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DIRECT AND INDIRECT COSTS OF STRUCTURAL OPPRESSION IN PRIMARY HEALTH CARE DELIVERY SYSTEMS: ETHNOGRAPHY OF HEALTH CARE PROVISIONING IN AGADAMA, DELTA STATE, NIGERIA

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ABSTRACT

Globally, all oppressed people suffer some inhibitions to their ability to optimally develop and exercise their capacities and express their needs, thoughts, and feelings and one of such inhibitions is limited access to primary health care (PHC). In Africa, particularly in Nigeria, certain structurally oppressive factors limit access to quality healthcare in some water-logged rural communities like Agadama in the Oil-rich Niger-Delta region. In this paper, structural oppression (SO) refers to systemic constraints on groups or individuals and its causes, embedded in unquestioned norms, habits, and symbols, in the assumptions underlying health institutional rules, cultural beliefs, and the collective consequences of following those rules. SO comes with direct and indirect costs on the people, society, and government. Through a qualitative ethnographic approach, this study employed 34 in-depth interviews, 6 key informant interviews and participant observation that lasted for over one year, as well as callbacks to elicit data from a rural farming community. Thematic analysis was employed to analyze data collected based on the study objectives. Findings reveal avoidable child and maternal mortality (deaths); traveling long distances in search of a healthcare center, poor health-seeking behavior due to ignorance and poverty. Patent medicine stores/vendors often serve as an intervening factor but results to over-reliance on patent medicine stores for all healthcare needs ranging from surgery, injections, intramuscular/vein drips, stitching of cuts, etc. These and more show overt and covert structural oppression confronting this agrarian water-logged rural community as a result of environmental realities, geographical location, traditional health beliefs/practices, and failure of the government to provide PHC. This paper, therefore, recommends a review of the grass root health care policy to eliminate inequality in healthcare access.

Keywords: *Structural oppression, Agadama, Primary Health Care, Health Beliefs, Direct, and Indirect costs, Systemic constraints and Deprivations*

Introduction

Health systems have a long history in the various locations and societies where human beings are found and this is because humans make conscious efforts to protect themselves from diseases via healthcare systems and practices. Globally, healthcare systems exist in all countries whether developed or developing (Sama & Nguyen, 2008). Hence, the existence of the traditional health care system associated with various cultures of the world. However, with the introduction of modern health care system to diverse societies of the world and in this case-African societies and cultures, existing traditional health care systems became relegated to the background to serve as alternative medicine (Barry, 2006; Clarke, Doel, & Segrott, 2004; Kelner & Wellman, 1997; Engebretson, 2002; Omar, 2008; WHO, 2007; World Health Organization, 2004). Over the years, conscious efforts have continued to be made to ensure organized modern health care system gets to all, through structures concerned with health delivery. Delivering health care to all nooks and crannies, whether rural or urban, remains the bane of healthcare system mostly in developing countries. Efforts to deliver quality healthcare have often been stalled by several factors; one of such factors is structural oppression which inflicts direct and indirect costs, particularly on citizens, residents and even on the government of most developing countries of the world. According to (Yong, 2004) structural oppression refers to systemic constraints on groups and its causes are embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules. This implies that structural oppression has both individual and group/collective consequences. In other words, these constraints may or may not be caused by people alone, but also by clinging to some health beliefs, cultural practices, environmental limitations, scarcity, ignorance or government inability to provide access

to primary health care. Structural oppression is similar to structural violence, a term coined by Johan Galtung and other liberation theologians during the 1960s (Farmer, Nizeye, Stulac, & Keshavjee, 2006). It operates with some covert strategic ambiguity such as corruption (Dumbili & Sofadekan, 2016). It has been described as "economic, political, legal, religious and cultural structures that stops individuals, groups, and societies from reaching their potentials" (Farmer et al., 2006 p.1686). Again, "it is the avoidable impairment of human needs or life which lowers the actual degree to which someone is able to meet their needs below that which is otherwise possible" (Farmer et al., 2006 p.1686). Young, (2004) has captured five 'faces' (types) of oppression namely; marginalization, powerlessness, cultural imperialism, exploitation and violence. People's inability to access healthcare present any of these identified faces of oppression.

