural communities of Nigeria, but still maternal and child health system still remains the major health problem in rural communities of western Nigeria like many other parts of Nigeria. The introduced health care development programmes included establishment of more hospitals, importation of drugs and provision of more trained medical personnel in the rural communities. Also specific maternal and child health programmes were initiated, such as the enunciation of Basic Health Services Scheme (BHSS) and Primary Health Care (PHC) System with emphasis on breastfeeding campaign. Also introduced were health promotion strategies such as health education and provision of infrastructures, yet mortality rates associated with preventable maternal and childhood diseases seem unabated (Jinadu 1998; Young 1981; Williams Bausmalang et. al. 1989).

In line with the above, it is probable that many Nigerians especially indigenes and residents of rural communities born within forty to fifty years ago might have managed to escape infant mortality by slim chances. During that time only few Nigerians survived to adulthood, while on the average fifteen pregnancies for a Nigerian woman would produce seven normal deliveries. These seven normal deliveries from a mother would avail her only three children surviving to adulthood. Cumulatively, on every 1000 children born with success, 150 of them might be committed to mother earth within three to five years of their births. No fewer than one thousand mothers out of 100,000 often lost their lives at childbirth (Jinadu 1998; WHO 1960; Population Bureau Bulletin 1999).

Some of the children that managed to survive were at one time or the other products of malnutrition, stunted growth and wasting. They regularly lived at the instance of many preventable diseases. The rural health ecology was too disturbing to the overall health development. This situation was partly due to exclusive reliance on traditional system of MCH, which failed to cope with various controllable infectious diseases, affecting the teeming population of both women and children. These diseases included cholera, marasmus, typhoid, tetanus and poliomyelitis. Diphtheria, diarrhea and measles also claim several lives of the under fives (Jinadu 1998; Ebrahim 1982; Williams Bausmalang et al 1989). Mothers too were not spared of these dreadful conditions. They suffered complications at childbirth, hemorrhage and the likes as a result of inadequate modern knowledge of motherhood. This situation in no doubt posed severe inhibitions

against individual development as well as national development (Lewis 1994; Clarke 1990; Raikes 1989).

In traditional rural societies, the survival of this important segment of the population (mothers and children) was not handled with levity. Traditional Birth Attendants/pediatricians (TBA), *eléwé-omo* and the herbalists have become prominent in the intervention approach (Owumi 1993; Odebiyi 1977). Although the traditional healthcare system then was accessible, triable and affordable, yet it could not solve the problem associated with maternal and child health in these communities (Owumi 1993). It was upon this that colonialism gained ground and subsequently embarked on westernization of health care system in these societies (Schram 1971). In the 1920s, when a maternity was established in Ilesa, Osun State, it seemed that a new ground to tackle maternal and child health problems was discovered, but this hope remains unascertained. In these societies, names like *Málomó*, *Ìgbékòyí* and *Ajítòní* imply the recurrent infant mortality through the spirit of *Àbíkú* (Soyinka 1982). Even as at 2009, with the development in modern medicine as shown in establishment of complex healthcare facilities, specialized training of medical doctors and other personnel, importation of drugs and provision of modern healthcare knowledge coupled with multisectoral approaches at finding a lasting solution to infant and maternal health care problem, the plight of mothers and children still seems insecured mostly in the rural communities. Hence, comparing the rural health care profiles in Nigeria with other western societies, a great difference is reflected against Nigeria success in western medicine.

The works of Bonsi (1982); Owumi (1993); Oke (1995); Pearce (1986) and Odebiyi (1977) have specifically talked on traditional healthcare systems in different parts of African societies. Owumi (1993) and Odebiyi (1977) have studied *eléwé-omo* that is traditional pediatricians in Yoruba society of Nigeria and announced it to be meeting the health requirements of vast majority of people. Their position was that there is a need for integration of these traditional healthcare practices with orthodox system if the utility and potency in traditional medicine is to be useful to mankind.

