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Poverty, Access to Health Care Services and Human Capital Development in Nigeria *(Pp. 41-55)*

Akpomuvie, Orhioghene Benedict – Department of Sociology, Delta State University, P.M.B. 1, Abraka, Delta State, Nigeria
E-mail: bakpomuvie@yahoo.co.uk

Abstract
The paper is aimed at examining the poverty profile of Nigeria and its consequences on access to health care services and human capital development in the country. It is a startling paradox that about two – thirds of Nigerians are poor despite living in a country with vast potential wealth. Apart from looking at the theoretical milieu, the paper also examined the nature and dimensions of poverty in Nigeria. The paper which employed secondary methods of data collection revealed that the achievement of even the modest goal of stopping the traumatic march of poverty has so far eluded Nigeria. It further revealed that health is a major component of a nation's socio-economic development because it is essential for a virile labour force for the creation and maintenance of its wealth. The paper however, recommended comprehensive health sector reform, aimed at strengthening the national health system and enhancing the delivery of effective and affordable health services.

Introduction

In the 60s and 70s, Nigeria's economy was very stable and was hinged on agriculture. Nigeria was the world's largest producer of groundnut, rubber, palm oil and kernel, soya beans, beniseed and also a major producer of cotton, 2nd world producer of cocoa. Solid minerals such as coal, tin and columbite, were mined in economic quantities and Nigeria was known to be a

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major world player in the production of these minerals. The buoyancy of the economy according to Osakwe (2009) was further boosted with the discovery of oil (black gold) and gradually, emphasis shifted from agriculture to petroleum ……. the mainstay of the Nigerian economy.

Nigeria was well served by road, rail, sea and air transport. During this period, there were over 95,000km of tarred roads; over 3,200km of one-metre gauge railway and Nigeria had just two international airports at Kano and Lagos. Both the northern and southern parts of the country attracted significant investments in infrastructural and human capital development and then Nigeria Airways was the pride of West-Africa. Today Osakwe (2009) further contended that Nigeria has traded her dignifying values of diligence, patriotism, high ethical standards, and her abundant natural resources of yesteryears for inglorious habits colloquially referred to as the “Nigerian factor”: the pursuit of injustice, upturned values, endemic corruption and gross misrule. Today Nigeria is fatally sick and poverty ridden from a deliberately self inflicted injury.

Nigeria produces 2 million barrels of oil per day and ranks the sixth largest producer in OPEC. Our proven reserves of oil amount to 32billion barrels enough to last for 37years at the current rate of production. Similarly, our proven natural gas reserves amount to 174 trillion cubic feet while about 20percent of this gas is used to generate electricity; at this rate of production, our gas will last another 110 years (NPC 2004). It is a startling paradox that about two-thirds of the Nigerian people are poor, despite living in a country with vast potential wealth. Although revenues from crude oil have been increasing over the past decades, or people have been falling deeper into poverty (NPC, 2005).

Publications and several studies have provided graphical details of the escalating poverty situation in Nigeria between the period of 1980 and 1996. These reports according to the National Bureau of Statistics (2005) revealed marked deterioration in the quality of life of Nigerians over the years since independence, resulting in the steady increase in the number of Nigerians caught below the poverty line. These reports also revealed that higher concentration of the poor, live in the rural areas and the urban fringes. Poverty statistics showed that poverty level declined from 46.3% in 1985 to 42.7% in 1992, it rose sharply to 65.8% of the population in 1996 (FOS, 1998). However, in absolute terms, the population of the poor Nigerians increased fourfold between 1980 and 1996.

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Further characterization of poverty showed that majority of the poor are resident in the rural areas. In 1980,1985,1992 and 1996, 17.2%, 37.8%, 37.5% and 58.2% were in the urban areas respectively, while the corresponding figures for the rural areas were 28.3%, 51.4%, 46.0% and 68.8%. In Nigeria, poverty is also a rural phenomenon where agricultural activities are concentrated. According to Poverty and Agricultural Sector in Nigeria Report (FOS, 1996), in 1985, 51.4% of the population in the rural areas were poor. It declined to 46.0% in 1992 and thereafter increased to 69.8% in 1996. On the other hand, the proportion of the poor in the urban areas was 37.8% in 1985, 37.5% in 1992 and grew to 58.2% in 1996. According to the Federal Office of Statistics report, poverty situation in Nigeria was worsened by the rapid annual population growth rate with the attendant feminization of gender.