In Africa, particularly in Nigeria, structurally oppressed people abound such as the old people, albinos, physically and mentally disabled people, nomads, minority ethnic groups, migrants and rural dwellers. One of the things some structurally oppressed people cannot access in Nigeria is quality health care. In Nigeria, there is a gross failure in the health care system, especially in providing equal distribution of health facilities, infrastructure, drugs, and personnel across the length and breadth of the country, particularly the rural areas (See: Adeyemo, 2005; Omar, 2008). Patent medicine stores and drug vendors found in rural areas often serve as an intervening factor (Brieger, Osamor, & Salami, 2004) but there is a limit to the quality and quantity of healthcare needs they can meet and their activities are not without some consequences. It has been established that these problems are hugely caused by the nature and structure of the health care system and governance (Sama & Nguyen, 2008) but not solely the fault of the government as there are some social, cultural and economic and geographical or environmental factors limiting health care access to some rural populace (Mott, 1978; Murphy & Baba, 1981; Abdulraheem et al., 2012). These factors can also be linked indirectly to the people' health beliefs, environmental conditions, attitudes towards illnesses, ignorance as a result of lack of education, distance to health facilities from rural areas among other factors (Chiwuzie & Okolocha, 2001; El Shiekh et al., 2015; Okonofua, Harris, Odebiyi, & Kane, 1997; Smith, 2004). These impinging health care

delivery problems has continuously led to the series of overlapping generations of reforms which the "worlds health systems has undergone over the years, progressing from the founding National Health Care Systems (NHC) to Social Insurance Schemes (SIS) and later to promotion of Primary Health Care(PHC) as a route to achieving universal coverage" just as seen in the series of reforms in the Nigeria Health Care System (Fmoh & National Health Policy, 2004; Sama and Nguyen, 2008, p. 3).

Following from the above, it is pertinent to state that the goal of attaining quality health at the grassroots in most developing countries like Nigeria is still a mirage. For instance, the expiration date for the vision 'health for all by the year 2000' is over two decades now (Massoud, 2008, p. 17). Nigeria is yet to navigate its bearing towards actualizing this goal even in 2018. This failure in the healthcare sector incurs lots of intractable costs for the nation and particularly her rural citizens. These include increased avoidable morbidity and mortality rates particularly in the medically underserved rural areas, financial wastes and losses in government investments in the health sector among others (Badaki & Akogun, 2001; Ebigbo, Elekwachi, & Nweze, 2014). Agadama, in the oil-rich Niger Delta of Nigeria, remains one of such rural communities which are medically underserved even in the 21st century due to what was observed and termed in this paper as structural oppression. Hence, this study is set to ethnographically examine the situation and quality of grass root health care access in Agadama -a water-logged rural farming community in the Niger-Delta region through the following specific objectives:

- Ethnography of the Nature of Health Care Available in Agadama
- Efforts by Agadama Community to get Access to Primary Health Care
- Direct and Indirect Costs of Structural Oppression in Agadamaa Rural Community in the Oil Rich Area of the Niger Delta, Nigeria.

Structural Oppression and Health Care Provisioning in Nigeria

The healthcare problems in Nigeria has been attributed to several factors namely inadequacies in the health care system (healthcare governance) and the behavior of the ill persons (Alubo, 1985); long years of looting suppressive military dictatorship (1983-1998), intractable corruption and total disregard for the continuously deteriorating public infrastructures and services as observed in the health care system (Hargreaves, 2002; Nnamuchi, 2007). In spite of being the most populous nation in Africa, providing quality health care to its citizenry no matter their environmental conditions (arid, swampy, hilly, rocky, or water-logged) and geographical locations in the country is still a mirage, even after 20 years of experimenting with democracy since 1999. This is a country where 70% of its citizens live below the poverty line in face of abundant economically viable natural resources like Oil (Hargreaves, 2002, p. 2030). Public healthcare systems in Nigeria have deteriorated to the extent that they are no longer used by the elite, who now prefer to seek quality health care in foreign countries (Onyeji, 2017). Poor healthcare infrastructure and services have become the springboard to local and international healthcare tourism among the Nigerian populace. There is the absence of equity in providing and financing health care in Nigeria (Lawanson & Opeloyeru, 2016). The elite including the president of Nigeria seeks for quality health care abroad, while the poor Nigerian masses are left to make do with the few poor health care services/infrastructure (Onyeji, 2017; Oseni, 2015). Even the 'seat of power- *Aso* Rock' clinic lacks basic drugs like paracetamol (Cable, 2017). Therefore, healthcare tourism has become the preferred alternative to local healthcare in Nigeria (See: Omisore & Agbabiaka, (2016), and only the wealthy few can afford. Three factors have been established as determinants of the patronage of medical tourism in Nigeria (Onyeji, 2017) namely the economy, services, and poor health facilities (Omisore & Agbabiaka, 2016).

