TRADO-MEDICAL PRACTICES AND THEIR EFFECTS ON SOCIO-ECONOMIC SECTOR OF THE RURAL AREAS OF FEDERAL CAPITAL TERRITORY - NIGERIA

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Abstract

Without prejudice to the type of health facility in place, healthy living is central to economic development. Nigeria has three tiers of health system- Primary, Secondary and Tertiary. This health system may be traditional or orthodox. However in this study, trado-medical practices have been focused and this is defined as, all total of knowledge or practices used in diagnosing, preventing or eliminating a physical, mental or social diseases. The study involved 172 household heads across the Six Area Councils of Abuja, Nigeria. Multi-stage sampling technique was adopted. In all, interviews were conducted and 400 questionnaires were also administered in the randomly selected settlements of the wards on the subject matter. Data from all these sources were subjected to regression analysis. The study revealed that trado-medical practices are still relevant among the populace of FCT, particularly those in the satellite settlements as manifested in income, education, productivity and health status. The study concludes that poverty level in the study area has made orthodox medicine unaffordable; this is in addition to the neglect on the part of government to provide health facilities at the rural areas. The study therefore recommended that, since trado-medical practices have become alternative medical practices in Nigeria, health education among others is essential.

Keywords: Healthcare management; Trado-Medical; Rural; Health System, Orthodox Medicine

INTRODUCTION

In any ideal human society, adequate health programmes are considered to be very important as a stabilizer of the social system (Ojua, Bisong and Ishor, 2013). The feats of wellbeing are achieved through adequate health system, which WHO (2015) listed to include effective, safe, quality, personnel and non-personnel health intervention to those who needs them when and where needed with minimum waste of resources. These attributes are related to orthodox medical practices and are very rare to come by in the developing counties, because of inadequate resources, thus the need for alternative medical provision.

According to the National Survey Health Development Program Fund (2009-2015), as cited by Akanbi (2014), Nigeria operates pluralistic health care system and this is structured into three tiers in hierarchical order -Primary, Secondary and Tertiary. Each of these tiers draw their finances and management from Local, State and Federal Governments respectively. To be noted also is that an analyses of the relationships between health and economic growth can be conducted at the individual level, at regional levels within a country, and at aggregate level for a country's aggregate data (Aluko and Adeniji, 2014) In all, there are 30,345 Primary Health Care (PHC) centers, 3,993 secondary health facilities and 85 tertiary health institutions (Olusesan, Aderemi, Bamidele et al, 2014). Out of these, Federal Capital Territory has 559 Primary Health Care Centers, 90 secondary health care facilities and 7 tertiary health facilities. Suffice to add that, majority of the primary care facilities are located in the rural areas, characterized by ill equipped facilities and inadequate personnel. This trend according to Adefolalu (2011) has resulted to an estimated 80% of Nigerians, particularly those in the rural area preferring to solve their health problems consulting traditional healers. This may not be unconnected with low disposable income among other reasons (Srvastava, 2011).

In the rural areas of Nigeria, there is inadequate health facilities required to meet the medical needs of the public (Akanbi, 2014), even though rural areas remain the life-wire and the basis of existence in many human societies (Onwuemele and Ekusa, 2011). Additionally, the rural area is faced with challenges including poverty and neglect by the governments in the provision of social infrastructural, all which have added to the wide gap in standard of living between rural and urban dwellers. Furthermore, the rate of Economic growth, increase in social amenities, infrastructures and natural resources are far behind population growth rate (Aluko and Areo, 2011). In a survey by National Bureau of Statistics (2010), the poverty level in Nigeria is generally high with 61.2% living on less than USD1.25 per day and most infrastructures are in the state of disrepair. A large percentage of rural areas suffer from diseases, thus meeting the MDGs target of health for all is a mirage, which has further aggravated the poverty level of the rural people (Ki-moon, 2011; WHO, 2014). Hence, the need for alternative to orthodox health

delivery practices at rural level. This alternative medical system is interchangeably used as complementary medicine, natural medicine, herbal medicine, phyto medicine among others.