Pearce also in 1986 distinctively noted that culture change witnessed in African societies has displaced the values of traditional system of various healthcare practices. While corroborating this assertion, Aregbeyen (1991) and Erinosho (1998) in their studies respectively observed that maternal and child healthcare systems are worst for this change. Hence, it was noticed in 1995 in another study particularly carried out in Osun State that the rural people in this State are seriously affected by imbalances introduced by the trends of change in their healthcare system (Ajala 1995, 1999).

Other writers like Williams Bausmalang and Jellife (1989), Iyun (1994), Odebiyi (1977), Oke (1993), WHO (1998), Smyke (1991) and Price (1994) have particularly observed that the need is opened to study particular socio-cultural

factors responsible for the resilience and high prevalence of maternal and infant morbidity and mortality in the rural communities of less industrialized countries. It is true however that there are paucity of facts on the influence of culture on the health and ill-health of the people, yet various works in existence seem not to have found clues to the problems of maternal and child morbidity and mortality especially in rural communities of Nigeria.

The recent health profiles confirm that out of 14.8 million people who go into demise annually as at 1998, 75-80% of these are from rural communities of less developed states (LDS). 45-50% of these are mothers and children in the third world societies (WHO 1998; WHO 1996; Population Data Sheet 1997). Health indications further revealed that prior 1960, infant mortality rate in sub-Saharan Africa was 257 deaths per 1000 live births. In 1960s, it was reduced to 145 deaths per 1000 live births; while between 1980s and early 1990s, the rate oscillated between 120 deaths – 110 deaths in every 1000 live births in Nigeria. Still between 1993 and 1999 when the country faced serious economic decline and political instabilities coupled with attendant harsh micro-economic policies infant mortality rate increased to 130 deaths per 1000 live births. All these affected under five children (WHO Annual Reports 1960-1998; UNICEF Annual Report 1965-1999). Rural communities are mostly affected by all these occurrences. From the death records in developed societies, there is high rate of significant reduction of infant mortality. For instance, in Sweden, Finland and France, it was reduced from 17.0% to 3.7% between 1960 and 1985, and since 1985 to the time of writing, the reduction was to 0.6 or 0.7% in these countries. Authors attributed this decline to the activities of PHC in those countries (Penny Price 1995). Despite the establishment of PHC also in Nigeria since 1985, why is MCH problems still remain resilient?

Solution to the existing problems transcends just importation of western ideas to secure mothers and children from the scourge of preventable diseases particularly in the rural communities of Osun State. In this society there is a gravery of poor maternal and child healthcare system, reflected in infants' malnutrition, poverty, poor infrastructural facilities to support health system, and lack of dependable economic system to avail the population an access to western healthcare facilities located in distant towns and cities. These again are the obvious causes of untimely deaths of large number of mothers and children. In view of these, some who might have escaped death are not strong enough to fall into the scope of a healthy person.

Having perceived this resilient silent crisis covers socio-cultural factors influencing the utilization of maternal and child healthcare services in Nigerian rural communities taking Osun State as a study sample. The principal intention is to establish a holistic knowledge towards understanding of maternal and infant mortality and morbidity in Nigeria. This work therefore examines the effect of education, traditional knowledge and practices among the population on

childbearing and childrearing practices in the study population. The research also examines the effects of micro-economic policies and available infrastructural facilities to sustain healthcare development programmes on maternal and child healthcare in the rural communities.

It considered that local customs, beliefs and certain traditional practices have effect on the success of maternal and child healthcare (MCH) programmes in rural communities. Furthermore, it also analyses various intervention strategies which have been instituted against maternal and infant mortality and morbidity and their impacts on the society.

The scope covers the examination of MCH between 1980 and 2008. MCH is phased into Traditional Methods (TM) of MCH and Western Methods (WM) of MCH for the purpose of careful examination on the changes associated with MCH over the time. MCH development programmes such as Primary Health Care (PHC) services, which incorporated Breastfeeding Campaign, Family Planning Campaign, Immunization and Health Education Strategies were carefully assessed.