Poverty and access to health care services are major development problems in Africa particularly in Nigeria. Health is central to community well-being as well as to personal welfare. According to Knox (1979), it has a strong influence on peoples earning capacity and productivity; it affects educational performance (and thus determines employment prospects); and it is fundamental to people's ability to enjoy and appreciate all other aspects of life. Health has also been shown to explain in statistical terms at least, a large proportion of the variation between people in their overall happiness or perceived well-being. Reports of studies conducted in Britain, the United States and other Western societies indicate that health and the provision of health care facilities are consistently valued higher than any other aspect of well-being including housing, money income, social status, education, family life and leisure (Abrams, 1976).

The challenges of health care provision in a less developed country such as Nigeria against the background of rapid population growth cannot therefore be under estimated. In Nigeria, as in most less developed countries, the allocation and distribution of health care policies and programmes occupy a major place in the development planning and implementation programmes of the government as it affects human capital development. This according to Onokerhoraye (1997) is especially important at the lower end of the socio-economic scale as well as in the rural areas where personal health can be shown to be an important component in localized cycles of poverty and deprivation. It is obvious from the preceding observations that the allocation of health services should be planned and evaluated in as wide a context as possible, with health services policies being coordinated if not directly linked

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with other policies specifically arrived at improving the socio-economic well-being of backward areas in the rural or urban setting. It is against this background that the paper examines the consequences of poverty on access to health care services and human capital development in Nigeria.

The Concept and Dimensions of Poverty

A search of the relevant literature shows that there is no general consensus on any meaningful definition of poverty. This is because poverty affects many aspects of the human condition including physical, moral and psychological. According to Anyawu (1997) a concise and universally accepted definition of poverty is elusive because different criteria have been used to conceptualize the phenomenon.

However, Central Bank of Nigeria (2002-2003) contends that poverty concerns individual's inability to a cater adequately for the basic needs of food, clothing and shelter. It reflects the inability to meet social and economic obligations; lack of gainful employment, skills, assets and self-esteem. The position of the CBN is anchored on limited access to social and economic infrastructures such as education, health, portable water and sanitation thus limiting the chance of advancing welfare to utmost level of capability.

World Development Report (1990) has also defined poverty, as the inability to attain a minimum standard of living. In addition, the report constructed two indices based on a minimum level of consumption in order to show the practical aspects of the concept. The United Nations has also drawn other indices such as life expectancy, infant mortality rate, primary school enrolment ratios and number of persons per physician.

Sen (1987) defined poverty as the lack of certain capabilities such as being able to participation with dignity in society. Expressed differently, Galbraith (1969) stressed that people are poverty stricken when their incomes, even if adequate for survival, fall radically behind that of the community … they are degraded, for in the literal sense, they live outside the grades or categories which the community regards as acceptable.

Poverty may be categorized along five dimensions of deprivation:

- personal and physical deprivation: deprivation can be experienced in health, nutrition, literacy, educational disability and lack of self-confidence.

- economic deprivation: these include lack of access to property, income, assets, factors of production and finance. One of the most vital and most common manifestations of poverty, is the denial of access to the basic necessities of human existence.
- social deprivation: These involve the barriers to full participation in social, political and economic life. People may be deprived of their human rights because of personal and economic deprivations. Nigeria is a signatory to the 1989 UN convention on the elimination of all forms of discrimination against women, children and adolescents.
- cultural deprivation: People are deprived in terms of values, beliefs, attitudes, knowledge, information and orientation. Consequently, they are not able to take advantage of economic and political opportunities.
- political deprivation: ignorance is a fundamental deterrent to the elimination of poverty because it compliments conditions of exploitation, domination and deprivation. It is the poor w ho lack political voice. Those who are politically deprived occupy lowly positions and are subjected to coercion through physical or economic threat.

