GLOBAL PHENOMENON OF HEALTH EQUITY AND INEQUITY: ATTENTION ON NIGERIANS ENVIRONMENT

[1] Okueso Samuel Adesina & [2]Johnson Fejoh
[1]Human Kinetics and Health Education Dept, Olabisi Onabanjo University.

[2]Institute of Education Olabisi Onabanjo University,
Faculty of Education

Abstract
This review examines the significant disparities in global health status, particularly highlighting the pronounced inequities between rural and urban areas in Nigeria, as well as between developed and developing nations of the world. Various factors, including social, economic, cultural, and geographical accessibility, contribute to these disparities. The paper identifies how healthcare resources are predominantly concentrated in urban areas having all the federal medical centres and teaching hospitals in the urban areas, disadvantaging rural and suburban populations in Nigeria. Additionally, the paper addresses the often-overlooked issue of occupational health within the country. To mitigate health inequities and promote health equity, the paper recommends enhancing the quality of Primary Health Care (PHC) to better serve the needs of rural communities in Nigeria.

Key Words: *Health equality, Inequality, Global phenomenon, Nigerians environment*

Introduction

In the year 1978 the World Health Organization (WHO) had a global conference as a result of the understanding of the crisis in the health sector, advancement in the biomedical sciences which led to improved technology in the health sector, especially in area of prompt diagnosis of cases, preventive strategies of various communicable and non-communicable diseases and lastly the improvement in the treatment of diseases through new discoveries. In spite of the aforementioned opportunities, it is obvious that many nations of the world may not be able to afford the cost of these technologies especially, the developing nations will be very far away at meeting the required health targets, considering the existing financial allocation to health care services and consequently, nations of the world cannot afford to provide universal access to many of the modern health technologies now in existence.

WHO consequently set the philosophical basis for the global vision for health development on the basis of fairness and social justice which led to the slogan *Health for All.*The goal set by WHO resolutely instituted the principle that health of the people globally, is the responsibility of the state to make sure that the highest level of health on the basis of available resources is attained through unrestricted access. Therefore national health services must include equity, which involves fairness in resource allocation with meticulous attention to the needs of the people with low socioeconomic status, value for money: which is to cautiously choose cost-effective involvement in effectively managing health services to

the people and with good sense of stewardship, which involves quick response to the needs of the people with utmost transparency to meet the sustainable development goal 3 (Odumosu & Okueso, 2021).

National Health Policy (NHP) of Nigeria

The development of NHP was an initiative of the federal ministry of Health, its agencies, representatives of development partners, the private health sector, civil society organizations, the regulatory bodies, state ministries of health, and the academia was constituted to form the Technical Working Group (TWG) that put in place the NHP. The goal of the 2016 NHP was to strengthen Nigeria's health system, particularly the primary health care (PHC) sub-system, to deliver effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians. There are ten policy thrusts which were derived from National Strategic, Health Development Plan (NSHDP) and the World Health Organization (WHO) health system building blocks which are: governance, health service delivery, health financing, human resource for health, medicines, vaccines, commodities and health technologies, health infrastructure, health information system, health research and development, community ownership/participation, and partnership for Health. In spite of the plan to make health care equitable, the level of inequity remained unimaginable which has caused significant effects on rate of diseases and high rate of vulnerability (Chukwudozie, 2015).

In the 2016 draft of the national health policy (NHP) in Nigeria, the situational analysis revealed that the Nigerian health system is weak and, hence, underperforming across all building blocks of the World Health Organization, that the health system governance is weak. There is inequity in access to services and job opportunities due to variation in socio-economic status and geographical distribution of the citizenry (Fejoh, Okoye and Onanuga, 2019). For instance, the difference in ante-natal, maternal health care, child welfare and other care facilities and access among rural and urban dwellers is very wide as a result of the aforementioned variables (Okueso & Odumosu, 2022). It is a known fact that the prevention and treatment of diseases in Nigeria, occupational diseases inclusive, are issues that have direct bearing with public health (Anuar et al, 2021). This function of public health is primarily predicated upon early detection through various investigations to allow the application of various preventive measures at an affordable cost. The situation can be underpinned on a theoretical model which is; Health Belief Model (HBM), since its application has been made easy for use to handle both communicable and non-communicable diseases and health planning strategies that relates to making health accessible, based on the needs of the individual and communities to achieve the global health needs of every citizen (Rosenstock, 1974). The model was originally built on four perceptive constructs of: perceived susceptibility, perceived severity, perceived benefit and perceived barriers which can be said to relate to several ill-health conditions that are health behaviour related (Okueso et al, 2018; Okueso et al, 2021). Several scholars and researchers of health promotion and health education have applied HBM in solving several public health problems relating to both communicable and non-communicable diseases and sometimes in phenomenon that relates to both situations. Health Belief Model have been