According to World Health Organization (2002), "trado-medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual, therapies, manual techniques and exercises applied singularly or in combination to treat, diagnose and prevent illnesses or maintain wellbeing.   WHO, affirms further that trado-medical comprises of therapeutic practices that have been in existence often for hundreds of years before the development of modern scientific medicines and are still in use today without any documented evidence of adverse effects. In many counties of the world, Nigeria inclusive demand for traditional medicine is on the increase because of its proven quality, safety and efficacy (Abdulahi, 2011; WHO, 2013).

This trend may have resulted in a WHO policy document 2002-2005 on Traditional Medicine Strategy, which has been revised in 2013 christened WHO Traditional Medicine Strategy 2014-2023. It has two goals vis:-

1. Harnessing the potential contribution of Traditional Medicine to health, wellbeing, people centered health care and universal health coverage.

2. Promoting safe and effective use of traditional and Traditional Medicine products, practices and practitioners into the health system as appropriate.

Although traditional medicine is an underestimated part of health delivery system, its function remains central in the wellbeing of many. In Nigeria, trado-medical practices have been incorporated into the health delivery system (WHO, 2002).Suffice to add that, trado-medical practices are socio-cultural heritage, acquired unconsciously with age long history (Elujoba et al,2005). The beauties of the trado-medical practices are aligned to its accessibility and affordability for the rural populace, where accessibility to orthodox medicine is limited by cost and inaccessibility.

Trado-medical system is made up of categories of traditional healers. According to Iwu, (1986) and Tella, 1986), trado-medicals are categorized according to the area of specialization. For instance:-

i. Herbalists-These are trado-medicals who rely on the use of herbs, roots leaves, stem among others to cure ailments.

ii. Traditional Birth Attendants (TBA): They are involved in delivery of babies.

iii. Traditional Surgeon: People in this category are concerned with circumcision, cutting of tribal marks.

iv. Bone Setters: These set of traditional specialists are knowledgeable in the art and skill of setting broken bones in traditional way, using their skill to see that bones unite and heal properly.

v. Traditional Medicinal Ingredient Dealers: Mostly women and they are involved in the procurement and sales of plants, animals that are used in making herbal preparation.

vi. Traditional Psychiatrists: They specialists in the treatment of people suffering from insanity.

vii. Therapeutic Occultism: These are fortune tellers.

Suffice to add that, trado-medical health practices are common in the rural areas. This may be associated to the fact that, most third world countries do not have health care facilities that commensurate to their population in the rural areas (Akanbi, 2014). Elujoba, Odeleye and Ogunyemi (2005) agreed that, most people result to trado-medical personnel for treatment of their problems because it is cheap, available, approachable and accessible. This trend according to Adefolalu (2011) and Adeshina (2015) has resulted to an estimated 80% of Nigerians particularly those living in the rural area preferring to solve their health problems consulting traditional healers. As at 2005, Elujoba et al (2005) submitted that, 80.0% of the population in Nigeria depends on traditional medicines for the treatment of high fever and other common ailments.

In the Federal Capital Territory, a survey shows that 17% of the health facilities are functional, 30% are fairly functional and 53% are not functional (FCT- MDG, *2015*). As a result of the above scene, the need for an alternative to orthodox medication becomes a necessity, if people must survive. The most common diseases in FCT are malaria, typhoid, cholera, abdominal pain, dysentery, chicken pox, diarrhea and diabetes (FCT- MDG*, 2015*).