This study emanated from my earlier study on cultural practices related to breastfeeding and their implications on Maternal and Child Healthcare system among the people of Ilobu, Osun State. This study on breastfeeding was conducted as Master's degree thesis in Medical Anthropology at the Institute of African Studies, University of Ibadan, Ibadan in 1995. In that study, it was discovered that despite the establishment of various maternal and child healthcare programmes and services, most rural people are still reluctant to utilize them or not utilizing them properly. Such services include family planning programmes, health education, safe motherhood initiatives, and immunization programmes among others. Non-utilization of these programmes were responsible for maternal and child morbidity and mortality in the area. Thus, following the commencement of doctoral research programme in the same University, I therefore decided to further my research on rural health provisioning, focusing on maternal and child healthcare in Osun state. This work is therefore a detail report of my doctoral research thesis focusing on socio-cultural factors affecting the utilization of maternal and child healthcare services in rural communities of Nigeria. It is a model of health care situation in Less Developed Countries (LDCs) of the world taking Osun State as a case study.

This study falls within a time-frame of 1980 up till 2008. This period is phased into three stages. The first is between 1980 and 1990 covering the period when Nigeria had just started the Second Republic; and when Nigeria first took foreign loan from International Monetary Funds. That implies that it was the time Nigeria acceded to Structural Adjustment Porgrammes, which the thesis establishes that have rippling effects on national healthcare system (Ajala 1999).

The second phase is between 1990 and 2000, when Primary Health Care (PHC) was vigorously pursued under military regimes of General Ibrahim Ba-

bangida as the Head of State and Dr. Olikoye Ransome-Kuti as the Honorable Minister of Health in Nigeria. This period saw the vigorous pursuit of PHC principles and practices. It is noted that Osun State was selected as one of the pilot studies for the commencement of PHC in Nigeria then.

The third phase is between 2000 and 2007 when the country entered into democracy under Chief Olusegun Obasanjo, who was the Nigerian president between 1999 and 2007, having firstly ruled the country as a Military head of state between 1976 and 1979. Following the initial severe economic depression and harsh micro-economic policies which the country experienced under the dictatorial government of Late General Sanni Abacha, subsidies on oil and agricultural inputs were removed and government abandoned the maintenance of infrastructural facilities at that time. More dreadful at that time was neglect of PHC programmes, and low commitment of the government to pursue Research and Development (RD) which could have yielded information on people's health profile. Frauds and corruption were the order of the day at that time, and the International community, due to political turmoil in Nigeria, began to treat the country with hostility and harshness especially on debt-servicing of the country. This study examined the effects of these experiences on the MCH system in the rural communities of Osun State. The study examines the habits, customs, beliefs and other cultural practices of the people as related to MCH in the past; juxtapose them with what they were between 1980 and 2000. Then bring out their effects on the MCH utilization pattern of services in the rural communities of Osun State.

This particular work therefore contributes to the research of others on one hand, by taking up from where they stopped. On the other, it opens a distinctive focus on anthropological study of rural healthcare development. The work investigates the present problems associated with maternal and child morbidity and mortality in the rural communities. Such scope is neglected in the existing work as a result of time constraint. These distinctions therefore make the work very relevant to subsequent researchers on culture and health development in rural communities. It is also relevant to health workers, policy makers and policy implementers of health programmes.

On the theoretical plane, the work employs multi-theoretical and multi-conceptual approaches in the analysis and investigation of its subject-matter, serving as a lasting legacy in the field of anthropology. The work specifically contributes to the potential significance of anthropological principles to solve real and practical problems affecting rural communities of Yoruba society.

Theoretical and Conceptual Framework

The study derived its theoretical strength from social change theory and underlying conceptual frameworks of rural healthcare development. Focus on social change is on Innovation and Social Impact Assessment theories. The study also

uses Health Belief Model (HBM) to examine people's perception of illness, as well as conditions determining taking particular health clues in maternal and child healthcare in rural communities of Osun State.