used expansively in establishing the connections existing among health behaviour and health beliefs and also to create a loophole for research interventions (Skinner et al, 2015; Sharma, 2017)

Health equity and inequity

There is no gainsaying that there exists, gross inequity in the health status of the people globally particularly between developed and developing nations of the world and also within countries which is socially, politically and economically unacceptable to global development that is therefore, of common concern to all countries of the world including Nigeria that has a large proportion of her population in the rural areas (WHO, 1978., Pravina, & Muthulakshmi, 2019). Equity in health can be defined simply as fairness and justice which can thus be described as; status of health of families, public and communities, allocation of resources and accessibility to and deployment of available resources. There is health equity when: race, gender class, sexual orientation, gender expression, and other dimensions of individual and group identity no longer determines one's health outcomes, as everyone has what they need to thrive; all people can reach their full health potential and well being and are not disadvantaged by their race, ethnicity, language, disability, gender identity.

The World Health Organization (WHO) has identified the causes of health inequities and provided compelling statistics. In Africa, children from the poorest 20% of households are twice as likely to die before their fifth birthday compared to those from the richest 20%, primarily due to malaria, diarrhea, and other diseases which are highly prevalent and among the main causes of morbidity and death in Nigeria. Additionally, 95% of tuberculosis (TB) deaths occur in the developing world, predominantly affecting young adults that forms the working class supposed to improve the Gross Domestic Product (GDP) of Nigeria. Furthermore, 87% of premature deaths from noncommunicable diseases occur in low-and middle-income countries. The disparity in life expectancy is also unambiguous: the average life expectancy in low-income countries is 62 years, compared to 81 years in high-income countries, reflecting a 19-year difference. Health disparities, such as these, vary widely between countries, with significant differences in life expectancy observed across different regions (WHO, 2023).

On the health status, inequalities reflect inequities in the health care system considering economic accessibility or inaccessibility, political accessibility or inaccessibility, geographical accessibility or inaccessibility and lastly cultural accessibility or inaccessibility especially in developing nations of Africa (Boutayeb, 2021). Variations in health status is strongly predicated upon the distribution of poverty which when alleviated will underpin health promotion. On resource allocation, equity relates to the distribution of health resources to the different divisions of the population; allocation equity means that available resources are shared fairly. On access and utilization, equity implies that every member of the population should have equal access to health care without any latent or manifest limitations. Distribution of health centres and other institutions in relation to the population is important, considering how far people have to travel to reach such facilities, health facilities should be near enough to encourage patronage and if reverse becomes the case,

geographical inaccessibility to health ensue and it is part of the component of health inequity which is a common phenomenon among the rural populace in Nigeria.

In many countries of Africa, socioeconomic, geographical, cultural and political factors are important determinants of varied level of disease vulnerability with little or no attention to occupational health matters for instance (Kendall & Zielinski, 1999; Dressler, 2004; Pell et al. 2011; Omoleke, et al. 2018). Socioeconomically, many members of the populace are either not employed or under-employed living with less than a dollar per day and many are not educated to be able to understand those things that can prevent a number of both communicable and non-communicable diseases and develop health promoting behaviour. Geographically, many of the people are not accessible to health care services as both community and referral health services are very far away from them locating them out of their geographical reach. Culturally, there are beliefs and practices 'which should have been demystified with functional health education interventions.' Practices that are inimical to health like; some food fads and fallacies, traditional mental health care procedures, burial practices, traditional maternal and child health principles and traditional hesitation to vaccinations (Umaru, et al, 2013; Sovran, 2013., Kahissay, et al. 2017; Bruns et al. 2020; Kaur, 2020). Political factors are preponderant as it affect vulnerability to ill-health conditions ranging from unequal distribution of health facilities having rural and urban dichotomy as an important variable, accessibility to social infrastructure in the rural area as a mirage with its numerous health consequences like absence of good cold-chain facilities for drug preservation such as vaccines, retaining good medical personals in the rural areas becomes difficult leading to active inaccessibility to good health care services (Shaikh & Hatcher, 2005., Pravina & MuthuLakshmi, 2019).