In the light of the foregoing, the present study is conceived and this is achieved through the following objectives: examine the status of trado-medical practices and evaluate the effects of traditional medical practices on the people Vis-a vis socio-economic sector in FCT, Nigeria.
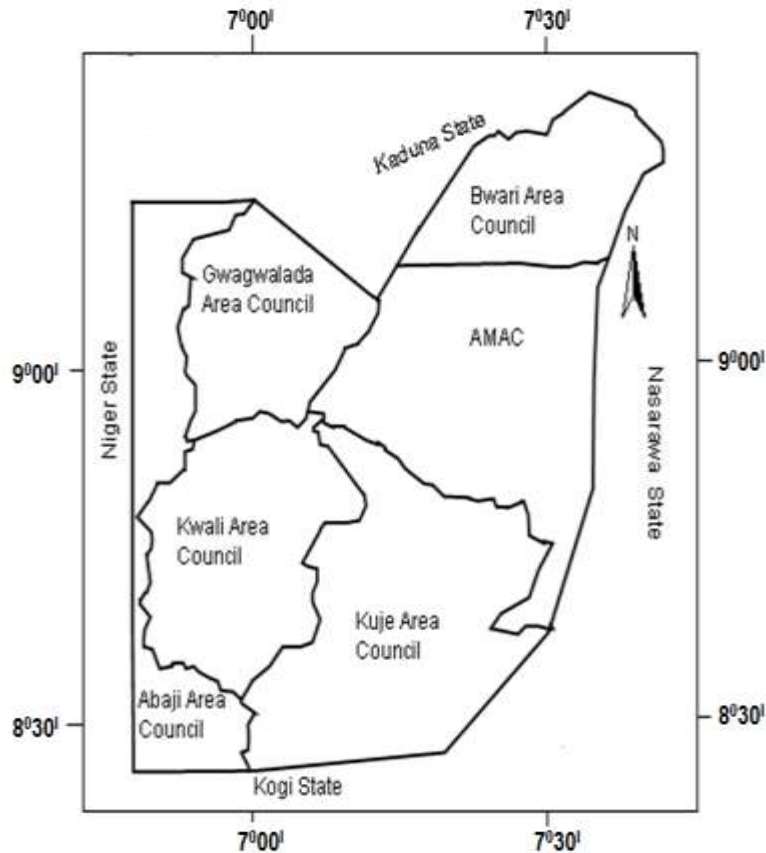
METHDOLOGY

The Study Area

The Federal Capital of Nigeria is located in the northern part of confluence of Rivers Niger and Benue. It is bordered in the West and North by Niger State; bordered in North-East by Kaduna State; Nasarawa State in the East and Kogi State in the South-West. Federal Capital Territory occupies a land area of about 7,315 SqKms.

It is located between latitude 8^0 30' and $9^0$00' north of the equator and longitudes $7^0$00' and $7^0$30' east of Greenwich Meriden. According to United Nation Fund for Population Activities-UNFPA (2015), FCT is estimated to have a population of 3,324,000people.

Figure 1: Map of Federal Capital Territory, Nigeria

The Data and Sampling

The data used in this study were obtained from primary and secondary sources. The secondary source included National Population Commission (NPC) publications and maps while the primary sources were questionnaire and interview. In obtaining relevant data for the study, multi-stage sampling technique was adopted.

Multi-stage sampling method has the advantage of reducing travelling time for discussions, which eventually reduces the cost of survey (Okoko, 2000). Three stage sampling method is adopted in the selection of household. The first stage of the method is the identification of wards from each local area councils (Table 1).

Table 1: Local Area Councils and Wards in Federal Capital Territory

Local Area Council	Wards	Local Area Council	Wards	Local Area Council	Wards
Kuje	i. Kuje Central ii. Chibiri iii. Gaube iv. Kabivi. v.. Kwaku vi. Rubochi vii. Gwagwalada viii. Gudun Karya ix. Kujekwe x..Yenche	Kwali .	i. Pai ii. Kilankwa iii. Kundu iv. Kwali Central v. Wako vi. Yabu vii. Dafpa viii. Yangoji ix. Ashara x. Gunbwo	Gwagwalada	i. Paiko-Kore ii. Ibwa iii. Dobi iv. Ikwa v. Tunga-Maje vi. Gwako vii. Quarters(Phasei,ii&iii) viii .Kutunku ix .Zuba x. Dagiri
Abaji	i. Agyana/Padangi ii. Gawu iii. Rimba/Ebagi iv. Nukun/sabongari v. Alu/Mawopi vi. Yaba vii. Gurdi viii. Abaji Central ix.Abaji North-East x. Abaji South-East	Bwari	i. Shere ii. Igu iii. Kawu iv. Ushafa v.Usuma vi.Kubwa vii.Byazhi viii.Bwari Central ix.Kuduru x.Dutse	AMAC	i. City Center ii. Garki iii. Wuse iv. Kabusa v. Kuyi vi. Gwarinpa vii. Karu viii. Orozo ix. Nyanya x. Gwagwa xi. Jiwa xii. Karsi

The second stage in the sampling process involves, picking of 10.0% of all the settlements in each area council, constituting the sampled settlements, in conformity with principle of Probability Proportional to Size (PPS); this permits the use of uniform sample size, particularly in a situation where there is variation in the number of settlements per ward, in order to ensure proportional coverage of the study area (Turner, 2003). The uniformity in the choice of 10.0% is as a result of variation in the number of settlements per ward and as to ensure total and proportionate coverage of the study area (Table 2).