Culture Change Theory

It is a consensus among the behavioral scientists that no society is static. According to Raymond Firth (1958: 149) the "bony structure", i.e. the basic underlying principles that give a culture form and meaning may not be easily altered but the "flesh and blood"- the traits and complexes that fill out the cultural configuration can and do change quite rapidly. Thus, healthcare system, which is an aspect of culture, similarly undergoes changes from time to time. In this wise, explanation of maternal and child healthcare emanates from social change theory. Analysis of social and behavioral change in maternal and child healthcare (MCH) reflects the causes of change, adoption of changing traits and assessment of the impacts of such changes on the population studied. In this context, innovation and its adoption is capable of explaining the changing patterns of MCH in rural communities of Osun state, western Nigeria.

Various definitions of culture ascertain that every human society has a distinctive culture which controls the behavior of its members. These cultural patterns are relative to their physical and socio-cultural environments (Oke 1987: 193). This assumption has made anthropologists to classify culture as modern and traditional, relying on the resilience and adaptive tendencies in some cultural traits. Cultural traits that are resilient are mostly referred to as traditional cultures, while the newly introduced cultural traits are referred to as modern cultures. It should be noted that the fact that there are certain cultural traits usually refer to as traditional does not imply that such aspect of culture is static. Apparently, all cultural traits do experience transformation from what they were in the past to new forms. When such transformation occurs, the beliefs and philosophy attached to such practices too are bound to adapt to the new forms.

Social change theory primarily explains the differences in attitudes, behaviours, technology or social institutions in comparison with what they were in the past. Social change involves the development of new patterns in all variables of life; which can either be synchronic or diachronic. This is to say that there are two methods of studying social change. That is synchronic and/or diachronic, thus social change assumes cultural stability and cultural change. Synchronism emphasizes culture resilience and adoption while diachronism holds to culture change as an evidence of lapse of time. However, studies tend to focus more on diachronic, but as warned by Oke (1987: 194), studying social change should not view synchronism and diachronism as mutually exclusive, rather stability and change should be considered as essential aspects of any culture of a living people. Furthermore, Linton (1945) suggested that instead of examining culture change in terms of synchronic or diachronic, a scheme for the description of cul-

ture content can be followed. He enumerated three main categories which include universals, specialties and alternatives. These three culture contents depict three concentric circles showing universals in the core zone, with the specialties making up the intermediate zone and the alternatives at the very outer zone. Linton (1945) further specifies that universal culture elements include ideas, habits and conditioned emotional responses, which are applicable to all normal adult members of a society. Specialties are those elements shared by the members of certain socially recognized groups who are distinctive categories of individuals. The total populations do not share such elements. The alternatives are those traits which are well known to all adults but with respect to which there is a free choice. Desirably, changes are more frequent in the zone of alternatives than either of the two layers. In actual fact, the universal zone seems more resilient but not static. This analysis is indicated in figure 1 below.

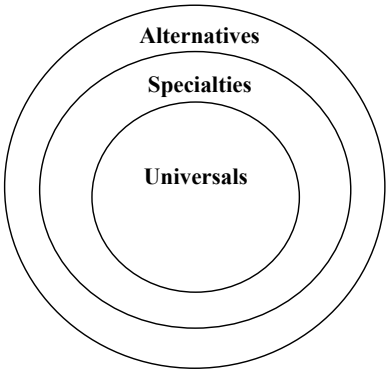

Fig 1: Culture Contents (Source: Linton's Examination of Culture)

However, as the classification of culture content fails to explain the forms of culture change and why some planned changes are often ignored, one therefore tends to associate more with Barnett in his work published in 1953. Barnett (1953) maintains that the major basis for culture change in any society is innovation. Innovation is the occurrence of new traits possible as a result of discovery or invention. In his analysis of innovations in six different cultures, he noted that innovation may occur within a particular society or by virtue of intersocietal contact or through diffusion. This simply suggests that innovation can either be endogenous or exogenous or both.