Sometimes in Nigeria, structural oppression wear an unconscious cloak but inherently remains a conscious strategic plot, which turns out benefiting a few for parochial self-aggrandizement and limiting the majority of the masses. Structural oppression is often manifest in such a way that it indirectly and directly affects and incapacitates 'others' not 'self'. This is why it was conceptualized by Young, (2004) as people reducing other

peoples potential to be fully human or less human. In this case, “others” use the concept of oppression, exploitation, marginalization, and deprivation to describe their condition (Yong, 2004). This raises concerns about equity and equality in accessing basic resources for survival like health care (Aagaard-Hansen & Chaignat, 2010; Lawanson & Opeloyeru, 2016; Odeyemi, 2013). Therefore, for this article, the concept of ‘structural oppression’ refers to the consciously and unconsciously systematically designed ways of inclusion and exclusion by governments, groups, and individuals through appropriate institutions to directly and indirectly inhibit and deprive rights to basic amenities like health care from certain strata/class of citizens in a society. One such institutions of structural oppression in Nigeria is the Ministry of Health. This is due to debilitating years of institutional inefficiency and structural ineptitude. The government of Nigeria through the Ministry of Health has over the years, had well thought out health policies designed to capture the health of all the citizens of the country (Federal Ministry of Health, 2016; Fmoh & National Health Policy, 2004). But reality reveals that the Ministry implicitly and strategically not executed or implemented them (Aderinoye, Ojokheta, & Olojede, 2007; Oyelade, 1979; Yacob-Haliso, 2012). This may be one of the reasons why many rural communities like Agadama in Nigeria find it difficult to access healthcare.

Theoretical Discussions: The Location Theory and the Health Belief Model

This study employed the location theory and the health belief model as explanatory frameworks in analyzing and understanding the strategic oppression of rural communities in Nigeria. First, the location theory emphasizes how economic factors affect the utilization of public facilities. ‘The central point of the theory is the location of welfare (health) services in areas where aggregate transportation costs are minimized (Asakitipi, 2001p. 42).’ The earliest versions of this theory focus on the spatial distribution of economic activities with a focus on transfer costs, and this refers to both transport and inconveniences of transporting one’s self to and from the place where such services are rendered. However, this theory has been employed in recent times to explain other facets of society like health system. This study therefore aimed at ascertaining the availability, accessibility, and affordability of health-care to river-

line/coastal villages/ communities; hence, the usefulness of the location theory in this study. The sitting of hospitals based on the location theory takes into consideration the hospital catchment area, with the aim of reducing transport costs, reducing stress and averting the unnecessary loss of life. The WHO 2004 report on Health services access and utilization pictures the actual situation in Nigeria like this:

> The overall availability, accessibility, quality, and utilization of health services either dropped or did not improve significantly in the past decade. The 1999 NDHS reported that nationally, 53% of the population lives within 1 kilometer of a health center, clinic or hospital, 75% within 5 kilometers and 47% within 15 kilometers. There are however zonal variations. The proportion of households residing within 10 kilometers of a health center, clinic or hospital is 88% in south west, 87% in south east, 82% in the central region, 73% in north east and 67% in north west region. However, the fact that health facilities physically exist, does not translate into functionality. Most of them are poorly equipped and lack essential supplies and qualified staff. In particular, the coverage of critical primary health care interventions such as immunizations, access to safe water and sanitation has dropped and marked inequalities exist between the regions, the rich and the poor, and between rural and urban areas (WHO, 2004).

The above reflects the degree of strategic oppression and poor/inefficient health system governance in Nigeria. It is pertinent to state that even in 2018, there seems to be no significant improvement in health facility access and utilization in Nigeria, due to poor implementation and its inability to capture the health needs of marginalized populations like most rural communities in Nigeria.