Poverty: A Theoretical Note

Just as the definitions of poverty are designed around the causes or visible attributes of poverty, theories are also woven around objects and subjects as well as the nature of the phenomenon. We have the "functionalist theory" which links economic inequality to the division of labour within a community as a function of the role or the job performed by the individual and the attendant reward. Capitalist entrepreneurial theory argue that the crude exploitation of the poor by means of low wages and poor condition of service allows for a possible rise in savings and the aggressive entrepreneurship that gave momentum to the industrial revolution in the developed countries. The resultant inequality in income could result in the prevalence of poverty at the lower end of society where the majority live.

The Individual Attributes Theory holds the view that the poor in the society are responsible for their misfortune. The argument of this theory is that the position of an individual in society's hierarchy of income and wealth is assumed to be determined mainly by that individual's motivation aptitudes and ability. As much as an individual's attributes can contribute to his location in the society's status hierarchy, it is true too, that these attribute

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function only within a structure of possibilities and limits set and defined by forces outside the grip of the individual. As Akeredolu-Ale(1975) rightly noted, these forces are usually determined by the prevailing system of property class relations and power.

The Power Theory of poverty argued rather vigorously that the structure of political power in society determines the extent and distribution of power among the population. From this context, the ruling class, constituted by the few, establishes and legitimizes an exploitive property system, through which it determines the allocation of opportunities, income and health, relying on the use of state power, including the use of oppressive state agents such as the police and the armed forces. Akeredolu-Ale (1975) contended however, that how effectively this exploiting class is able to entrench its agenda depends on the revolutionary consciousness of the subject class, their organizational capacity to resist exploitation and ability to over throw the yoke of an oppressive property system.

The Natural-Circumstantial Theories are generally more concerned with the issue of property. The focus of these theories is the identification of certain important explanatory variables responsible for poverty. Among these are geographical location and the natural endowment of the individual's environment, unemployment, old age and so on. A major advantage of these theories is that they have a more immediate bearing on policy than the other theories. These theories hold that poverty reduction can be attained without substantial changes in the larger economic, social and political environment.

The Importance of Access to Health Care Services, Structure and Components of the Health Care System in Nigeria

As Onokerhoraye (1976a) rightly noted, one of the most significant development problem in Nigeria as in other parts of the developing world is the lack of adequate health facilities in various parts of the country. However, the problem of inadequate health facilities is aggravated by the persistence of regional inequalities in the distribution of the available health institutions. The geographical disparity in the provision of health facilities is most severe between urban and rural areas. Although, the vast proportion of the population of Nigeria still lives in the rural communities, yet in terms of health facilities, these are the most neglected segments of the population. Furthermore, there are intra-rural disparities in the provision of health care facilities in rural communities as functionally much of the available manpower of the existing health services is distributed in the larger villages.

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The frustration with the trickle-down approach to development that infected the major productive sectors in the late 1960s, reached the health field in the early 1970s. Following the lead of rural development, health experts and policy-makers began to argue that the strategy of building from centres of excellence was flawed by its inability to keep pace with population growth and by its unacceptable cost (Golladay, 1980.27). In 1971, the World Health Organization established the Joint Committee on Alternative Approaches to meeting Basic Health Needs of populations in developing countries. This committee examined the obstacles to providing broad access to health care in the developing world and analysed the experiences of all successful attempts to adapt health care to the needs and resources of low-income countries and peoples.

According to the Federal Ministry of Health, in its document, "A Report on the National Health Policy and Strategy" prepared in 1985, the national health care system has three major components which should provide the basis for the future development and expansion of the modern health care system. The three components are the primary, secondary and tertiary health care sub-system. Primary health care is defined by the Federal Ministry of Health as the essential health care made universally accessible to individuals and families in the country by means acceptable to them through their full participation and at a cost that the community and country can afford. It is therefore community-based and closest to the people. Secondary Health Care: according to the Federal Ministry of Health , exists to 'provide specialised services to patients referred from the Primary Health Care level through out-patient and in-patient services at hospital centres for general, medical, surgical and paediatric patients'. It is also expected to provide administrative, training and technical support to and supervision for the subordinate level. While Tertiary Health Care which is at the apex of the national health system consists of highly specialized services which provide care for specific diseases and conditions of specific groups. The institutions which it consists of include teaching hospitals, specialist hospitals and according to the Federal Ministry of Health's document, orthopaedic, eye, psychiatric and paediatric hospitals. These often are centres of high level research, training and the source of provision of specialized services in the clinical, scientific, diagnostic and technological spheres. This level exhibits greater capital and technological intensity than the other levels.