Innovation is the process of acculturation and integration. Acculturation is a change which occurs in a culture or subcultures. This process occurs when members of a cultural system have contacts with a usually more powerful group. It entails extensive borrowing in form of superordinate-subordinate relations.

External pressures in terms of information network, diplomacy and warfare usually from more powerful group are exerted on less-powerful group, and the less-powerful group assimilates the more powerful cultural traits.

Acculturation is a complex phenomenon which depends partly on the size of the population involved and the media power, the adaptability and the flexibility exhibited by the culture involved. Notably acculturation can lead to accommodation or fusion or pluralism. On the other hand, integration is the process of mutual adjustment especially when the innovation made is compatible with the pre-existing practices. This is often referred to as progressive adjustment which results to modification. It is clear that there cannot be integration without modification. In essence, it is a condition for the acceptance of innovation. In short, the concept of integration is concerned with the process of interaction which is more of what happens to the host culture during the process. Effect of this interaction may be in three folds namely replacement, alternative and syncretism.

Replacement involves extinction of one trait for the newly introduced trait, while alternative depicts the two traits co-existing while either of the two serves as alternative to other. Syncretism is blending, that is, accommodation of the two elements into one form.

From the above analysis, what is germane to our discussion here is the application of the above to changes in medical sector in Nigeria and in particular the maternal and child healthcare system in rural communities of Osun State. Changes in maternal and child healthcare in Osun State can be better analysed within synchronic and diachronic perspectives. Before the advent of colonialism, the practice was traditional which featured indigenous practices, such as long-term breast-feeding, the use of concoction and local herbs; and the patronage of traditional healers. Traditional birth attendants undertook child delivery and women were faced with numerous cultural prejudices, which posited threat to their healthcare system. Patriarchy and male-child preference principally associated with Yoruba social relationship also had effects on maternal and child healthcare in the Yoruba communities. All the above are the synchronic aspects of maternal and child healthcare which still seem resilient among the people.

The advent of colonialism, and the subsequent independence and internationalization of culture exposed the Yoruba communities to new health culture. The new health culture featured specialized training of personnel in maternal and child healthcare, nationalization and globalization of health policy and the introduction of exogenous innovations in healthcare management. Such newly introduced health cultures include modern health institutions, primary healthcare and other Maternal and Child Healthcare Development Programmes (MCHDP). All these are aimed at reducing the morbidity and mortality grossly affecting mothers and their children. Despite all these diachronic elements in MCH development, certain traditional practices are still impossible to replace. Such include the belief and practices associated with *abiku* – child mortality; high patronage

and confidence in traditional therapeutic options; the practice of polygyny and preference for male-children, which are indications of patriarchy. A careful analysis of MCH development therefore depicts some resilient cultural practices such as the use of local herbs and concoction and the practice of traditional medicine as a common culture among the Yorubas. These culture contents to a large extent dominate and were given boost by socio-economic conditions of the people. The use of baby food, midwifery and immunization are the specialties which changes have brought into the MCH culture contents. Individuals too are left with the option as to either rely on western healthcare system or traditional healthcare system.

The above analysis reflects the effects of these socio-cultural changes, showing on one side, replacement and alternative; and on the other there is syncretism. Replacement occurs where certain traditional practices have gone into extinction for new practices; the alternative favors the presence of both traditional and modern practices co-existing and syncretism shows the accommodation of the two practices. All these are the features of MCH in the modern context.

Authors have noted that the effects of changes have not yielded desired development in maternal and child healthcare system in Nigeria (Odebiyi 1977; Jinadu 1998; Jegede 1998). They are of the opinions that introduction of western medicine which refuses to accommodate and integrate traditional medicine portends a great danger to a sustainable MCH development. This problem as noted by Tella (1992) is not unconnected with the process of innovations, which can be better analysed in maternal and child healthcare in rural communities of Nigeria.