The situation of increased disease vulnerability in Nigeria has remained unabated for several reasons ranging from; daily decrease in the socioeconomic status which is presently becoming worst as a result of high rate of unemployment, increased number of school dropout, poor per capital income, lack of political will, which relates to dwindling exchange rate of over one thousand Naira to a US Dollar making the purchasing power of an average Nigerian to be very low which further deepens the health inequity parameter in terms of financial accessibility to heath resources. The poor rural agrarian community members of the populace can hardly afford the basic necessity of life such as nourishing food, good housing, and access to health care services is difficult due to increased cost of health care materials like drugs and other medical consumables (Gong et al. 2014; John & Stanley, 2014; Oladigbolu, et al. 2017).

Closing the gap of health inequity and promoting health equity

Optimization of equity and reducing the gap of inequity that is highly desirable in Nigeria, necessitate conscious thought on a great number of concerns that should be addressed: health policy formulation issue which calls for all policy attention both within the health sector and other sectors should be significantly scrutinized such as the macro-economic policy on health should be cautiously evaluated. Pertinent researches should be conducted to bring about macro-economic policies that would not harm the health of vulnerable groups both globally and locally. Also, political obligation on the part of government is a great tool for

upholding equity and reducing inequity in health. Promoting equity is complicated where the political outlook is dominated by free market ideas and market forces. Political commitment is required correct the inequities which is as a result of discrimination on the foundation of race, ethnic group, gender religion with government policies characterized by marginalization of disadvantaged groups like the rural agrarian farmers in Nigeria with low access to basic infrastructural facilities., community involvement is a crucial tool through which equity cam be promoted, therefore health services have to devise strategies for obtaining informed view from all the community members irrespective of the demographic differences (Ndili et all, 2021). Lack of consultation and involvement of all the civil society members will further widen inequity (World Bank Group, 2018., WHO, 2008., Odumosu & Okueso, 2021). Hence, authorities must consult to provide relevant information and make everyone organized to be on the same page for health promotion.

Resource allocation is an important responsibility of government which should take cognizance of fairness and justice without any bias but hinged on the principle of special needs of the disadvantaged group. It is on record that most times, the enthusiastic elite groups have disproportionate shares of scarce resources at the expense of the disadvantaged rural agrarian community members. Data collection is important to monitor performance of health services with equity as the measuring parameter. The instrument for data collection must be designed to adequately consider groups and subgroups which are disadvantaged due to limited access to services by economic, social, geographical and cultural variables. Equity check in health services is very important hence mechanism must be designed to regularly and objectively monitor equity. Health authorities must add to their services sensitive indicators that will periodically remind them of their performance with special reference to equity and access to care.

The World Health Organization (WHO) conference held at Alma Ata in1978 set the philosophical foundation for the global idea of health development on the basis of social justice (Lucas and Gilles, 2003). The historical declaration at the conference established the various health goals till date including the sustainable development goal 3 (SDG3). This firmly established that health care is the responsibility of government to make sure that all the citizens have equal right to highest health care in consonance with the available resources. Preferably, the health care services of every nation should include: fairness in resource allocation taking into cognizance the individual and group needs, selecting and managing resources carefully and efficiently by adopting cost-effective intervention models and identifying the felt needs of the people and responding to them most transparently, prudently and accountably (Hajat et al, 2015; Hufe et al. 2015; Rani, 2017; Roth & Johannes, 2018).

Health state of inequality between the rural poor and the elitist city dwellers can no longer be tolerated; hence, the existing political, social and community variables that tend to allow this inequity must be addressed because it is of great concern to public health and legal practitioners. Equity in health care means justice and fairness which has three varied meanings: health status of families and groups, resource allocation, access to resources and utilization of available resources (Lucas & Gills, 2003, Goldmann & Lakdawalla, 2005., Boutayeb, 2006., Boutayeb & Helmert, 2011).