As in other aspects of health statistics in Nigeria, comprehensive and reliable data on health institutions in the country are not available. Generally, there

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are strong indications of under-counting because accurate reporting is not provided by agencies expected to report on various components of the health care system. Furthermore, many private facilities especially those owned by individual health personnel operate without registering with government. Consequently, the available data can only be used to analyse broadly, the relative position of the different levels and types of health care facilities in the country. The latest comprehensive data on health care facilities in Nigeria is provided by the National Bureau of Statistics (2006) relates to 2001-2005 (Table 1 below).

In Nigeria according to the National Bureau of Statistics (2005) very few members of households cared to consult any health provider in a two-week period. Only 7.64 percent made any formal consultation. The responses from those who consulted had some pattern by quintile distribution. The percentage of those consulting increased from the 3.50percent in the first quintile (See Table 2) below.

Health care consultation showed a majority of the people sought the services of modern medicine. In the first quintile 25.56 percent used modern medical services with an increasing trend to 55.96percent for the least poor or the fifth quintile. Although not as prevalent, it is important to note that both the non-poor and the poor patronized the traditional healer: 11,64per cent in the first quintile decreasing to 7.71 per cent in the fifth quintile (See Table 3) below and illnesses suffered in the past one year in Nigeria (Table 4) expressed in(figure 1) below.

The Consequences of Poverty on Access to Health Care Services and Human Capital Development in Nigeria

The social charter refers to the contract between the individual and the government in which the government recognizes the individual's rights and responsibilities and promises to deliver the basic necessities for a decent human existence. These necessities include portable water, food, clothing, shelter, adequate nutrition, basic education, productive assets, security, protection from shocks, risks and health care which is the focus of this section of the paper.

The growing incidence and the dynamics of poverty in Nigeria have stratified and polarized Nigerian society between the haves and the have-nots, between the north and the south, between the educated and the uneducated in terms of their access to the basic things of life which health care is one (NPC, 2005). The challenge is not only to reform the economy in order to boost growth but

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also to empower the people as a means of revitalizing the weakened social pillar. Doing so calls for a human rights approach to development planning, that places people at the centre of development efforts.

Health care is the prevention, treatment and management of illness as well as the preservation of mental and physical well being of man through the services offered by the health workers such as: medical doctors, nurses, paramedic staff etc. According to the World Health Organisation (2000) health care embraces all the goods and services designed to promote health, including preventive, curative and palliative intervention, whether directed to individuals or to populations.

In Public Health Economics, health is treated as a "special good" and its distribution as argued, should not be determined by the levels of the people's income. According to Democrit, writing in the 5th century (see Anand, 2000), "without health, nothing is of any use, not money nor anything else". Some 2000 years later Rene Descartes contended that health is the highest good. In "Discours de la Methode" published in 1637; Decartes noted that "… the preservation of health is … without doubt the first good and foundation of all the other goods of this life".

In realization of its obligations to the people, primary health care is now provided at various levels of government and the community for both the mother and the child. Expectant and nursing mothers are given health education at health centres and clinics. Except in extreme emergency cases, child deliveries now take place in clinics, maternity and health centres. Thus has been largely alleviated, many problems of high maternal mortality which for long had been the bane of motherhood in Nigeria. Apart from health education, basic sanitation measures, immunization against known deadly diseases of childhood and Oral Dehydration Therapy (ORT) is administered nationwide. Immunization on an extended scale began in 1975 in a few states with the assistance of UNICEF and it has since covered the whole federation. The service is available free of charge at health centres, selected dispensaries in rural communities, general hospitals and government epidemiological units. The arrangement has since been followed up with house to house campaigns originally designated as Expanded Programme of Immunization (EPI) (Okunola, 2002).