Innovation Adoption Theory

Considering the problems of integration of modern medicine (MM) with the traditional medicine (TM) as well as the chance of adopting the newly introduced traits, we need to examine innovation adoption theory. Innovation as noted above is a set of new ideas, knowledge, practices and object. It encompasses specific constructs, cultural codes and forms of management and co-operation. Its adoption reflects the workings of various processes affecting the actions of individuals (Feder et. al. 1993: 256; Saginga 1998).

In consideration of the above therefore, our focus on innovation adoption theory relies on three basic factors necessary for the adoption of new healthcare programmes. These factors are:

1) Socio-economic characteristics of the adopters, which include age, education, family size, income, risk and uncertainty, belief system etc.
2) Structural and institutional factors such as information availability, policy intervention, contact, infrastructural facilities, locational factors and culture contexts etc.

3) Technological characteristics, as perceived by individuals, which include relative advantage, compatibility, complexity, triability and observability.

All the above indicated factors have effects on the utilization of new healthcare development programmes. It is evidenced from this study that the process of innovation fails to take into consideration the above factors. The above analysis provides explanation on why innovation failed to have positive impact on health care development in the rural communities of Osun state. However there are certain impacts associated with the changes in the healthcare development in rural communities of Osun state.

Social Impact Assessment Model

To describe and analyze the real impact or potential effects of health development programmes upon specific groups of peoples, we need to identify the groups of people that are affected, the distributional effects and the differential impacts of such development programmes on different categories of people. In doing this, we employed social impact assessment framework. Social Impact Assessment (SIA) is a broad concept applied to studies on social and cultural impact of development plans and programmes as well as projects (Carley and Derow 1998). It provides information on the socio-economic impacts which are associated with a new project, policy and programmes. It emphasizes the impacts of alterations on the living conditions which include changes in community patterns of life; such changes include productions, distributions and consumptions of goods and services (Campbell 1990). Thus, SIA is concerned with impact analysis focusing on how far the programme has been successful in meeting social and environmental objectives as well as appropriateness of the programmes. That is, to measure how the improved health development programmes equate with the needs and priorities of household and other units in the target population. This implies looking at the improved health technologies from the viewpoint of the users; i.e. both male and female members of the households, actual and potential and examine their social features.

From the above, it is clear that in the rural communities where western education is too low, the family size is too large with low income level, rural health provisioning is faced with a lot of uncertainties and risks. These reflected in their conception of health, by the rural people and their belief on western medicine. As their conception and perception of modern health care system is negative; the adoption of planned changes in health care system becomes problematic. Complicating the situation is the lack of positive means of health education that could have positively changed the people's conception and perception towards adoption in the rural communities. This suggests that basic information about planned change is a necessary condition for innovation adoption.

Although in some places, information was provided, yet such information is very limited and not available to vast majority of the people. Also the available infrastructural facilities could not merge the requirements of western medicine and in some cases the locations of health institutions are too remote to the users. Similarly, the attitudes of health workers in most cases are non-receptive to the health users. All these accounted for the failure of innovation in maternal and child healthcare system. In view of these factors, individuals feel that technologies associated with modern medicine do not have relative advantage because they seem to be too complex. They are therefore non-compatible, non-observable and non-triable to the rural communities.

To measure the level of utilization of rural healthcare services, there is need to examine the health decision-making of the rural people. To this end, the most appropriate theory that can explain health decision of the rural people is Health Belief Model (HBM) associated with Rosenstock (1966).