On the other hand, due to some behaviours and health beliefs of some of the rural dwellers, which consciously and unconsciously; directly and indirectly exclude them from accessing basic health facilities and care due to preference for the utilization of some autochthonous traditional health remedies, cultural practices and beliefs (Izugbara & Afangideh, 2005; Umeh, Essien, Ezedinachi, & Ross, 2008). Hence, the prevalence of the health belief model as a model for analyzing health-related behaviours (Quah, 1985). The health belief is a model based on the assumption that the people's beliefs and attitude influence their responses to illness and health-seeking behaviour. The model was first propounded by Rosenstock in 1966 (Quah, 1985). The main of the model is how perception and motivation influences action towards an illness or disease. Four generic health beliefs are the fundamental elements of HBM. The first is the

individual's perceived susceptibility to a given illness. The second is the perceived seriousness of the target illness. Thirdly, the benefits that are likely to occur from contact with a health care system. Fourthly, these beliefs are considered to be significant determinants of an individual's readiness, to approach health facilities/services, and subsequently adhere to the prescribed treatment (Asakitipi, 2001.p. 41). Thus, this study is poised to unravel those beliefs among the Agadama people that either encourage or discourage them to approach the modern health-care system, when provided by the government for them. Also, this paper is set to ascertain efforts by the community to stop some direct and indirect structural inhibitions to health care access and identify the direct and indirect consequences of these inhibitions on this rural community in the Niger-Delta region of Nigeria.

Methods of Study

The Agadama community was ethnographically studied in order to have a holistic understanding of health care systems available to them. This paper is a product of one-year total emersion of this researcher into the Agadama community from August 2008 to September 2009 and subsequent callbacks every December from 2012 to 2018 to find out if there is any improvement. This study employed in-depth interviews, key informant interviews and participant observation in the day to day activities of the people. A total of 34 study participants were randomly selected for in-depth interviews after meeting the criteria of being indigenes of Agadama, while six patent medicine store owners were purposively interviewed as key informants on the study interest. These study participants were mostly patients who often visited these patent medicine stores for one treatment or the other. The researcher often positioned herself in the identified patent medicine stores and patients who came for treatment were approached to participate in the study as respondents. After granting oral consent with promise for anonymity, their home addresses were collected after which they were visited for in-depth interviews which lasted between 20-35 minutes. Volumes of ethnographic data collected were analyzed thematically according to the study objectives in order to

enable adequate extrapolations to be made from the commonly shared views of the study participants on the problems of accessing health care in Agadama. This was possible because the interviews were based on the social constructionist perspective (Galbin, 2014) which is hinged on people's shared meanings of their individual and collective experiences as it relates to the nature of health care in Agadama, the costs and their efforts towards improved access to health care. The interviews continued until 'point of saturation' and redundancy was attained (Saunders & Townsend, 2016). They were recorded with a phone memory card and on the field note. The recorded data was later transcribed and transliterated because a few were collected in the Urhobo local language and others were mostly collected in Pidgin English. After the transcription, the data was coded and categorized into three main themes namely nature of health care accessible, efforts by the community to improve access to health care and costs/consequences of accessing health care in Agadama. Findings were presented under these themes with coded sub-themes which were also discussed to highlight cogent issues. The themes and observations were supported by interview extracts where necessary.

Findings

Ethnography of the Nature of Agadama Community Health Care system

Agadama is a coastal community in Uwheru clan, Ughelli-North Local Government Area, located within the oil-rich Niger-Delta region of Delta State in South-south Nigeria. The geographical feature of being located in a swampy terrain makes accessibility and provision of basic resources a huge task. For instance, it was observed that there exist a dearth of basic welfare infrastructural facilities and the most disturbing is the lack of healthcare facilities and adequately trained skilled health professionals. The only presence of government in this rural community is the new road constructed by the Delta State Government- a road that connects Agadama community to a town known as

Bomadi. It was observed that this new road is not without some consequences: For instance, the Agadama rural populace especially children are often run down by speedy cars and this sometimes results to deaths and deformity almost on weekly basis. This researcher witnessed at least two accidents during the period of this study and in-depth interviews revealed previous accidents as pointed out by this participant: **'…the disheartening thing is that, when these accidents occur, there are no health care centers like hospitals in the community to cater such emergencies even though, our children are constantly run down by vehicles on this road but' (Participant 12).** This prompted the researcher to write the community heads asking them to construct bumps (speed-breakers) on the portions of the road within the community so that drivers can slow down when approaching the community. From our findings, previously there were no paved roads in Agadama community and few motor vehicles plied the area, people travelled on foot to their farms or used canoes because of the swampy nature of the community. It is therefore important to understand change historically in order to provide appropriate remedies and health care to a rural community like Agadama.

Observations also show that other basic facilities like electricity that could sustain health centers when provided are also in poor supply. In terms of power supply/ electricity, as at the last research conducted in June 2018, the respondents complained of no power supply to the community since the last one year due to a breakdown of their community's transformer. The pertinent question is how a quality primary health care facility can function effectively to optimum (if and when provided), where there is little or no power supply in a rural community?