The fact still remains that the majority of the people cannot afford the cost of health care services because they live below the poverty line. According to the Central Bank of Nigeria (1999) report, life expectancy is a mere 54 years

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and infant mortality (77 per 1000) and maternal mortality (704 per 100,000 live births). Similarly CBN (2005) reported that only about 10% of the population of Nigeria, had access to essential drugs; among children under 5 almost 30% were underweight due to malnutrition and only about half the population h ad access to safe drinking water (40% in rural areas, 80% in urban areas).

In most developed countries of the world, health care is provided to everyone regardless of their ability to pay. This is done to maintain a healthy and virile labour force for efficient productivity. Alternatively, compulsory government funded health insurance scheme with minimal fees are also put in place. Health policies have been formulated in various forms in Nigeria either as part national development plan or specific government decision on health care. For example, the National Health Insurance Scheme of 2006 and the comprehensive Healthcare scheme of 1988 as the key to the attainment of health for all by 2010. This was to address the problem of availability, accessibility, affordability and reliability of health care services particularly at the grassroot. Sadly, these programmes are hardly implemented due to corruption, poor policy formulation, insincerity, mismanagement, bad leadership and inadequate consultation with the people.

Given the endemic nature of poverty, the poor is pushed to scavenging the environment for survival leading to the over exploitation of environmental resources. The resultant environmental degradation is in all ramifications against the spirit of sustainable development and the cause of most diseases. According to the CBN (2005) more than 90% of the rural population depended on forests for livelihood and domestic energy source; rural households spent an average of 1.5hours a day collecting water and fuel wood and some 29% of the population lived at risk from annual floods. In most cases they leave in filthy environments and die of avoidable and curable diseases.

Health is a major component of a nation's socio-economic development. Good health does not only contribute to better quality of life but is also essential for a virile labour force for the creation and maintenance of a nation's wealth. The importance attached to the health of a people and level of economic well being necessitate the commitment of governments worldwide to health care issues. Poverty has an inverse relationship with health and health care. The two socio-economic phenomena are therefore

very crucial determinants of the well being and survival of man in his ecological niche.

Perhaps the best way of appreciating the importance of the problem under investigation, is to place it in the context of the Millennium Development Goals (MDGs) adopted by the United Nations in 2000. According to the United Nations (UN) the "development goals set out in the Milennium Declaration expressed the resolve of the world's political leaders to free their fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to make the right to development a reality for everyone and to free the entire human race from want" (UN, 2002).

Conclusion

The health of individual members of the family is the wealth of the nation as virile and productive labour force will be available for sustainable development. Poverty has robbed the nation of this opportunity of maintaining a healthy population to create wealth because over 70% of the population of Nigeria cannot afford the luxury of health care services. Since poverty has an inverse relationship with health care, the two socio-economic phenomena must be vital in determining the well – being and survival of man in his environment. The health component in any development strategy is to improve the health status of the citizenry in order to maintain a virile labour force for efficient productivity. The strategy emphasizes the strengthening of preventive and curative primary health care services. The initiative should involve comprehensive health sector reform aimed largely at vitalizing the national health system and enhancing the delivery of effective, efficient, good quality and affordable health services to Nigerians.

Table I: Public Health (2001 - 2005)

Description	2001	2002	2003	2004	2005*
Medical Institutions:					
Number of Hospitals	23,601	23,607	23,618	23,641	24,522
Number of Health Centers & Dispensaries	20,570	20,580	20,610	20,653	21,222
Number of Hospital Beds	7,930	72,600	73,230	73,680	85,523
Medical Personnel:					
Number of Physicians	35,215	38,355	40,159	41,935	42,563
Number of Nurses & Midwives	109,790	128,559	136,751	158,920	169,923
Reported Incidents:					
Patients treated in medical institutions	6,635,180	6,713,181	698,712	728,522	734,263
Total births in medical institutions	411,053	422,283	512,871	580,151	620,523
Total deaths in medical institutions	35,822	37,215	41,283	43,674	52,986

Source: Fed. Min. Health, State Statistical Agencies, National Bureau of Statistics.