Health Belief Model (HBM)

HBM assumes that beliefs and attitudes of people are important determinants of their health related actions. The model accounts that when strategies for actions, such as assumptions are present, there can still be variations in health care utilization behavior. These variations can be explained by beliefs concerning four sets of variables. These are:

1) individual perception of his own vulnerability to illness;
2) the belief about the severity of the illness which may be defined in terms of physical harm or interference with social functioning;
3) the person's perception of the benefits associated with actions to reduce the level of severity or vulnerability; and
4) the evaluation of potential obstacles associated with the proposed actions. These actions may be physical, psychological or financial (Oluwadare 2000; Jegede 1998; Rosenstock 1966).

In essence, there must be a belief that there is intervention in disease and that the intervention would produce the desired result. Also there is a consideration for the benefit, costs and inconveniences involved in seeking a particular healthcare service.

This model therefore generates two broad actions in health care seeking, which are:

1) health seeking behaviour; and
2) decision-making process.

In decision-making process, for somebody to remain healthy, he must take positive step and act upon them. Decision-making is dependent on three other factors:

1) human nature;
2) culture; and

3) human nurture and pattern of learnt health-related behaviours.

According to Rosenstock (1974), for somebody to make a health decision, he must first believe that he is susceptible to that particular disease and also that the level of susceptibility is either severe or mild. This particular position was supported by Jegede (1999) when he analyzed three levels of susceptibility. These are:

1) high susceptibility – this is when a person expresses the feeling that he is in real danger of contracting a disease;
2) medium susceptibility – that is a situation when a person believes that even though he is immuned to a disease, yet at a particular moment, he is likely to be adversely tormented; and
3) low susceptibility – this happens when an individual completely denies any possibility of his contracting a disease.

Analysis from this study suggests that certain beliefs especially associated with disease and death have strong effect on maternal and child health. These factors include the conception of MCH; beliefs associated with MCH and certain customs which are harmful to MCH. Among the non-formal educated people, the belief that death is predetermined and that it is beyond human control plays a factor in taking preventive measures against health problems. In the rural communities of Osun State, the people hold the belief that even if a child dies at a tender age and such death is caused, for example, by cholera or any other noticeable illness, it is the destiny, believing that even if the victim had being taken to a standard hospital, he would still die.

Taking therapy is regarded as a mere trial – *ìyànjú lásán*. The action which an individual takes depends on the perceived effect and consequences of such disease. Since the cosmology of disease and illness among the Yoruba does not believe that mortality can occur, due to human health behavior, rather death is predetermined. Hence, many reasons are devised when death occurs. Such include the possession of *Abiku* spirit for children, and *Emèrè* or *Àjé* – witchcraft for maternal death. All these play important factors in taking particular actions concerning the effects and consequences of a particular disease.

Some diseases are regarded as mild and normal, even when symptoms of these diseases which are regarded as mild are the same as serious one. Since there is no scientific proof to distinguish such cases, they are treated with levity until such might have caused irreparable impairment. For instance, diseases like headache, malnutrition especially shortly after weaning, and kwashiorkor, among others are treated as mild and normal. So, these cases are not usually taken to hospital for caring, rather they are referred to traditional medicine or keeping the patients at home using home medication.

Although HBM relates with group attitudes to health care system, yet as HBM explains how and why people take particular therapy but certainly at user's perception of disease, belief system and therapeutic choice, in MCH certain

variables are connected with desires to take action in MCH problems. As shown in figure 2 below these variables are analyzed to explain why individual perception and behaviours lead to utilization of MCH services.