Further findings reveal that, since there is no health center in Agadama community, there is also no modern health personnel. The only health personnel seen once in a while in this rural community are the immunization officers who move around with iced vaccines but complained of the need for constant electricity, fridges to cool and store vaccines.

Interventions from Patent Medicine Stores: It was also observed that Agadama has about seven (7) patent medicine/chemists stores owned by private individuals, who are either retired health personnel, graduates from the school of health, persons who acquired drug dispensing skills through apprenticeship among others. Although, about 60% of the study participants assert that government presence was only felt during National Immunization exercises as shown by this participant **'it is only during immunizations that we see government people here and they don't come always. When I gave birth to my first baby, I traveled to Ughelli before I could get her immunized' (Participant 4, 2012)**. The above and other similar responses show there is no government presence at all in terms of healthcare infrastructure. Another study participant said **'The closest health/maternity centers are located at neighbouring communities like Ovwarovwo, Uwheru, Unenurhe, and Evwreni which is over five to ten kilometers away' (Participant 19, 2014).** The people made use of Ughelli General Hospital which is about 45 minutes to one hour drive, (not always) only when a health condition is critical and severe, and in most cases, victims often die before getting to the health facility. A study participant had this to say when queried on how pregnant women get access to maternity care **'my sister there is no maternity for here, na Uwheru we do go and if the matter serious, we travel go Ugheli and some us de die before we reach clinic' (Participant 30, 2012 at Agadama).**

Health Beliefs: The findings also show that the people tend to be attached to the 'presumed efficacy' of their long-held traditional health practices and health care systems and they hold herbalists in high regard. For instance, this researcher witnessed/observed a pathetic case where a little girl had a cut from the farm, the parents preferred to dab her legs with hot water and administer concocted herbs given to her by an herbalist; after which her leg was tied with a dirty rag. Consequently, after a while, the little girl contacted tetanus but was taken to one of the patent medicine stores instead of a hospital. She was administered with tetanus injections but at this time she had already started jerking due to the tetanus infection, the injections seem to be of no positive effect as she kept jerking at every 5minutes. The most pathetic aspect of this

observation was that after each jerk, the little girl asked her parents if she was going to die. On interviewing the father of the girl, I discovered that the parents of the little girl were separated and this had implications on how the health of the girl was handled as shown in his response:

> **My former wife (the girl's mother) packed out of my house and took the two children we had with her. When my daughter had this wound, she didn't inform me until it became very serious. It was when I knew that I brought her to Doctor (Agadama people refer to the owners of patent medicine stores as Doctors and Nurses depending on the gender of the owner-Participant 22, 2014).** When I interviewed the mother of the little girl, she said:
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> **Their father abandoned two children to me and followed another woman. Since, then, I have been the only one taking care of them. I don't have a job. I only do farm work and it is from there I take care of them. When she had this wound, it was little so used hot water and rag on it but instead of healing, it was enlarging. I didn't have money to take her to the General Hospital at Ugheli (Participant 23, 2014).**

Here, financial power, ignorance on how to treat the wounded child and poor timing in terms of determining the right time for a frantic decision about the health of her child cost her a lot. Anyway, the inevitable happened, because the little girl actually died a few days after she was taken to this patent medicine store. Here, healthcare decisions as in when, how and where such healthcare should be approached depends on a lot of factors such as gender (In Agadama men decides), age (children cannot take such decisions and have no economic power to do so, even if they want) and belief/religion (Agadama residents are mostly traditionalists and only resort to modern healthcare when illness is severe). The incidence narrated above is a common phenomenon in Agadama community as revealed by all the owners of the existing seven patent medicine stores who were interviewed. One of the patent medicine stores owners had this to say **'the villagers do not bring their health cases here on time. They will wait**

until it has gotten out of hands' (become very serious) before coming to the chemists. They prefer farm work to their health (Participant 28, 2014)'.

This is true of some rural communities in Nigeria particularly swampy water-logged communities where the terrain is often difficult to access by government health officials. Are we then saying that environmental determinism is one covert factor that conditions access to health care? In some communities in the Niger Delta, one has to travel on a boat for over three hours or more before arriving at these communities. This reflects environmental inhibitions, natural and artificially created impediments limiting access to quality primary health care system in this rural area. It was also observed from our findings that the swampy location of this community also scares health personnel away like immunization officers from the area. Whenever trained health personnel is transferred there, they vehemently refuse to report or prefer to resign and in some other cases they pretend to have assumed duty in the rural area but would never report to duty.