Table 2: Sampled households and Distribution of Questionnaire in the Study Area

Local Area Council	No. of Settlements	Sampled Settlements (SS)	Estimated Household= (SS × Mean HH (4.2*)	Number of Questionnaire
Kuje	60	6	25	58
Kwali	60	6	25	58
Gwagwalada	54	6	25	58
Bwari	108	11	46	107
AMAC	40	4	17	40
Abaji	82	8	34	79
TOTAL	404	41	172	400

The third stage is the selection of households purposively in the settlements that make up the study area. Household (HH) is a group of people living together and maintaining unique eating arrangement (NBS, 2010). The respondents (Households) were estimated using National Population Commission (1991) estimated mean household for each settlement in Federal Capital Territory (as at 1991) put at 4.2.

ANALYSIS AND DISCUSSION OF FINDINGS

Socio-Economic Characteristics of Respondents

This part of the study explains the socio-economic characteristics of the respondents in relation to sex, marital status, occupation, educational attainment, religion and income.

Table 3: Distribution of Respondents by Socio-Economic Characteristics

	Frequency	Percentage
Sex	Male(155)	Male (90)
	Female(17)	Female(10)
Marital Status	Married(163)	Married (95)
	Spinster(9)	Spinster (5)
Occupation	Farming(166)	Farming (96.3)
	Civil Service/Others(6)	Civil Service/Others(3.7)
Education	Formal(100)	Formal(85)
	None (72)	None (15)
Religion	Christianity(65)	Christianity(37.5)
	Muslim (56)	Muslim (32.5)
	ATR (51)	ATR (30)
Income	Less N5,000 (86)	Less N5,000 (50)
	N5,000-N10,000(34)	N5,000-N10,000(20)
	N11,000-N16,000(17)	N11,000-N16,000(10)
	N17,000-N22,000(11)	N17,000-N22,000(6.2)
	N23,000-N28,000(19)	N23,000-N28,000(11.3)
	More than N29,000(4)	More than N29,000(2.5)

The profile of respondents in Table 4 shows that, 90.0% are male, while the remaining 10.0% are female. In Africa society, discussions that has to with family lies with heads, who are mostly men. Furthermore, 95.0% of the respondents are married, while 5.0% are spinsters. The married are able to give detail knowledge of what they understand as traditional medicine, and whether it should be encouraged or not. In the same vein, majority of the respondents are

farmers. Farmers constitute 96.3% of the respondents, while civil service and others are 3.7%.The others in this study includes traders, artisans and unemployed. About 85.0 % of the respondents have formal education, and 15.0 % do not have formal education. Lastly, 37.5% and 32.5% of respondents are Christians and Muslims respectively, while African Traditional Religion is 30.0%. Similarly, Table 1 reveals that, 50% of respondents earn less than N5, 000 per month, while 20% earns between N5, 000 and 10,000. In the same vein 10% of respondents earn between N11, 000 and N16, 000 and 6.2% earns between #17,000 and N22, 000 monthly. Suffice to add that 11.3% and 2.5% earn between N23, 000 and N28, 000 respectively. Income is central to the attainment of many things in life including water, house, and health facilities. A person, whose income can afford him/her to access clean water or house, may not go for an unclean water or house. But reverse may be the case with somebody with little or no income. Majority of respondents in the study area earns less than N5, 000 per month from the sales of their farm products. Even in a situation where government fails to supply social amenities, this meager income is not enough to embark on self help project.