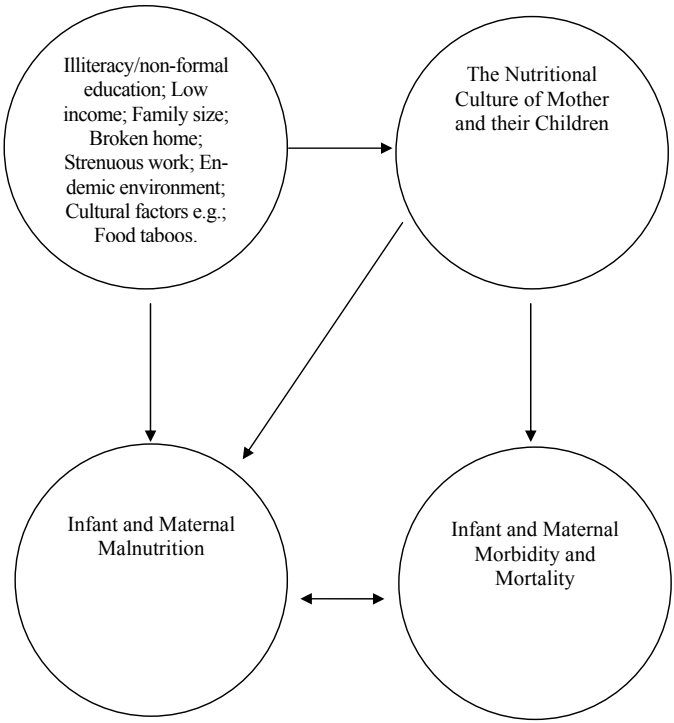

Fig. 2: Social and cultural variables influencing utilization of MCH service

The above conceptual framework explains certain social and cultural variables that are more important to individuals in relationship with group behaviors that causes maternal and child morbidity and mortality. It explains that certain dependent variables such as education, income, family size, occupation and environment may hinder or promote MCH. In actual fact, as indicated in the above model, non-formal education, low income, family size, broken home, food taboos, strenuous work and endemic environment are some dependent variables which determine the nutritional culture of mothers and children. Thus, they lead to infant and maternal malnutrition which may eventually result to infant and maternal morbidity and mortality.

Following the above, the following propositions further explain factors influencing MCH:

1) large family size has greater chance of causing ill-health among the children in that family;
2) income level of the father may affect the health conditions of children and mothers;
3) maternal health information at the household level may have positive effects on MCH system;
4) eradication of common child and maternal diseases may require a multi-disciplinary approach;
5) women's formal education may influence their usability of MCH development programmes in the rural community.

Rural as a Concept

While it is often assumed that it is difficult to define rural communities just like many other concepts in social sciences, it is apparent that rurality is discernible. For clarity and not for the sake of social science dilemma of cultural relativity that makes many of its concepts inappropriately definable, rural communities are those communities that are structurally differentiated from urban in a number of factors which include infrastructural presence; distinct population nature (usually homogenous) and dynamics and location and localization of culture (Ajaga 2004). Thus, rural communities can be identified by predominantly informal economic sector largely driven and relied on agricultural activity either in small scale (as in the case of many rural communities in sub-Saharan Africa) or large scale (as in the case of developed countries and some few intermediate countries of the World); adherence to traditional values and beliefs; low level of technology and infrastructures; widespread poverty (as experience in sub-Saharan Africa); and a small population of less than a thousand people depending on the country's population trends.

The dichotomy between rural and urban communities is therefore clearly marked by the presence of certain facilities meant to improve the quality of life. It is necessary to point out here that there may not be any community where its entire people are equally accessible to high quality of life. However, there is a sharp division in term of access to high quality of life among the people of a particular society based on division marking access to infrastructure. Hence, community that has less quality of life and differentiated by what obtains in another community that has a high quality of life with attendant quantity of infrastructure is thus referred to as rural community. In other words rural communities lack basic needs that sustain healthy living. Economic growth is low while the degree of modernization is equally very slow especially in sub-Saharan Africa. Many of these communities are resilient to changes. Thus, in the word of Ajaga (2004) rural communities are the dens of poverty. In other words rural communities are bedeviled with poverty, where it is assumed that 75% of its population

is in dreadful poverty lacking in all basic needs of life such as good health care, shelter, clothing and political power as in the case of Nigeria (Mabogunje 2003).

Following from the above background, the concept of rural, as used in this text refers to the communities in Osun state that fall within the context of the above description. Thus, as stated above, how such rural communities in Osun state manage their health care and their understanding of health in relation to maternal and child health is the central thrust of this text.