Health equity can be promoted through the following important issues: political commitment, which is the responsibility of government to promote health equity. It is difficult in Nigeria because the political stance is dominated by free market idea and it is capitalistic in nature, it is important to note that political commitment is required to correct the inequities that results from discrimination on the basis of gender, ethnic, race, and other demographic variables and also policies that marginalize disadvantaged groups like the rural agrarian dwellers and when the law fails to take cognizance of these variables, the level of vulnerability of the disadvantaged group members will be high which can be reduced through good legal framework and legislation (Piketty, 2018)., policy formulation within the health sector should be critically scrutinized on its effect on health equity to reduce the incidence of high vulnerability by the rural poor and this can be achieved by legal input for peace and justice (Kanbur & Adam, 2014., Hughes et al, 2019., (Ndili *et all,* 2021) resource allocation, the government should allocate financial resources fairly evenly to the whole population irrespective of geopolitical variability but should be based on the needs of the people especially the most vulnerable groups identifying their felt needs. Intersectoral action, this can best be utilized for equity by enacting in the health policy the various integrative policies that will promote health equity within all related health sectors., community involvement is an integral part of the process of health policy formulation that will promote equity, the needs of every individual community members should be put into consideration before anything and if this is not considered, the administrators/implementer of policies may be working at variance with the need of the people which will further complicate issues of vulnerability (Donatti et al, 2018., Diffenbaugh & Marshall, 2019). And also, to monitor equity, for good evaluation of all health activities, it is meant to identify the area of strength and weaknesses in order to move in line with various emerging issues from time-to-time. To make equity possible and effective, there should be a well-defined framework through which the health policy implementation can be monitored.

The information provided by the tables 1and 2 is to further reveal and inform that health inequity in Nigeria is of great concern as almost all the referral teaching hospitals and specialist hospitals are geographically inaccessible to the rural community members as all of them are located in the state capitals and major cities of the country.

Table 1: List of all Teaching Hospitals (Federal, State and Private) in Nigeria

Name of Hospital	Ownership	Location	State
North East (3)			
University of Maiduguri Teaching Hospital	Federal	Maiduguri	Borno
Abubakar Tafawa Balewa University Teaching Hospital	Federal	Bauchi	Bauchi
Federal Teaching Hospital	Federal	Gombe	Gombe
North West (3)			
Aminu Kano University Teaching Hospital	Federal	Kano	Kano

Ahmadu Bello University Teaching Hospital	Federal	Zaria	Kaduna
Usman Dan Fodio University Teaching Hospital	Federal	Sokoto	Sokoto
North Central (6)			
Jos University Teaching Hospital	Federal	Jos	Plateau
University of Ilorin Teaching Hospital	Federal	Ilorin	Kwara
University of Abuja Teaching Hospital	Federal	Gwagwalada	FCT
National Hospital	Federal	Abuja	FCT
Benue State University Teaching Hospital	State	Markudi	Benue
Bingham University Teaching Hospital	Private	Jos	Plateau
South West (10)			
Lagos University Teaching Hospital	Federal	Idi Araba	Lagos
Lagos State University Teaching Hospital	State	Ikeja	Lagos
Olabisi Onabanjo University Teaching Hospital	State	Sagamu	Ogun
Ladoke Akintola University of Technology Teaching Hospital	State	Osogbo/Ogbomoso	Oyo/Osun
University College Hospital	Federal	Ibadan	Oyo
Obafemi Awolowo University Teaching Hospital	Federal	Ile-Ife	Osun
Federal Teaching Hospital	Federal	Ido-Ekiti	Ekiti
Afe Babalola University (ABUAD) Multi-System Hospital	Private	Ado-Ekiti	Ekiti
Ekiti State University Teaching Hospital	State	Ado-Ekiti	Ekiti
Babcock University Teaching Hospital	Private	Ilishan-Remo	Ogun
South East (8)			
Abia State University Teaching Hospital	State	Aba	Abia
Nnamdi Azikiwe University Teaching Hospital	Federal	Nnewi	Anambra
Alex Ekweme Federal University Teaching Hospital	Federal	Abakaliki	Ebonyi
Ebonyi State University Teaching Hospital	State	Abakaliki	Ebonyi