Table 2: Health Care Consultation by Quintile

	Quintile					Sex		Total
	1	2	3	4	5	Male	Female	
Yes	3.50	5.25	6.98	8.14	12.47	7.3	8.00	7.64
No	96.50	94.75	93.02	91.86	87.53	92.7	92.00	92.36
Total	100	100	100	100	100	100	100	100

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Table 3: Health Care Consultation by Service Provider and by Quintile

	Quintile					Sex		Total
First Consultation	1	2	3	4	5	Male	Female	
Traditional Healer	11.64	10.33	8.61	6.6	7.71	9.35	7.2	8.25
Doctor	25.56	31.79	35.03	43.5	55.96	43.59	44.54	44.08
Dentist	0.2	0.08	0.81	0.62	0.59	0.56	0.53	0.54
Nurse	14.56	15.6	15.92	13.19	11.26	12.78	13.8	13.31
Medical Assistant	20.34	18.99	18.42	15.23	7.51	13.45	13.75	13.6
Midwife	0.87	0.23	0.95	1.37	0.79	0.93	0.85	0.89
Pharmacist	8.42	11.03	12.65	10.35	10.28	10.99	10.34	10.65
Traditional Birth Attendant		0.24	0.45	0.25	0.11	0.1	0.32	0.21
Spiritualist		0.54	0.66	0.39	0.43	0.38	0.5	0.44
Others	18.41	11.17	6.49	8.5	5.37	7.87	8.18	8.03
Total	100	100	100	100	100	100	100	100

Table 4: Type of Illness Suffered in the Past One Year

	Quintile					Sex		
	1	2	3	4	5	Male	Female	Total
Cholera	1.39	1.68	1.5	2.09	1.1	1.64	1.43	1.54
Malaria	48.15	48.06	50.15	51.39	54.59	51.5	50.26	50.89
Typhoid	2.86	2.84	3.27	4.4	5.23	3.8	3.97	3.89
Hypertension	0.25	0.35	0.55	0.77	1.18	0.63	.73	0.68
Common Cold	6.94	7.67	7.02	7.26	6.71	6.69	7.5	7.09
Flu	0.52	0.61	0.74	0.53	0.48	0.55	0.59	0.57
Catarrh	6.2	6.91	6.65	6.14	5.22	6.08	6.22	6.15
Cough	6.43	6.23	6.24	5.91	5.16	5.68	6.16	5.92
T.B.	0.11	0.08	0.07	0.07	0.18	0.11	0.1	0.1
Headache	9.15	9.03	8.63	7.53	6.22	7.53	8.32	7.92
Diabetes	0.16	0.06	0.12	0.15	0.2	0.16	0.12	0.14
Diarrhea	1.47	2.35	2.14	1.63	1.17	1.75	1.67	1.71
None	12.76	10.27	8.47	7.73	6.21	9.26	8.13	8.7
Others	3.6	3.88	4.46	4.4	6.37	4.62	4.79	4.7
Total	100	100	100	100	100	100	100	100

Source;National Bureau of Statistics.

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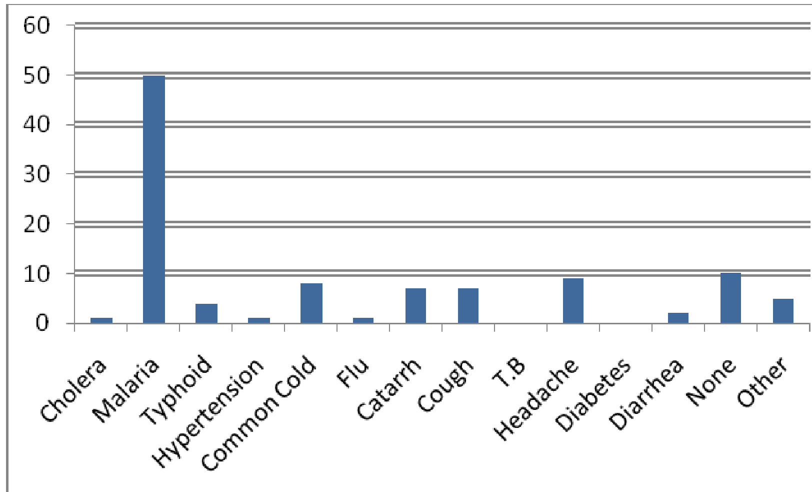
Figure 1: Type of Illness Suffered in the Past One Year in Nigeria Expressed in Graph.



Source;National Bureau of Statistics.

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