Ignorance/Low Education: over 60% of the Agadama community residents are unschooled farmers who depend solely on the cultivation of potatoes and fishing as a major source of livelihood. The community has only one dilapidated secondary school, one community primary school, and one privately owned nursery and primary school namely:

(i) Izeze Primary School Agadama, founded in 1945.
(ii) Agadama Secondary School, founded in 1980.
(iii) Koja International Nursery and Primary Agadama, schools 1990.

Only a few children are allowed to go to school because children's labour is often needed in the farm, while almost all students abscond from school on Agadama community market days and during the period of harvest. These structural inadequacies leave members of this rural agrarian community totally unformed educationally and health wise. The resultant costs and effects of this is over-reliance on traditional healthcare systems which is obsolete, and on patent medicine stores and herbal vendors. A patent medicine store owner said:

When we prescribe drugs for them, we have to explain with the local language (Urhobo) and describe how many times they need to take them because some of them cannot read. Again, most Agadama people prefer natural herbs to modern drugs. They only come to us when the herbs cannot cure them but you see whenever they make up their minds to come to the chemist, that illness has become chronic and beyond what we can handle (Participant 26, 2012).

The low rate of education, therefore, deprives this community of literate human resource who could write petitions to the Ministry of Health; engage in advocacy for the provision of basic welfare infrastructures and health facilities for the community. This reflects and unravels some indirect costs of structural oppressions on some rural communities in Nigeria.

Efforts by Community to Get Access to Primary Health Care

Findings from the interviews reveal that the community has not made any appreciable effort to get access to quality healthcare and a lot of factors account for this seeming ineptitude on the part of the community. This problem is tackled individually and there are no collective efforts made as at the time of this study. Again, this could be also tied to the low level of education of some of the elders who possess the power to make decisions for the community. This is because about 60% of the Agadama rural dwellers are mostly non-literate farmers who to a large extent do not see reasons why children should abandon farm work to lazy about in a building called the school. The other reason is that the people have a strong attachment to the traditional health care system and thus, believe they have been effective over the years in catering for their health needs. Another thing is that health care provisioning is essentially a political issue. In other words, who gets access to quality health care in terms of availability and affordability is also politically determined. The Agadama community has little or no elected representatives in government as rightly pointed out by this participant:

> **We don't have anybody in government and we have no hospital or health center, the closest health center is at ovwarovwo which is about 5 Kilometers away from Agadama community... That community had it because some persons from the community worked with the past executive chairman of Ughelli North local government area who is from another community known as Uwheru main town- (Participant 16, 2016).**

One of the elders who served as key informant also remarked in this manner: **'…My daughter, we really need a hospital or a health center but there are no moves yet whether at the community or government levels'- (Participant, 2015).**

About 50% of the in-depth interview participants observed that it is only during election campaigns that a few politicians come around promising to provide health center and other amenities like water and power supply if voted into power. All these constitute direct and indirect forms of structural oppression confronting these rural dwellers.

Direct and indirect costs of structural oppression in Agadama

The identified varying forms of structural oppression in this study inevitably come with all kinds of direct and indirect consequences on the people and the government institutions alike. This rural population seems to bear majorly the direct cost of structural oppression, while the government bears the indirect costs. The costs come in forms of loss of lives; a host of these rural dwellers are groping in the darkness of little or no health access due to negligence by health providers (Ministry of Health), farm produce often get wasted due to little or market and lack storage facility. **Participant 5** had this to say: '***our pregnant women suffer most because of the absence of maternity and hospitals in Agadama. Until we take them to neighbouring communities like Uwherene and Uwheru, they may continue to use the services at the chemists' shops'.***

Another respondent opined that:

> **We produce a lot of potatoes and other farms produce in Agadama but only a few traders come from Port-Harcourt and Ughelli to buy from us.**

The farm produces that cannot last until the market day, we throw them away when they get spoilt (Participant 17, 2012).

Again, the findings from the participant observation show that out of the seven patent medicine stores within the community, only one patent medicine store seems more functional and preferred by members of the community. The other six are empty stores with few drugs placed on scanty shelves. One common factor to these patent medicine stores is that they serve as the only source of modern medical care for the Agadama community dwellers. It was observed that all sorts of healthcare activities are rendered by these patent medicine store owners ranging from surgery, injections, intramuscular/vein drips, stitching of cuts, among others. The consequence of this covert health practices in this community is better imagined than experienced.