University of Nigeria Teaching Hospital	Federal	Ituku-Ozalla	Enugu
Imo State University Teaching Hospital	State	Orlu	Imo
Anambra State University Teaching Hospital	State	Amaku Awka	Anambra
Madonna University Teaching Hospital	Private	Elele	Rivers
South South (8)			
University of Uyo Teaching Hospital	Federal	Uyo	Akwa Ibom
University of Calabar Teaching Hospital	Federal	Calabar	Cross River
University of Benin Teaching Hospital	Federal	Benin City	Edo
University of Port Harcourt Teaching Hospital	Federal	Port Harcourt	Rivers
Delta State University Teaching Hospital	State	Oghara	Delta
Niger Delta University Teaching Hospital	Federal	Okolobiri	Bayelsa
Igbinedion University Teaching Hospital	Private	Okada	Edo
Irrua Specialist Teaching Hospital	Federal	Irrua	Edo

Source: data collected by authors

The table 1 is the list of teaching hospitals in Nigeria with their locations in the various state of the federation. It can be concluded that all the hospitals are far from the rural populace which limits accessibility to referral health services without access to functional ambulance services as it is in the developed nations of the world.

Table 2: List of all Federal Government Owned Hospitals and Medical Centres in Nigeria

Name of Hospital	Location	State
Federal Medical Centre	Abeokuta	Ogun
Federal Medical Centre	Asaba	Delta
Federal Medical Centre	Azare	Bauchi
Federal Medical Centre	Bida	Niger
Federal Medical Centre	Birnin Kebbi	Kebbi
Federal Medical Centre	Birnin Kudu	Jigawa
Federal Medical Centre	Ebutte-Metta	Lagos
Federal Medical Centre	Gombe	Gombe

Federal Medical Centre	Gusau	Zamfara
Federal Medical Centre	Ido-Ekiti	Ekiti
Federal Medical Centre	Jalingo	Taraba
Federal Medical Centre	Katsina	Katsina
Federal Medical Centre	Keffi	Nassarawa
Federal Medical Centre	Lokoja	Kogi
Federal Medical Centre	Makurdi	Benue
Federal Medical Centre	Nguru	Yobe
Federal Medical Centre	Owerri	Imo
Federal Medical Centre	Owo	Ondo
Federal Medical Centre	Umuahia	Abia
Federal Medical Centre	Yenogoa	Bayelsa
Federal Medical Centre	Yola	Adamawa
Federal Medical Centre	Abakaliki	Ebonyi
Federal Staff Hospital	Jabi	FCT

Source: data collected by authors

The information provided in Table 2 further corroborates the fact that the referral hospitals are far from the rural areas which further inhibits access to health care hence promoting health inequity geographically and technologically malfunctioning.

Local Government Primary Health Care (PHC) Centres in Nigeria

The Nigeria Health Sector: Market Study Report, commissioned by the Embassy of the Kingdom of the Netherlands and organized by Pharm Access Foundation's Office, revealed that there are 34,076 Primary Health Centres (PHCs) in Nigeria, constituting 85.3 percent of the country's total hospitals. Unfortunately, the report highlights that only 20 percent of these PHCs are functional. Many of these centres lack the capacity to provide the essential healthcare services they were established to deliver. Challenges such as poor staffing, inadequate equipment, deteriorating infrastructure, and shortages of essential drugs hinder their optimal functioning. Additionally, the local government PHC centres, intended to serve rural communities, suffer from poor funding, further exacerbating health inaccessibility in Nigeria (Ibeh, 2023).

Conclusion

It is pertinent to conclude that health inequity is a common phenomenon that has been globally recognized, and efforts are geared towards reducing it, especially in the advanced countries of the world to improve equity as proposed by the World Health Organisation. Alas, the phenomenon of health inequity remained unabated in African countries with special reference to Nigeria where some limiting factors to health equity remained unabated considering socioeconomic, political and cultural and geographical variables among others. It is therefore recommended that rural community members should be given special preference in terms of billing when referred to specialists and teaching hospitals for further health management when necessary. The PHC centres should be better equipped by the

local government where both human and material resources needed are adequately provided and lastly, advocacy through health education should be improved upon for the rural poor agrarian community members for improve access to health care by having the required knowledge needed.

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