Inferential Statistics

In carrying out the inferential analysis of data collected, regression analysis test was used and of form:

$Y = \beta_0 + \beta_1 X_1 + \varepsilon$

Where Y=Dependent Variable

X_1 =Independent Variables

β_0 and β_1 = Coefficients

ε = Error

Table 4: Result of Simple Regression Analysis on Education

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	.694	.204		3.401	.001
	EDUCATION	.777	.045	.705	17.169	.000
a. Dependent Variable: education						

Table 4 shows that, trado-medical practices have influence on education and vice versa; with education at 0.777, this is a positive relationship. This may be linked to the level of formal

education, as it enhances ability to discern between a sound healthy living and productivity, without prejudice to the available medical practices.

Table 5: Result of Simple Regression Analysis on Health Status

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	.118	.196		.598	.550
	HEALTH STATUS	.929	.044	.777	21.301	.000
	a. Dependent Variable: health status					

Table 5 reveals furthermore that trado-medical practices have positive significant effects on health status of the respondents in the study area at .929. Health is one of major indices of measuring development in relation to how productive a people is.

Table 6: Result of Simple Regression Analysis on Productivity

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	-.859	.206		-4.168	.000
	PRODUCTIVITY	1.062	.046	.803	23.237	.000
a. Dependent Variable: productivity						

Similarly, Table 6 has equally shown that trado-medical practices have significant positive effects on the productivity on of respondents in the study area. This is very important as the saying go, health is wealth: thus a healthy society is likely to be productive than the sick one. In an interview, a resource person averred that:

" Trado-medical practices have assisted many to overcome menial health problems in this locality and by extension assisted farming activities of all the places I had the opportunity of traversing in my civil service career" (IDI, Mamagi,Abaji Area Council,2015)

Table 7: Result of Simple Regression Analysis on Income

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	.040	.255		.158	.875
	INCOME	.832	.057	.648	14.699	.000
a. Dependent Variable: income						

Lastly Table 7 shows that trado-medical practices have positive significant effects on the incomes and at .832 at 5% level of significance. The implication is that, low disposable income has forced many to result to trado-medical practitioners in the area.

In an interview with one of the household heads who has traversed the nooks and crannies of FCT, he averred that:-

"The source of income around here is mainly dependent on peasant farming. This highly manifested in the level of development here from all ramifications." (IDI, Naharati, Rimba / Ebagi ward, Abaji LAC, 2015)

Central to the above is that, a well programmed trado-medical practices can add to the well-being of the populace, leading to the opening of these areas with its attendant advantages. The conscious opinion from all the interviews across the study area was echoed by a head of a house, who submitted that:

"Trado-medicine has been part of African medical system since the time immemorial. Thus, there is no known African society, no matter how remote that has not imbibed a practice of African medicine." (IDI, Gwargwada, Rubochi Ward, Kuje Area Council, 2015).

From the foregoing, the potentials in the rural areas can be harnessed using trado-medical practices as a complement of the orthodox medicine.

CONCLUSION AND RECOMMENDATIONS

Majority of people still revert to traditional medicine for their health problems, as the majority, particularly those living in the rural area prefer to solve their health problems consulting traditional healers. A case in mind is traditional birth attendants, whose presence in the rural areas have assisted in delivery of babies. The orthodox medicine has not been able to meet health needs of people, particularly those in the rural areas, partly because of the apathy of the

people and largely because of inadequacy of health facilities.   In the light of this, traditional medicine can serve as an alternative to the orthodox medicine in the face of the above scenario. From the foregoing, it is recommended that:

i. Researches should be encouraged vis-avis on the how best to utilize trado-medicine in the health sector. It has been established that orthodox has its limitation on the cure of certain diseases, but for which the traditional medicine has been found to be useful.

ii. Necessary education on the efficacy of traditional medicine is also imperative. Currently, traditional practitioners are considered to be uneducated, thus not consider relevant in the dispensation of Medicare to humanity. However with education on the positive side of trado-medical practices, health for all can be achieved.

iii. The need for institutionalization of traditional medicine as it with regard to acceptable production standard, their constituent and dosage. There must be political will to formalize the status of traditional medicine.

However, the study has its limitation in the area of household data, which are estimated because no population data in recent time contains such data. It is believed that, as Nigeria progressed, the need for such will be appreciated.

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