For instance, a typical incidence witnessed by this researcher while employing participant observation occurred one evening, when one of the patent medicine store owners who practices itinerant drug-hawking from one rural market to another had an accident with his motorbike. On this fateful day, the drug seller had two of his little girls in front of his motor bike, while the drug box was tied at the back of the bike. He unknowing hit a stationary vehicle parked by the side of the road. He died on the spot, one of little girl's skull tore into two; the other little girl had little bruises. Since there are no hospitals in the community; the little girl with a broken skull was rushed (brought) to this most functional patent medicine store in Agadama community. On seeing the severity of the case, the patent medicine store owner administered first aid, used the wrapper (cloth) on her waist to tie the broken skull together and advised the mother of the child to hurry the child to the General Hospital located at the Local Government Headquarters at Ughelli North which is over 45minutes to one hour drive on a private vehicle but can take up to two hours on a commercial vehicle. Again, the reality is that most of these rural residents have little or no private vehicles with which to attend to health emergencies; neither did the government provide any ambulances to rural communities. They have to wait for hours for a public taxi to take them to Ughelli. As usual, the child died on the way before they could get to the General Hospital. The above incidence reveals the extent of avoidable costs of lives, severe deprivations and

structural oppression which most rural residents in Nigeria go through due to poor healthcare governance, delivery, and evaluation.

Discussion

This paper so far describes the absence of basic primary health care in a rural waterlogged community of the Oil-rich Niger-Delta. It observed that the Nigerian PHC system has failed in reaching some of its target populations, particularly rural areas and this stems from a covert strategic oppression, implicitly bedeviling the health sector of Nigeria. It is no gainsaying that Nigeria has continued to grapple with the burden of managing direct and indirect costs incurred due to poor healthcare delivery and governance (Ogbonna, Okafor, Ejim, & Samuel, 2016).

The consequences of innovations in a rural setting were also highlighted, for instance, increased avoidable deaths recorded was due to change (the newly developed road) to which the members of the community have not completely adapted. In this case, modern technology like cars and new roads is changing social life in Agadama community at a faster pace. These innovations require new adaptive strategies which the people yet acquired. It is known that 'rapid change puts social and cultural systems under extreme strains and produces serious health problems' (Kiefer, 2007 p. 15) and in extreme cases death. To understand problems arising from change and developments, one must first have a broad knowledge of the traditional culture, environment, and technology of the rural community concerned.

Also, the intermittent visits of immunization officers in the area puts paid to the news report "that about 66% of Nigerian children escape immunization yearly in Nigeria" (Association of Primary Health Care Agents on African International Television on April 12, 2014). All these are manifest structural oppression inhibiting access to quality health care and other basic facilities to all, particularly rural dwellers in this case study.

Again, traditional and cultural beliefs related to health, influence the people's decisions on 'where, why and when' to approach modern healthcare. This is not surprising as

Kiefer, (2007 p. 14) noted that “the way people understand and deal with their own health and illness problems has a major effect on the kinds of health care they seek. In fact, medical anthropology offers tools for learning people’s health-related perceptions and motivations”. Cost of healthcare resulting from poverty also remains one of the root causes of strict adherence to certain traditional health beliefs and behaviours by rural populace, since quality health care remains unavailable, inaccessible and unaffordable in the area. The poverty cankerworm must, therefore, be addressed as a matter of urgency as it is “your pocket that cures you” (Folley, 2010). Also, there is a need to sensitize the rural populace how best to handle health care needs where it is easily available in rural areas to ameliorate avoidable deaths. The activities of patent medicine stores and drug vendors who via into areas like surgery should be monitored and discouraged.

On the other hand, the rural dwellers, as well as the Nigerian government, share the costs of structural oppression as a result of the inefficiencies in healthcare delivery by the Ministry of Health. One of the areas the government bears these indirect costs of not providing adequate rural health care is in the area of food security (Onyima, 2014; Onyima & Iwuoha, 2015). It is arguable that, apart from importations into Nigeria, cultivation of food majorly rests on rural populations. It is also a fact that a healthy population is equal to a wealthy population. When the rural population is grossly weakened due to improper distribution of quality health care, the outcome, in the long run, is that the government imports more food spends more of its foreign reserves, run the risk of experiencing food crisis, amounting not only to food insecurity but general insecurity. Arguably true also is the fact, rural communities are major suppliers of the food needed not only in urban centers but in all nooks and crannies of Nigeria. The study contends that the crime rate may increase when the people are hungry and unhealthy at the same time. These costs can be ameliorated or totally eliminated through structural reforms in the health sector and for this to be possible the political will to do so is highly needed in order to expunge oppression.

Oppression is, therefore, the second horror of human existence after rape (Yong, 2004). All groups are not oppressed to the same extent or in the ways. It seems rural populations suffer more inhibitions than the urban populace. However, in a more general sense, all oppressed people suffer some inhibitions to their ability to optimally develop and exercise their capacities and express their needs, thoughts and feelings; and in the above sense all oppressed groups face a common condition (Yong, 2004). The term structural oppression/violence is one way of describing any social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in political and economic organizations of our social world; they are violent or oppressive because they cause /deprivation/pains/injury to people (Farmer, et al. 2006). Inhibitions stem from inhumane practices of bureaucratic administration, production, and distribution of consumer goods, education, power supply, and medicine among other necessities (Farmer, 2003; Farmer et al., 2006). These are tied to peoples conscious and unconscious actions which on daily basis keeps maintaining and reproducing oppression but these people believe that they are doing their jobs and do not understand themselves as agents of oppression.

This study established that poor health care delivery remains a structural oppression that immobilizes and diminishes the capacity of this rural agricultural community. It also observes that structural oppression comes with a lot of costs such as avoidable loss of lives, wastages in appropriating government welfare resources among other costs, particularly on the rural dwellers. The far distance needed to be covered before accessing the seeming nearest healthcare facility in the area is a serious issue inhibiting potentials of this rural community in Nigeria. Another inhibiting factor is the water-logged nature of this community and other environmental inhibitions is also an inhibition of accessing health care (Onyima, 2014). A lot of studies attest to the influence of the environment on human life (Coombes & Barber, 2005; Erickson, 1999; Peet, 1985).

This study observed that sometimes, health personnel sent to the rural community bribes the health directors to change their postings to urban areas instead of a rural community (Hargreaves, 2002). This corrupt action continues to perpetuate the covert

oppression of the rural populace in Nigeria from accessing quality health care (Dumbili & Sofadekan, 2016). These issues seem to perpetuate as a result of the low educational status of most of the rural populace. The rhetorical question is what, should be done to alleviate the health problems of environmentally-restricted rural communities in Nigeria? The issue of corruption remains a reality and common practice in most rural waterlogged communities in Nigeria as a result of ineffective, and inefficient monitoring and evaluation systems in the health ministry (Abdulraheem et al., 2012; Ajuwon & Brieger, 2007; Brieger, Ramakrishna, & Adeniyi, 1990).

The next factor is the fact that health is first a political issue (Sama and Nguyen, 2008). The community had few representatives in government and who only return the community during elections in search for votes with humongous promises. These political campaign promises have become a permanent feature of politicians in Nigeria and they are never fulfilled and as such people no longer take political promises serious (Olugbenga & Soremekun, 2014). In addition is, this results to a total absence or low quality of rural/grass root health facilities, services, and personnel, poorly unmonitored primary health care delivery programs like immunization, among others. Sama & Nguyen, (2008) had observed these inadequacies and described Africa as a continent that has grown too used to bearing a heavy burden of preventable health care issues like treatable diseases. There is therefore the need to generally summon the political will to develop rural communities. This is because, who gets what, is politically determined. The Ministry of Health must rise up to its statutory responsibility in order to eradicate inequality in healthcare distribution, policy evaluation and monitoring and ensure implementation. There is also need to provide ambulances to rural communities in order to facilitate quick response to emergencies when needed. In sum, all forms of structural and institutional inefficiency pervading the health care sector and the Ministry of Health must be eliminated to assure equal and equitable access to health for all, particularly rural communities in Nigeria.

Conclusion

This study has so far explored factors such as the rural healthcare delivery inhibited by the nature of the rural environment, health beliefs, distance, cultural practices related to health care, socio-economic status of the rural populace, in Agadama community of Delta State Nigeria. This accounts for a high morbidity and mortality observed in the area. Being an agrarian community, the pertinence of accessing quality health care cannot be overemphasized. It also described how patent medicine stores in rural areas serve as an intervening factor in this rural community but highlighted some consequences due to over-reliance on these drug vendors. The study also discussed the existence of a significant dearth of essential social and economic facilities as well as health infrastructure in Agadama community and how these acts as oppressive structures in the agrarian rural community.

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